Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 27 August 2009 at 1430h

Members

Mrs S Davis	(SD)	[Chair]
Mr R Trotman	(RT)	
Miss I Bartram	(IB)	
Dr S Sahota	(SS)	
Mrs G Hunjan	(GH)	
Prof D Alderson	(DA)	
Miss P Akhtar	(PA)	
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)	
Mr C Holden	(CH)	
Mrs J Kinghorn	(JK)	
Miss J Whalley	(JW)	
Mr J Cash	(JC)	

Secretariat

Miss R Fuller	(RF)	[Secretariat]

Item	Title	Reference No.	Lead
1	**Apologies for absence**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Chair's opening comments**	**Verbal**	**Chair**
4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 30 July 2009 as true and accurate records of discussions*	**SWBTB (7/09) 149**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (7/09) 150 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	MATTERS FOR APPROVAL		
7	**Response to the Healthcare Commission Investigation into Mid Staffordshire NHS Foundation Trust**	**SWBTB (8/09) 164** **SWBTB (8/09) 164 (a)** **SWBTB (8/09) 164 (b)**	**KD**
8	**Policy on the development, approval and management of policies**	**SWBTB (8/09) 158** **SWBTB (8/09) 158 (a)** **SWBTB (8/09) 158 (b)** **SWBTB (8/09) 158 (c)**	**KD**
9	**Whistleblowing policy**	**SWBTB (8/09) 161** **SWBTB (8/09) 161 (a)** **SWBTB (8/09) 161 (b)** **SWBTB (8/09) 161 (c)**	**CH**

MATTERS FOR INFORMATION/NOTING			
10	**Strategy and Development**		
10.1	'Right Care, Right Here' programme: progress update	SWBTB (8/09) 151 SWBTB (8/09) 151 (a) SWBTB (8/09) 151 (b)	RK
10.2	New acute hospital project: progress update	SWBTB (8/09) 159 SWBTB (8/09) 159 (a)	GS
11	**Performance Management**		
11.1	Monthly performance monitoring report	SWBTB (8/09) 163 SWBTB (8/09) 163 (a)	RW
11.2	Monthly finance report	SWBTB (8/09) 152 SWBTB (8/09) 152 a)	RW
11.3	NHS Performance Framework monitoring report	SWBTB (8/09) 165 SWBTB (8/09) 165 (a)	RW
12	**Governance and Operational Management**		
12.1	Corporate planning process and timetable	SWBTB (8/09) 160 SWBTB (8/09) 160 (a)	RK
12.2	Staff engagement update	SWBTB (8/09) 156 SWBTB (8/09) 156 (a)	CH
12.3	Infection control quarterly update	SWBTB (8/09) 162 SWBTB (8/09) 162 (a)	BAO
12.4	Infection Control Assurance Framework	SWBTB (8/09) 155 SWBTB (8/09) 155 (a)	RO
12.5	Cleanliness report	SWBTB (8/09) 154 SWBTB (8/09) 154 (a)	RO
12.6	Safeguarding Steering Group report	SWBTB (8/09) 157 SWBTB (8/09) 157 (a)	RO
13	**Update from the Board Committees**		
13.1	Finance and Performance Management Committee		
▶	Minutes from meeting held 23 July 2009	SWBFC (7/09) 071	RT
13.2	Governance and Risk Management Committee		
▶	Minutes from meeting held 23 July 2009	SWBGR (7/09) 044	IB
14	**Any other business**	**Verbal**	**All**
15	**Details of next meeting** *The next public Trust Board will be held on 24 September 2009 at 1430h in the Anne Gibson Boardroom, City Hospital*	**Verbal**	**Chair**
16	**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 Anne Gibson Boardroom, City Hospital **Date** 30 July 2009 at 1430 hrs

Present:	Mrs Sue Davis	Mr John Adler
	Mr Roger Trotman	Mr Robert White
	Miss Isobel Bartram	Miss Rachel Overfield
	Mrs Gianjeet Hunjan	Mr Donal O'Donoghue
	Dr Sarindar Sahota	
In Attendance:	Mr Colin Holden	Mrs Jessamy Kinghorn
	Mr John Cash [Sandwell LINK]	
Guests:	Mr Matthew Dodd	Mr Rob Banks [Item 10]
Secretariat:	Mr Simon Grainger-Payne	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson, Miss Parveen Akhtar, Mr Richard Kirby, Mr Graham Seager and Miss Kam Dhami.	
2 Declaration of interests	**Verbal**
No declarations of interest were made in connection with any agenda item.	
3 Chair's opening comments	**Verbal**
The Chair advised that approval for the Outline Business Case for the new hospital had been received from the Department of Health and that the Secretary of State would now be asked to approve the initiation of a Compulsory Purchase Order for the acquisition of the land. The Chair suggested that the news will be well received by staff and the local population, particularly amid the current economic downturn. Although absent for the meeting, Mr Seager and team were thanked and congratulated for all the efforts made to secure the approval. Local elected members and the relevant councils, together with the regional minister were also thanked for their support and interest.	

4 Minutes of the previous meeting	**SWBTB (6/09) 127** **SWBTB (6/09) 128**
The minutes of the meeting held on 11 June and 25 June 09 were approved.	
AGREEMENT: The minutes of the previous meeting on 11 June and 25 June 09 were approved as true and accurate reflections of discussions held	
5 Update on actions from previous meetings	**SWBTB (6/09) 127 (a)**
The updated action list was reviewed. There were noted to be no outstanding actions.	
6 Questions from members of the public	**Verbal**
There were no members of the public in attendance at the meeting.	
7 Single tender action – interim care beds scheme	**SWBTB (7/09) 140**
Mr Dodd presented a single tender action arrangement for approval in respect of payment to Carehome Select for the occasional short-term usage of nursing home facilities to enable early discharge of patients awaiting finalisation of their post-discharge package of care. As Carehome Select was reported to be the only local organisation operating this service, the Trust Board ratified the decision to approve the single tender arrangement and raising of a requisition for £100k to cover the payments.	
AGREEMENT: The Trust Board approved the single tender action for payment to Carehome Select	
8 Single tender action – salary recharge for academics from University of Birmingham	**SWBTB (6/09) 114**
Mr White presented a single tender action arrangement for approval in respect of payment of £1,289k for salary recharge costs for clinical academics from University of Birmingham. The individuals hold joint appointments with the Trust, although salaries are met by the University of Birmingham Medical School, for which there is an agreed recharge mechanism. Mr Cash asked to how many individuals these arrangements applied. He was advised that the arrangements apply to approximately seventeen individuals. The Trust Board approved the single tender arrangement.	
AGREEMENT: The Trust Board approved the single tender action for payment of salary recharge for University of Birmingham academics	
9 Learning and Development agreement with the Strategic Health Authority	**SWBTB (7/09) 138** **SWBTB (7/09) 138 (a)** **SWBTB (7/09) 138 (b)**
Mr Holden highlighted that a vital component of any health education and training programme includes the provision of practice placements , which requires a collaborative approach between the Strategic Health Authority (SHA), the Trust and higher education institutions. To formalise this arrangement, a Learning and Development Agreement has been developed by the SHA. The agreement was	

also reported to require that the Trust submits workforce planning data at the appropriate time in order to assist the SHA in commissioning the appropriate number of education places with the various education bodies. Mr Holden advised that the agreement did not change the current arrangements, but practice was formalised by the agreement. Mr Trotman asked whether the Trust would be prevented from receiving the full funding from the SHA if it did not deliver on the arrangements. Mr Holden confirmed that under the terms of the agreement, this was the case. Miss Bartram asked whether the agreement covered physiotherapy students. She was advised that it did and that commissions come from the annual workforce plan. Mr Cash asked what the duration of the agreement was. Mr Holden reported that this was an annual agreement. The Trust Board approved the request for the agreement to be signed by the Chief Executive.	
AGREEMENT: The Trust Board approved the proposal that the Chief Executive should sign the Learning and Development agreement with the Strategic Health Authority	
10 Fire safety management policy	**SWBTB (6/09) 123** **SWBTB (6/09) 123 (a)**
Mr Banks presented the fire safety management policy for ratification, advising that the policy had also been recently reviewed and approved by the Trust Management Board. Mr Banks advised that the changes to the policy were not significant, however the Trust had a legal duty to ensure that an up to date policy covering fire safety is in place. The main change to the policy was reported to concern the training requirements in fire safety. The Chair asked what incidents were responsible for false fire alerts. She was advised that many cases relate to the use of toasters, therefore a confiscation process is in place to reduce the number of unwanted signals. Mrs Hunjan asked after what period were toasters returned to those areas responsible for a false alert. Mr Banks reported that toasters were returned after a month to ensure appropriate arrangements were put in place to prevent any further instances. Mr Trotman asked how the fire safety procedure was locally managed. Mr Banks reported that a fire response team is in place to respond to 2222 calls. Two mock patient evacuations are also conducted on each site per year. Mr Cash remarked that there was an overall need for staff to bear in mind their own safety and asked whether there was a particular general safety issue for front line staff. The Chair advised that any incidents would be reported in an annual Health and safety report. Mr Holden reported that 127 people were assaulted during 2008/09, 75% of which were clinical staff. A quarter of the incidents relate to physical assaults, therefore although it is concerning that staff have been assaulted, this is not a major health and safety issue for the Trust. Mr Grainger-Payne offered to send Mr Cash a copy of the latest health and safety annual report.	

Mr Banks was asked how duplicate 2222 alerts are managed. He advised that a centralised switchboard co-ordinates the alerts. Mr Adler commended Mr Banks and team on the work of the Fire Committee. The Trust Board approved the fire safety management policy.	
ACTION: Mr Grainger-Payne to send a copy of the annual Heath and safety report to Mr Cash	
AGREEMENT: The Trust Board approved the fire safety management policy	
11 Self certification action plan	**SWBTB (7/09) 134** **SWBTB (7/09) 134 (a)**
Mr Grainger-Payne reminded the Board that at the February 'Time Out' session, that it had considered the evidence that would be used to support the self-certification exercise as part of the Foundation Trust application. The exercise required the Trust Board to make a set of statements to assure Monitor that adequate controls were in place to ensure the robust operation of the Trust under Foundation status. As part of the consideration of evidence, a number of actions arose either to address gaps in evidence or as good practice activities to improve the current Board processes. These actions have been collated into a plan and progress against these was reported. The Board noted that the majority of the actions were on track or completed, although a number of the actions were observed to be dependent on further progress with the Foundation Trust application. Mr Adler remarked that the exercise had been very helpful. The Board received and noted progress with the action plan.	
12 Strategy and Development	
12.1 'Right Care Right Here' programme: progress report	**SWBTB (7/09) 137** **SWBTB (7/09) 137 (a)** **SWBTB (7/09) 137 (a)**
The Trust Board was asked to receive and note the latest version of the 'Right Care Right Care' programme progress report. The Board was advised that out of the twelve projects within the programme, the majority were on track, with only three reported as amber due to a slight underperformance on activity.	
12.2 New acute hospital project: progress report	**Verbal**
Mr Adler reported that the most significant development in the new hospital project related to the approval of the Outline Business Case (OBC). Further review of the finances for the project is in hand via the review of the overall 'Right Care, Right Here' programme. The Secretary of State's authority is required to invoke a Compulsory Purchase Order	

and the Board was asked to approve plans for the Project Director to make the necessary arrangements to seek this authority. This approval was given. Ongoing plans for the voluntary acquisition of premises where possible continue to be pursued. The Board was pleased to hear that the 'Right Care, Right Here' partners had restated their commitment to the new hospital plans at a recent meeting and the approval of the OBC had been welcomed. Dr Sahota expressed his congratulations for the OBC approval and remarked that the news will be good for public interest. Mrs Kinghorn reported that many messages of support had already been received from patient representatives.	
AGREEMENT: The Trust Board approved the request for the New Hospital Project Director to seek the Secretary of State's authority to invoke a Compulsory Purchase Order to acquire the land for the new hospital	
13 Performance Management	
13.1 Monthly performance report	**SWBTB (7/09) 135** **SWBTB (7/09) 135 (a)**
Mr White reported that there had been a number of breaches to the two-week waiting time for cancer referrals, all of which are attributable to patients wishing to change their offered appointment. There has been an increase in cancelled operations, to 0.8%, of which the majority are due to operational pressures in general surgery and ophthalmology. In terms of the stroke care target, the Board was advised that the current performance had been discussed at the Trust Management Board and an improvement is anticipated to be seen shortly, when the stroke pathway is revised to ensure that patients are admitted directly to a stroke unit rather than through the Medical/Emergency Assessment Units. There has been good performance in-month against the Accident and Emergency waiting time targets, which remain above 98%. Infection control rates remain within national trajectory and within the local stretch targets. Mr White reported that the Finance and Performance Management Committee had considered an analysis of CQUIN targets. Changes are due to be made to the way in which progress against smoking cessation targets is tracked and reported. Current performance reported relates to the number of patients attending a clinic, whereas the target is number of actual referrals made. Activity was noted to be strong, although this is not necessarily translating into a similar pattern for income due to the increased number of short stay cases and commensurate reduction in longer stay cases. Sickness absence was noted to be below the Trust's target and the number of PDRs undertaken has increased. Mr Trotman reported that the September meeting of the Finance and Performance	

Management Committee will be used to review the theatre utilisation position in detail. Dr Sahota remarked that the declining sickness absence rate was encouraging. Mr Holden advised that there are currently pockets around the Trust where sickness absence needs attention and there may be a rise over the next few months due to the impact of Swine 'Flu. Mr Cash asked to what activity the target regarding inpatient satisfaction survey related. Mr O'Donoghue advised that this target was one of the suite of CQUIN targets agreed with the local PCTs and requires the Trust to undertake more frequent local surveys. Mr Cash asked why there had been an increase in ambulance turnaround times at both sites. Mr Dodd reported that this was reflective of recent operational pressures. Work is underway to address the bottlenecks and to validate to data with ambulance teams. The Chair added that it was important to ensure that the ambulance turnaround data is validated to ensure that an accurate picture of performance is presented.	
13.2 Monthly finance report	**SWBTB (7/09) 131** **SWBTB (7/09) 131 (a)**
Mr White reported that there had been an in-month deficit of £5k against a target surplus of £202k; £207k below plan with significant variation among divisions. During the month, a number of vacancies had been filled, although a commensurate reduction in expenditure associated with bank and agency staff had not been seen. Operating divisions have been asked to prepare rectification plans which will be presented to the next meeting of the Financial Management Board for consideration. Mr Cash asked what the ratio of nurses to managers was currently. Mr White advised that the Trust's management costs are not out of line with expectations and that the definition of management costs is included in the Trust's annual report, with an upper limit of 4% being stipulated; the Trust's declared position is 3.25%. Furthermore, in a recent report on management costs prepared by the SHA, the Trust was ranked 14 out of 17 Trust's for management costs. Mr Adler assured the Board that the year-end surplus target will be met, with corrective measures being taken to achieve this if necessary.	
13.3 Foundation Trust compliance report	**SWBTB (7/09) 132** **SWBTB (7/09) 132 (a)**
Mr White presented the Foundation Trust compliance performance report. The report highlighted that the Trust's governance risk rating has been maintained as green status. Mr Adler suggested that consideration should be given as to whether the NHS performance framework report should be presented to the Trust Board in future, as this was the one against which the Trust was currently being measured.	

13.4 Progress against corporate objectives – Quarter 1	**SWBTB (7/09) 141** **SWBTB (7/09) 141 (a)**
Mr Adler presented the progress against the Trust's corporate objectives, highlighting that the status against many of the objectives was green or amber. Red status was reported against the objective to continue to deliver new hospital project as planned and against the objective to achieve Foundation Trust status. It was suggested that in the light of the recent OBC approval, the red status against the new hospital objective may now be downgraded to amber. In terms of that to achieve Foundation Trust status, it was proposed that it was unlikely that the Trust would meet this objective within the current financial year, however a more detailed consideration would be given in September when the position on the Foundation Trust application was due to be reviewed..	
14 Governance and Operational Management	
14.1 Assurance Framework update – Quarter 1	**SWBTB (7/09) 142** **SWBTB (7/09) 142 (a)**
Mr Grainger-Payne presented the quarterly update on actions taken to address the gaps in control and assurance against the risks to the delivery of the Trust's corporate objectives. The Committee was asked to note that the pre and post mitigation assessment of the risks to the objectives, together with their respective controls and assurances was now included in the Assurance Framework, in line with feedback from various corporate meetings and as a specific recommendation from the Historical Due Diligence audit held in Autumn 2008. The pre mitigation scores were noted to be amber for the majority of the risks, although when treatment plans were applied, the status of the risks reduced to yellow for the majority. The risk status remained red for three objectives, after mitigation: achievement of national targets, which concerns the potential disruption due to Swine 'Flu; the delivery of the new hospital; and the achievement of Core Standards in the light of difficulty with the delivery of single sex accommodation requirements. The Trust Board was advised that the update had been recently reviewed by the Governance and Risk Management Committee.	
14.2 Corporate identity proposals	**SWBTB (7/09) 143** **SWBTB (7/09) 143 (a)**
Mrs Kinghorn presented a range of corporate identity proposals, following recent branding exercises, which had been developed by an in-house team of designers. Examples of other local Trust's corporate identity were reviewed. Mr Trotman suggested that uniformity was needed to create a strong brand, but urged caution to prejudicing the 'Right Care, Right Here' programme identity. Miss Bartram also reinforced the need to ensure that the identity ensures that there is no confusion as to which location the patient is expected to attend. The Chair remarked that work was to be done around branding of the new hospital in due course. The Board and observers were asked to register their preference against a selection	

of branding designs.	
14.3 Nursing midyear update	**SWBTB (7/09) 147** **SWBTB (7/09) 147 (a)** **SWBTB (7/09) 147 (b)**
Miss Overfield presented an update on ward level nursing work, noting that this was the third report received by the Board on such matters. An establishment review has been undertaken for all wards apart from in paediatrics and surgery as these areas were undergoing reconfiguration at the time of the review. All ward managers and matrons were required to present the establishment, after which time the wards were assigned a status according to the position. Green wards are those where budget allocation meets the needs of the ward; amber wards are those where there is sufficient budget but work is needed to review the operation of the ward to improve the efficiency and effective staffing levels; red wards are those where regardless of mechanisms put into place to deploy staff in different ways, there is not sufficient budget to meet the needs of the ward. Miss Overfield assured the Board that despite there being some efficiency and financial concerns, all wards were operating to required safety standards. Action plans have been developed to address areas requiring attention as identified by the review, notably the small number of "red" wards. The Chair asked whether there were any wards identified where allocated budget exceeded the need. Miss Overfield responded that work is underway with the Divisional General Managers to determine if there is any reallocation of budgets that may be undertaken to address the balance between some green and red wards. There is however, to be no further planned investment, apart from in stroke units where additional funding is necessary. Administration support is also being considered, as the current provision of ward clerk services is insufficient. The review also considered the use of bank and agency staff and found that in general adult inpatients wards, the costs for bank and agency staff are in line with budget. Specialist areas were noted to be the areas most heavily reliant on the use of bank and agency staff, therefore the relevant departments are being encouraged to fill substantive vacancies to reduce the need for temporary staff to be used. It is anticipated that the new bank pay rate due to be introduced from September 2009, will assist with managing the costs of these resources. Miss Overfield acknowledged that there will always be a need to use temporary staff on occasion, however this should be within the confines of the budgeted expectation. An analysis of reasons for requesting the use of bank and agency staff is currently underway and may be considered by the Finance and Performance Management Committee. Mr Cash asked which specialities would most rely on bank and agency staff. He was advised that most specialities would have some need for temporary staff, however Accident and Emergency, Critical Care and Midwifery areas would be most likely to need these staff given that workflow through the units was difficult to anticipate. Mr Cash asked whether there was a possibility that permanent staff could be used for this purpose in future. Miss Overfield advised that this was not an efficient use of staff and that a flexible approach to cope with demand in fluctuation caused by sickness for instance, was more favourable. Miss Overfield reported that nursing is due to become a graduate profession, which poses some challenges in view of the current output from schools. Graduates will also command a higher salary, therefore the overall workforce is expected to be more costly in future.	

The Board was advised that the Optimal Wards initiative is a workstream aligned to the 'Listening into Action' programme, which is aimed at ensuring wards work in a cost effective way and that staff and patients are happy within their environment. Much assistance has been provided from the Estates and Facilities divisions to support this work, particularly in terms of the rapid improvement events. The overall philosophy of the Optimal Wards work hinges on the concept that 30% of the time that a ward operates is unproductive, yet this can be reduced when processes encourage smarter working. Measures boards are being introduced to capture and monitor the efficiency of activity. It was noted that the approach only works with strong leadership. Miss Overfield reported that the ward review tool had been revised to be more effective, therefore a comparison between the most recent round of ward reviews and that of previous rounds was not simple, yet comparisons that have been possible have shown an improvement across a number of indicators. An evidence file is now required to demonstrate that a ward is meeting particular standards. Mr Adler highlighted that the ward establishment review was the first of its kind to be undertaken in the Trust and had been performed without the need for any sophisticated tools. The work was noted to link into the mainstream divisional performance reviews. Mrs Hunjan remarked that it was encouraging to note that action plans have been developed for all red status wards. Miss Overfield reported that in connection with the administration review, ward establishments are being considered to determine if administration support can be found within existing establishments to release clinical staff back to clinical duties. A number of ward managers are considering these plans. It was noted that the position against the nutrition standard remains poor, although Miss Overfield stressed that this indicator reflected the poor use of a nutritional assessment tool, rather than suggesting that patients were poorly nourished. Mr Cash asked whether the Trust still operated a red tray policy. Miss Overfield advised that the Trust does operate such a policy, together with a blue beaker policy for patients requiring assistance with drinking.	
14.4 Annual workforce plan	**SWBTB (7/09) 146** **SWBTB (7/09) 146 (a)**
Mr Holden presented the annual workforce plan for receiving and noting, advising that the primary purpose of the plan was to inform the SHA of commissions needed from educational establishments. The plan has been submitted to Sandwell PCT, as the lead commissioner and then onwards to the SHA which looks at commissions holistically. The PCT has commented favourably on the plan and feedback from the SHA is due by mid August. It was noted that this is the first time that workforce planning had been done in this way in the Trust and the SHA's programmes have been used to gain expertise in such planning. In parallel to this is workforce planning for the new hospital is continuing. The Chair asked if the current workforce plan was aligned to the 'Right Care, Right Here' programme. Mr Holden advised that there is a process, albeit embryonic at this stage. Some information will be included within the Right Care, Right Here workforce plan and will also be considered by the clinical workforce planning group.	

Miss Bartram asked how the commissioning processed worked, given that the staff requested are for a time significantly in advance of being needed. Mr Holden advised that the process was a best attempt at mapping out the requirements, although it is acknowledged that the requirements may change as time progresses.	
14.5 National staff survey	**SWBTB (7/09) 133** **SWBTB (7/09) 133 (a)**
Mr Holden presented the outcome of the staff survey which was undertaken in late 2008 and early 2009. The response rate to the survey was excellent at 58% and a good set of results had been obtained. Three issues of concern were raised, one of the most notable being that relating to violence and aggression. A 'Listening into Action' group has now been established to handle this issue. The survey reported an good response relating to completion of PDRs and linkage to Key Skills Frameworks (KSFs). The Vital Signs staff satisfaction score was noted to have risen from 3.35 at the last survey to 3.41, representing a significant improvement in satisfaction and exceeded the target of 3.38. The score remains less than that for other Acute trusts, however so work will be undertaken to ensure a higher score next survey. A 'Listening into Action' event was held at the beginning of May to think through corporate issues and identify those that can be handled quickly. Mr O'Donoghue asked, in terms of the bullying and harassment score, whether the effectiveness of conflict resolution training was a factor. Miss Whalley suggested that this training equips staff to handle harassment and bullying from outside parties, but did not necessarily assist staff in managing these circumstances with peers, managers and other internal staff. Mr Cash noted that a comparison of the performance against the 'worthwhile job and chance to develop' indicator was not included in the report. He was advised that as this is a new indicator, there was not information available against which a comparison could be made. Mr Adler reported that the divisional-specific information had been considered as part of the recent round of divisional reviews.	
14.6 Swine 'Flu update	**SWBTB (7/09) 136** **SWBTB (7/09) 136 (a)**
Mr Dodd presented the latest position regarding the impact of the Swine 'Flu pandemic on the Trust. He advised that there was a peak in cases at the end of May and beginning of June, which impacted on City Hospital mostly. The Accident and Emergency department at City Hospital saw a considerable number of patients, presenting with 'flu-like symptoms, a significant proportion of which were admitted. The number of patients seen has now declined however, with very few individuals presenting in Accident and Emergency. The forecast issues around staff sickness and bed availability did not materialise,	

however management of isolation facilities and standardising communications to staff have needed considerable attention. The clinical attack rate for a second wave of the pandemic has been suggested to be 30%, which is being worked through in terms of staffing requirements and bed capacity. This will be translated into a readiness statement for the September meeting of the Trust Board. Mr O'Donoghue reported that the good planning, proactive communication and staff support had been instrumental in the Trust's successful response to the recent outbreak. Dr Sahota asked whether all groups had been affected as widely as predicted or to the extent expected. He was advised that different groups than expected had been affected. The Chair congratulated Mr Dodd on the effectiveness of the actions taken to handle the Swine 'Flu outbreak**.**	
14.7 Update on maternity services	**Verbal**
Mr Adler reported that the risk mitigation plan developed to address the concerns around maternity services delivered from Sandwell Hospital, had been signed off by the external review group and handed to the standing Clinical Quality Group of Sandwell PCT to monitor. The process to evaluate the need to reconfigure is also progressing well and a shortlist of options is being considered. The local Overview and Scrutiny Committee has been briefed on the potential reconfiguration. The outcome of the work to determine whether there is a need to reconfigure maternity services will be presented to the Trust Board at its September meeting. The draft report from the National Clinical Advisory Service has been received following the recent visit, which has been considering whether there is a case for change.	
15 Update from the Committees	
15.1 Finance and Performance Management	**SWBFC (6/09) 061**
The Board noted the minutes of the Finance and Performance Management Committee meeting held on 18 June 2009.	
15.2 Audit Committee	**SWBAC (5/09) 046** **SWBAC (6/09) 047**
The Board noted the minutes of the Audit Committee meeting held on 7 May and 11 June 2009.	
15.3 Governance and Risk Management Committee	**SWBGR (5/09) 032**
The Board noted the minutes of the Governance and Risk Management Committee meeting held on 21 May 2009.	
15.4 Charitable Funds Committee	**SWBCF (5/09) 010**

The Board noted the minutes of the Charitable Funds Committee meeting held on 7 May 2009.	
16 Any other business	**Verbal**
There was none.	
17 Details of the next meeting	**Verbal**
The next meeting is scheduled for Thursday 27 August 2009 at 14.30pm in the Churchvale/Hollyoak Rooms, Sandwell Hospital.	
18 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1 (2) Public Bodies (Admission to Meeting Act 1960).	

Signed .....

Print.....

Date .....

Next Meeting: 27 August 2009, Churchvale/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

30 July 2009 - City Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Ms I Bartram (IB), Mrs G Hunjan (GH), Mr J Adler (JA), Mr D O'Donoghue (DO), Mr R White (RW), Dr S Sahota (SS), Miss R Overfield (RO)

In Attendance: Mr C Holden (CH), Mrs J Kinghorn (JK), Mr J Cash (JC), Miss J Whalley (JW)

Apologies: Miss P Akhtar (PA), Professor D Alderson (DA), Mr R Kirby (RK), Mr G Seager (GS), Miss K Dhami (KD)

Secretariat: Mr S Grainger-Payne (SPGP)

Last Updated: 20 August 2009

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 085	New acute hospital: progress report	Verbal	30-Apr-09	Present the process for consultation on the name of the new hospital at the next Trust Board meeting	GS	28-May-09	Deferred to a future meeting. Suggest revisiting in September	Review next meeting	24-Sep-09
SWBTBACT. 094	Patient Experience update	Hard copy papers	28-May-09	Present an update on progress against the Patient Experience Action Plan at a future meeting of the Trust Board	RO	24-Sep-09	Next report due at the September meeting	Review next meeting	
SWBTBACT. 098	Delivering single sex accommodation	SWBTB (6/09) 123 SWBTB (6/09) 123 (a)	25-Jun-09	Present an update on delivery of single sex accommodation at the September meetings of the Trust Board and TMB	RK	24-Sep-09	**ACTION NOT YET DUE**	Review next meeting	
SWBTBACT. 099	Single Equality Scheme update	SWBTB (6/09) 126 SWBTB (6/09) 126 (a)	25-Jun-09	Include benchmarked data and contextual information into future versions of the Single Equality Scheme update	RO	24-Sep-09	**ACTION NOT YET DUE**	Review next meeting	
SWBTBACT. 100	Integrated risk and complaints report	SWBTB (6/09) 121 SWBTB (6/09) 121 (a)	25-Jun-09	Provide an analysis of the personal injuries claim position and present at a future meeting of the Trust Board	KD	24-Sep-09	Will be included in the next version of the integrated risk and complaints report	Review next meeting	
SWBTBACT. 084	MRI business case	SWBTB (4/09) 093 SWBTB (4/09) 093 (a)	30-Apr-09	Present a post implementation review of the City Hospital MRI scanner	RK	29-Apr-10	**ACTION NOT YET DUE**	Future	
SWBTBACT. 096	Sustainability	Presentation	25-Jun-09	Present the sustainability strategy at the November meeting of the Trust Board	GS	26-Nov-09	**ACTION NOT YET DUE**	Future	
SWBTBACT. 102	Fire management safety policy	SWBTB (7/09) 130 SWBTB (7/09) 130 (a) SWBTB (7/09) 130 (b) SWBTB (7/09) 130 (c)	30-Jul-09	Send Mr Cash a copy of the annual Health and Safety report	SGP	27-Aug-09	Sent as requested	Completed Since Last Meeting	

Next Meeting: 27 August 2009, Churchvale/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

30 July 2009 - City Hospital

Members: Mrs S Davis (SD), Mr R Trotman (RT), Ms I Bartram (IB), Mrs G Hunjan (GH), Mr J Adler (JA), Mr D O'Donoghue (DO), Mr R White (RW), Dr S Sahota (SS), Miss R Overfield (RO)

In Attendance: Mr C Holden (CH), Mrs J Kinghorn (JK), Mr J Cash (JC), Miss J Whalley (JW)

Apologies: Miss P Akhtar (PA), Professor D Alderson (DA), Mr R Kirby (RK), Mr G Seager (GS), Miss K Dhami (KD)

Secretariat: Mr S Grainger-Payne (SPGP)

Last Updated: 24 July 2009

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAG.100	Minutes of the previous meeting	SWBTB (6/09) 127 SWBTB (6/09) 128	30-Jul-09	The minutes of the previous meetings were approved as a true and accurate record of discussions held
SWBTBAG.101	Single tender action - interim care beds scheme	SWBTB (7/09) 140	30-Jul-09	The Trust Board approved the single tender action for payment to Carehome Select
SWBTBAG.102	Single tender action - salary recharge for University of Birmingham academics	SWBTB (6/09) 114	30-Jul-09	The Trust Board approved the single tender action for payment of salary recharge for University of Birmingham academics
SWBTBAG.103	Learning and Development agreement with the SHA	SWBTB (7/09) 138 SWBTB (7/09) 138 (a) SWBTB (7/09) 138 (b)	30-Jul-09	The Trust Board approved the proposal that the Chief Executive should sign the Leaning and Development agreement with the SHA
SWBTBAG.104	Fire safety management policy	SWBTB (7/09) 130 SWBTB (7/09) 130 (a) SWBTB (7/09) 130 (b) SWBTB (7/09) 130 (c)	30-Jul-09	The Trust Board approved the fire safety management policy
SWBTBAG.105	New Acute Hospital project: progress report	Verbal	30-Jul-09	The Trust Board approved the request for the New Hospital Project Director to seek the Secretary of State's authority to invoke a Compulsory Purchase Order to acquire the land for the new hospital

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Response to the Healthcare Commission Investigation into Mid Staffordshire NHS Foundation Trust
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	27 August 2009

SUMMARY OF KEY POINTS:

This paper summarises the main findings of the Healthcare Commission report into Mid Staffordshire NHS Foundation Trust and includes a brief description of how issues of this nature are managed at Sandwell and West Birmingham Hospitals NHS Trust. Actions required to strengthen existing arrangements are also included.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to NOTE the Trust's position statement against the main findings of the HCC investigation into Mid Staffordshire and to APPROVE the proposed actions.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

Financial		
Business and market share		
Clinical	**X**	
Workforce	**X**	
Environmental		
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:	Policy for the Development, Approval and Management of Policies
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	27 August 2009

SUMMARY OF KEY POINTS:

The Policy for the Development, Approval and Management of Policies is presented for approval.

The key changes to the policy are:

- Revised 'POLICY PROFILE' section (Pages 2 and 21)
- Greater clarity on the process for gaining approval of a policy (Pages 12 - 13)
- Addition of roles and responsibilities of the Trust Secretary and Head of Equality and Diversity (Pages 6 - 7)
- Reinforced requirement for all policies to be subjected to an Initial Equality Impact Assessment and Full Equality Impact Assessment if required (Page 11)
- Additional requirement when submitting for approval, to provide a cover sheet summarising the policy and key areas of change if appropriate (Page 18 - 19)
- Revised implementation plan template (Page 27 - 30)
- Addition of a flowchart to summarise the policy procedures (Page 31)

The Policy has been circulated to 'ALL MAILBOXES' for consultation and comments received have been incorporated into the policy where appropriate.

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 consider and ratify the policy.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	2.1.2 – Policy on procedural documents
Core Standards	
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical		
Workforce	**X**	Policy impacts on all staff with responsibility for the development, approval and management of policies
Environmental		
Legal & Policy		
Equality and Diversity	**X**	All policies are required to undergo an euality impact assessment prior to being submitted for approval. Copies of the EIAs are to be copied to the Head of Equality and Diversity.
Patient Experience		
Communications & Media	**X**	The policy requires all policies to be communicated appropriately using 'Hot Topics', staff communications and Heartbeat (where appropriate)
Risks		Failure to comply with the policy may contribute to a poor assessment against the NHS LA risk management standards which is due in December 2009

PREVIOUS CONSIDERATION:

The policy has been circulated for consultation to ALL MAILBOXES and was approved by the Trust Management Board on 18 August 2009.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

DRAFT

POLICY FOR THE DEVELOPMENT, APPROVAL AND MANAGEMENT OF POLICIES

Reference	SWBH/ORG/011
Category	Organisational
Date Approved	27-08-2009
Date of Next Review	27-08-2011

POLICY PROFILE	
Overview	
Key overall purpose of policy	To provide clarity and consistency to the process of policy production, approval, implementation and review
Principal target audience	All staff responsible for the development, dissemination and control of Trust-wide policies
Application	Staff only
Accountable Executive Director	Director of Governance
Author(s)	Trust Secretary
Impact Assessment	
Resource implications	None specifically
Training implications	None specifically, although support and guidance from the Trust Secretary and Trust Policy Co-ordinator will be required until the enhanced process is fully embedded
Communications implications	All staff are to be made aware of the new template and process leading to presentation of the policy for approval. Staff communications and an article in Heartbeat will be used to ensure all staff are aware of these changes.
Date of initial equality impact assessment	July 2009
Date of full equality impact assessment (if appropriate)	Not required
NHSLA risk management standards/ CQC core standards	CNST General Level 2 – Standard 2.1.2
Consultation and referencing	
Key stakeholders consulted/involved in the development of the policy	Trustwide – policy issued to ALL MAILBOXES for comment
Complementary Trust documents for cross referencing	Clinical guidelines development policy Single Equality Scheme
Approvals and monitoring	
Approving body	Trust Board
Date of implementation	August 2009
Monitoring and audit	Trust Management Board

DOCUMENT CONTROL AND HISTORY				
Version No	**Date Approved**	**Date of Implementation**	**Next Review Date**	**Reason for Change** **e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.**
3	April 2007	April 2007	April 2009	
4	August 2009	August 2009	August 2011	Amended to include new profile, responsibilities of Trust Secretary & Head of E & D and to strengthen the requirement for EIA

Policy for the Development, Approval and Management of Policies

CONTENTS

1. Introduction

1.1 To ensure the Trust provides a robust and clear governance framework within which service delivery can occur, the organisation needs to develop and implement policies that are appropriate and practical. The control of policies is essential in achieving compliance with legislative and governance requirements. The recent changes in equality legislation, especially the Race Relations (Amendment) Act 2000, mean the Trust must take concerted action to identify and eliminate inequality. Developing policies that ensure that all individuals are treated equally is the first step towards delivering health services that are patient focused and effective. In order to achieve this, the Trust is committed to scrutinising the way in which it discharges its functions and develops its policies.

1.2 In addition to the need to identify and eliminate inequality, the control of policies is essential in achieving compliance with corporate and clinical governance standards. Organisations have a statutory duty to have in place appropriate policies to comply with relevant legislation to enable staff to fulfil the requirements of their role safely and competently. In addition, there needs to be an effective process for managing and reviewing policies on a regular basis to ensure they are safe, legal and efficient. The National Health Service Litigation Authority (NHSLA) Risk Management Standards require the Trust to have in place an effective process for the development, approval and management of Trust-wide policies.

1.3 The main purpose of policies is to standardise practice and service delivery to reflect the best available evidence thereby reducing unjustified variations, hence improving quality. Having effective, up to date and easily followed policies minimises risk to patients, employees and the Trust.

2. Objectives

2.1 To provide clarity and consistency to the process of policy production, approval, implementation and review.

2.2 To ensure that staff have access to the most up-to-date versions of Trust-wide policies.

2.3 To ensure that all policies in use are current and relevant and have been reviewed within the last three years.

2.4 To ensure equality assessment is completed and appropriate action taken to ensure the identification and elimination of inequality.

2.5 To ensure that systems exist to monitor the use of and compliance with agreed policies.

2.6 To avoid duplication.

2.7 To establish a corporate format and ensure all policies are of a consistently high standard.

2.8 To develop and maintain a corporate database of policies and relevant information.

2.9 To maintain an archive of past policies for reference and legal requirements.

2.10 To ensure processes are in place to highlight policies due to expire, so that sufficient time is available for review and presentation to appropriate approving bodies

3. Scope

3.1 This policy applies to all staff involved in the development, approval and management of policies.

3.2 This document relates to Trust-wide policies, defined as those impacting on the majority of staff within the Trust. Policies developed at and relevant to divisional, directorate or service level are expected to follow the same format detailed in this document, yet do not need to be presented to the corporate boards for approval. Local arrangements should be made to develop, approve and manage policies in a manner consistent with that for Trust-wide policies. They must be wholly consistent with corporate policies if they address the same or related subject matter.

3.3 The development, format and dissemination of locally produced/adapted clinical guidelines is covered by a separate Trust-wide document entitled 'Clinical Guideline Development Policy' (clin/043)

3.4 Procedures, protocols, guidelines and standards set out a process for enabling staff to comply with a policy. As the various terms are open to different interpretation, the definitions adopted for the purpose of this document are set out below.

4. Definitions

4.1 Policy

A written statement of intent, describing the broad approach or course of action the Trust is taking with a particular issue. Each policy must have a purpose and specific steps (procedures) as to how it is to be accomplished. A policy enables management and staff to make correct decisions and deal effectively and comply with relevant legislation, Trust rules and good working practice. Once implemented policies are mandatory on all staff; failure to comply may result in disciplinary action.

4.2 Procedure

A documented series of related steps designed to accomplish a specific task in a specified chronological order. The procedure will accomplish the goals and directives of a related policy. Procedures included within a policy are mandatory

4.3 Guideline

Tools to close gaps between current practice (and the outcomes associated with current practice) and other alternative practices (and the outcomes associated with those practices). Guidelines are decision tools to help staff make informed decisions by making clear the benefits, harms and costs of different options.

4.4 Protocol

A formal set of procedures to follow in order to achieve a specific course outcome, specifically agreed for designated staff. A protocol sets out a precise sequence of activities to be adhered to.

4.5 Standards

Statements specifying a required level of performance for the purpose of monitoring or auditing

5. Roles and Responsibilities

5.1 Chief Executive

Overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

5.2 Trust Board

a) The Trust Board is responsible for setting the strategic context in which organisational policies are developed and for the formal review and approval of the policies listed in Appendix 1 and those which external agencies require to have Board approval.

b) The Trust Board has delegated powers of policy approval to the Chief Executive, who has chosen to discharge this duty through the following Boards:

- The Trust Management Board
- The Governance Board

5.3 Director of Governance

Oversight and accountability for ensuring that effective arrangements are in place for the development, approval and management of policies.

5.4 Trust Secretary

The Trust Secretary has responsibility for ensuring that effective processes are in place for development, approval and management of policies.

The Trust Secretary will undertake to check that all appropriate documentation is completed adequately and confirming that necessary consultation has been undertaken prior to the policy being presented for approval.

The Trust Secretary will work with the Trust Policy Co-ordinator to ensure that policies are lodged on the Trust intranet and are communicated effectively to the Trust when approved.

5.5 Trust Policy Co-ordinator

a) Ensure that an electronic database of policies is maintained and that documents are readily accessible to all relevant staff.
b) Initiate the review of policies by informing the author of the need six months prior to the review date.
c) Advise authors on the correct format/content of the document.
d) Ensure appropriate systems for dissemination of agreed policies, including within the daily internal staff news issued by the communications department and the 'Hot Topics' briefing programme
e) Administer the approval process in line with this policy.
f) Ensure policies are posted on the Trust's intranet and internet, as appropriate
g) Maintain a central database of all equality impact assessments.
h) Maintain accurate records of approval.
i) Maintain an accurate archive of the previous versions of any revised or reviewed policy.

5.6 Head of Equality and Diversity

The Head of Equality and Diversity will review any equality impact assessments undertaken to confirm that appropriate consideration has been given to potential equality and diversity issues. They will ensure that any full equality impact assessments reporting significant equality and diversity issues are presented to the Service and Policy Assessment Group for review, prior to the policy being presented for approval at the appropriate body.

5.7 Accountable Directors

Executive Directors (referred to as the 'accountable director' hereafter) are responsible for overseeing effective implementation of policies relevant to their areas of responsibility. Draft policies are to be reviewed by the relevant accountable directors, as part of the consultation process, as appropriate, before the presentation for approval to the relevant approving body.

5.8 Policy Author

a) Ensure that policies are implemented appropriately and, where necessary, audits compliance with those documents
b) Monitors progress against the approved implementation action plan
c) Ensure appropriate review of the documents, either in line with the review timescale set at the time of approval or as a result of changes to practice, organisational structure or legislation.

d) Ensure appropriate consultation has taken place with the relevant individuals or groups during the policy development process.
e) Ensure the requirements set out in this policy are followed.
f) Ensure the necessary Equality Impact Assessment is carried out prior to the document entering the approval process and incorporates any necessary amendments to the policy arising from this assessment
g) Provides the Head of Equality and Diversity with a copy of any Equality Impact Assessments undertaken
h) Provides the Trust Policy Co-ordinator with an executive summary of the contents of the policy or a summary of the amendments proposed

5.9 Line Managers

a) Ensure staff are aware of and have access to relevant policies.
b) Work within approved policies.
c) Ensure staff have read and understood the relevant policies and work within them.
d) Ensure systems exist to identify staff training needs on the implementation of policies and take necessary action to address these where necessary.
e) Audit compliance with policies within the service.

5.10 All Staff

Ensure that their practice is in line with current policies in use across the Trust and specific to their work. Information regarding the failure to comply with a policy must be reported to the line manager and the incident reporting system used where appropriate.

6. Organisation of Policies

6.1 The diverse nature of healthcare means there will be a large number of policies in place. Some will apply across the Trust and be relevant to all staff, and others will be specific to certain areas or activities. The Trust has a duty to ensure that staff are aware of and have access to policies relevant to their area of responsibility. Line managers need to ensure that staff are aware of the policies that are relevant to them.

6.2 For ease of reference, policies will be listed and numbered under the following headings (categorisation is for convenience and does not indicate that a policy is applicable only to a particular staff group):

a) Organisational
b) Finance
c) Human Resources & Occupational Health
d) Risk Management
e) Control of Infection
f) Patient Care
g) Nursing
h) Information Management and Technology

6.3 All policies logged on the intranet will be categorised as per 6.2

6.4 The Trust Policy Co-ordinator will maintain an electronic index of Trust policies along with a database that will be developed and maintained to manage the review process. The database will be the central register for all policies in the Trust.

7. New Policy Development

7.1 The need for a policy may be triggered by many things, such as:

- Helping staff
- A change in Law
- New guidelines
- Department of Health directives
- Sandwell and West Birmingham Hospitals NHS Trust directives
- Identification of standards
- New research evidence
- New area of service development
- Partnership working arrangements
- Local needs because of inconsistencies
- As a result of an incident, complaint, disciplinary action or litigation claim
- Changes to buildings or equipment
- Need for systems management

7.2 When a requirement for a new policy is identified, the initiator must, in the first instance, review existing documents to ensure that the issues are not already covered to avoid duplication. The initiator should also consider whether an amendment or addition to an existing policy is more appropriate than a new stand-alone document.

7.3 The need for a new policy to be developed must be brought to the attention of the relevant Accountable Director, who will nominate a 'policy author'.

7.4 The author should register the intent to develop a policy with the Trust Policy Co-ordinator to minimise the risks of duplicated effort.

7.5 At the time of writing, the policy must comply with all relevant and current legal and statutory requirements, NHS policy and guidance and professional guidance.

7.6 All policies must be presented in a standard structure and format (see Section 8).

7.7 In order to ensure documents comply with legislation and do not discriminate on any of the equality and diversity strands (race, gender, disability, sexuality, age, religion and language) all new policies must undergo an Equality Impact Assessment (see Section 9). This process tests the impact of a policy and identifies any possible direct or indirect discrimination. Adjustments should be made to remove or mitigate adverse impacts and, where possible, promote equality. It is the responsibility of both the author and relevant Accountable Director to ensure compliance in this area.

7.8 The policy author will be responsible for ensuring that the relevant committees and groups, service users, carers and Trust solicitors, where necessary, are consulted about the draft policy (see Section 10 below).

7.9 Policies which would impact on the user's contract of employment must be discussed with the Director of Workforce or his/her deputy.

7.10 Implementation issues and training needs must be identified and arranged for each new policy as an integral part of the approval process. Policies will only be approved when accompanied by an implementation plan (see Section 12).

7.11 The language used in policies should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes.

7.12 The names of individuals will not be contained within policies. Individuals with particular responsibilities will be identified by their job title only.

7.13 A flow diagram, outlining the key procedures within the policy should be included where appropriate, as an appendix to the main document. The flow diagram relevant to this specific policy is attached at Appendix 6.

8. Document Format

8.1 A document template has been developed to provide guidance on what should be contained in policies along with some standard clauses that can be used as appropriate (see **Appendix 3**). This template identifies the fields that are mandatory. It also contains the standard 'PROFILE' that is to be applied to Trust policies.

8.2 Below are some specific points regarding policy format.

Electronic format	Microsoft Word
Paper size	A4
Margins	2 cm – top, bottom, left and right
Gutter setting	0 cm
Headers and footers	1.5 cm from the edge
Front cover and page 2	As per template (see Appendix 2)
Body text font	Arial 12 point
Headings font	Arial 14 point
Front page title font	Arial 20 point
Tables and charts	Arial (size as appropriate)
Alignment	Left
Line spacing	Single
Paragraph spacing	One line between paragraphs. Two lines between main sections
Underlining	None (unless for websites)
Trust logo	Title page only

Use of bold	Headings only
Headers and footers	Arial 9 point – must include name of policy (left aligned) and page numbers in the footer
Page numbers	Page x of y (right aligned)

9. Equality Impact Assessment

9.1 Developing policies that ensure individuals are treated equally is the first step towards delivering health services that are patient focussed and effective. This requires the Trust to take action to identify and eliminate inequality. Undertaking an equality impact assessment (EIA) in relation to all policies provides a means of doing this.

9.2 The EIA process has been developed to help promote fair and equal treatment in the delivery of health services. It is intended to enable the Trust to identify and eliminate detrimental treatment caused by the adverse impact of health service policies upon groups and individuals for reasons of race, gender, disability, sexuality, age, religion and language.

9.3 The trust has developed an Equality Impact Assessment Tool. Policy authors should refer to this document which provides guidance on the equality impact process. The tool is available on the Intranet.

9.4 It is the responsibility of the policy author to undertake the initial equality impact assessment by completing a proforma (see Appendix 4) to determine if the proposed policy is relevant to the Trust's General Duty under race, gender and disability equality.

9.5 If it is established that the proposed policy is likely to be relevant to the Trust's legal duties the author should:

a) undertake a full assessment of the impact of the policy and, where appropriate, design monitoring and reporting systems.
b) contact the Head of Equality and Diversity for advice if required.
c) provide the Head of Equality and Diversity with a copy of all Equality Impact Assessments completed prior to presenting the policy for approval.

9.6 A copy of the completed initial Equality Impact Assessment must accompany the policy when it is presented to the relevant body for approval and, where applicable, the outcome of the full impact assessment.

10. Consultation

10.1 Consultation enables interested parties to offer their views on proposed policy. The main purpose of consultation is to improve decision-making, by ensuring that decisions are based on all available evidence, that they take account of the views and experience of those affected by them, that innovative and creative options are considered and that new arrangements are workable.

10.2 All policies should be developed in consultation with their target audience involving appropriate managerial and clinical staff and staff representation.

10.3 The Trust will undertake to develop a mechanism to involve patients and members of the public, where appropriate. This will strengthen stakeholder involvement within the Trust and demonstrate commitment to working with the local community.

10.4 In the case of resources and employment policies, consultation and/or negotiation will take place at the Policy and Procedures Advisory Committee and/or the Joint Consultation and Negotiation Committee. Agreed policies will be presented to the Governance Board, Trust Management Board for final approval and, if required, the Trust Board.

10.5 All consultation will be led by the author and must be completed before the policy begins the approval process.

11. **Approval Process**

11.1 Following the consultation period and ratification by the Accountable Director, the final draft of the policy must be sent to the Trust Secretary who will check that the correct format has been used and the supporting documentation properly completed. If necessary, the author may be required to undertake some further work prior to the commencement of the approval process.

11.2 The following supporting documentation must accompany the draft policy when it is submitted for approval:

- Meeting paper cover sheet (Appendix 2)
- Equality Impact Assessment (Appendix 4)
- Policy Implementation Plan (Appendix 5)

11.3 Following validation, the draft policy and supporting documentation will be added as an agenda item to the matters for approval at the:

- Governance Board - if the policy is relevant to clinical or corporate governance
- Trust Management Board - where there is an operational impact
- Trust Board – if the policy is one of those contained within Appendix 1 or is advised by the policy author that there is an external requirement for the policy to be ratified by the Trust Board

If the policy is both clinically/governance biased and has an operational impact, then the forum at which the policy will be presented will be determined by the Trust Secretary, based on the policy's predominant issue. In exceptional circumstances, the policy will be presented to more than one approving body.

11.4 No policy will become a valid document until the policy has been formally ratified in the appropriate forum.

11.5 The Trust Secretary will provide the Trust Policy Co-ordinator with a copy of the final policy approved by the Board, which includes updates to the 'DOCUMENT HISTORY' to reflect the approval.

11.6 Once approved the document will be allocated a policy number by the Trust Policy Co-ordinator and placed onto the Intranet.

12. Implementation Arrangements

12.1 Implementation issues and training needs must be identified for each new and reviewed policy as an integral part of the approval process. Policies will only be ratified when accompanied by an implementation plan. This will ensure that a systematic approach is taken to the introduction of policies in order to secure effective working practices.

12.2 The template in Appendix 5 provides a checklist to be used as a starting point for developing an implementation plan.

12.3 If there are likely to be resource implications these must be discussed in the early stages of development with the manager or managers who have responsibility for the budget. The funding source required must be identified and secured before the policy is presented to the relevant approvals body. These resource implications and the funding arrangements also need to be highlighted in the 'PROFILE' section of the policy on Page 2.

12.4 If there are significant training implications associated with the introduction of the policy a detailed plan of how this will be provided is also required. The training arrangements must be identified and arranged before the policy is presented to the relevant approvals body. These training implications and arrangements also need to be highlighted in the 'PROFILE' section of the policy on Page 2.

12.5 Policies will only be approved when accompanied by an implementation plan.

12.6 The policy author should indicate in the 'PROFILE' section of the policy on Page 2, where progress against the implementation plan will be monitored.

13. Dissemination Process

13.1 The author has responsibility for overseeing the effective communication of the approved policy to all relevant staff by deploying the most appropriate communication mechanisms.

13.2 The Trust Policy Co-ordinator will extract the contents of the 'SUMMARY OF KEY KEY POINTS' from the meeting cover sheet and send to the communications team to issue within the daily internal news. The same will also be added into the next available 'Hot Topics' briefing material. Information concerning new and revised policies will also be included within Heartbeat where appropriate.

13.3 The Trust Policy Co-ordinator will place policies and equality impact assessments that have been approved on the Trust Intranet, which will be the primary location for all policies. Relevant policies will also be published on the Trust's Internet site. The Trust Policy Co-ordinator will maintain a definitive list of all policies.

13.4 Line managers may, at their own discretion, keep hard copies of policies relevant to their area. However, it is the responsibility of those managers to ensure that the hard copies are the most current ones.

13.5 Individual members of staff have a responsibility to ensure they are familiar with all policies that impinge on their work and should ensure that they are working with the current version of a policy. Therefore, the Intranet should be the first place that staff look for a policy. In the event of any doubt, the member of staff should contact the Trust Policy Co-ordinator to obtain the latest version.

13.6 Line managers are responsible for ensuring that their staff are aware of Trust policies and that they understand and use them. This information must be given to all new staff on induction.

13.7 In addition, line managers are responsible for ensuring that a system is in place for their area of responsibility that keeps staff up to date with new policies and policy changes.

14. Policy Review

14.1 Policies require regular review to take account of changing circumstances. All policies must be subjected to a review three years after approval unless there is a specific requirement for this to be undertaken sooner.

14.2 The review of the policy must commence before the due date. The Trust Policy Co-ordinator will maintain a central register of corporate policies and ensure systematic identification of documents due for review. A reminder will be issued to the author and relevant Accountable Director six months prior to the review date.

14.3 Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance. It is the responsibility of the author to be constantly aware of these influencing factors and to initiate reviews promptly.

14.4 The following applies to reviewed/revised polices:

a) Reviewed policies where no changes have been made may be signed off by the appropriate Accountable Director. The date that the next policy review is due should be decided.

b) Revised policies where there have been changes to the document - it is the responsibility of the Accountable Director to decide whether the changes made during review are significant enough for the full document to be returned to the approving body for formal approval. If the alterations are minor and deemed not

to have altered the document in any significant way then the Accountable Director may sign-off the review. The 'DOCUMENT HISTORY' should be updated to reflect the nature of this change.

c) Where required, formal approval for a revised policy should be obtained via the process set out in section 11 above.

d) An implementation plan and equality impact assessment to reflect any changes should accompany the revised policy in the usual way, should it need to be presented for approval.

14.5 When revisions are made to policies, the obsolete document must be archived (with explanatory notes of the revisions) for reference purposes in case of subsequent litigation or complaints. The Trust Policy Co-ordinator is responsible for archiving policies.

15. Training and Awareness

15.1 Managers are responsible for raising awareness of this policy amongst their staff who are involved in writing policies.

15.2 Ad hoc training in the policy development process will be available via the Directorate of Governance, as required.

15.3 Training will be arranged to cover the full impact assessment process for equality on request.

16. Key Performance Indicators/Process for Monitoring Effectiveness

There is a need to ensure that, the policy is being correctly implemented and maintained within the organisation and that there is sufficient tangible evidence to demonstrate this. Assessments such as that against the NHS Litigation Authority Risk Management Standards (previously CNST) requires this information as part of the routine evidence collection.

17. Equality and Diversity

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

18. Review

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

19. Appendices

20. Further enquiries

Further information relating to this policy can be obtained from the Trust Secretary.

POLICIES REQUIRING TRUST BOARD APPROVAL

- Infection Control Policy
- Policy for the Development, Approval and Management of Policies
- Blood Transfusion Policy
- Claims management Policy
- Complaints handling Policy
- Consent for examination and treatment Policy
- Disciplinary and Grievance Procedure
- Do Not Attempt Resuscitation (DNAR) Policy
- Environmental Management Policy
- Equal Opportunities in Employment Policy
- Fire Safety Policy
- Media Relations Policy
- Health and Safety Policy
- Long Service Awards Policy
- Fraud and Corruption Countering Policy
- Whistleblowing Policy
- Security Policy

Appendix 2

Sandwell and West Birmingham Hospitals NHS
NHS Trust

GOVERNANCE BOARD/TRUST MANAGEMENT BOARD/TRUST BOARD

POLICY TITLE:	Title of policy presented for approval
ACCOUNTABLE DIRECTOR:	Executive Director supporting the policy
POLICY AUTHOR:	Name of person responsible for writing the policy
DATE OF MEETING:	Date of the meeting at which the policy will be presented for approval

SUMMARY OF KEY POINTS:

Please provide a summary of the key points of the policy, highlighting either the reason for the development of the policy or the key changes from the previous version. The main impact on staff of introducing the new policy or the amended policy should be detailed.

c. 20 LINES MAX

PURPOSE OF THE REPORT:

To seek approval for the implementation of the policy attached and request that the policy is added to the Trust's intranet for access by all staff.

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is requested to approve the policy, together with the proposed implementation plan and Equality Impact Assessment.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		*Explain any proposed risks associated with the implementation of the policy and the process by which they will be managed*

PREVIOUS CONSIDERATION:

Please indicate if the policy has been considered by any Boards or Committees prior to presentation at the meeting. Please indicate the date of the meeting at which the policy was considered and any decisions made concerning the proposal, if applicable.

Appendix 3

Sandwell and West Birmingham Hospitals NHS Trust

POLICY TITLE

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

POLICY PROFILE	
Overview	
Key overall purpose of policy	*Single sentence description of the policy purpose*
Principal target audience	*State to which groups of staff the policy applies*
Application	*State whether the policy applies to child patients, adult patients, both or staff only*
Accountable Executive Director	*Insert title only*
Author(s)	*Insert title only*
Impact Assessment	
Resource implications	*State financial, personnel or any other resources required to implement and support the policy*
Training implications	
Communications implications	
Date of initial equality impact assessment	
Date of full equality impact assessment (if appropriate)	
NHSLA risk management standards/ CQC core standards	*List any standards which the policy supports – details available from Trust Secretary if needed*
Consultation and referencing	
Key stakeholders consulted/involved in the development of the policy	
Complemetary Trust documents for cross reference	*State which other policies, procedures or documents should be read in conjunction with the policy*
Approvals and monitoring	
Approving body	*Board or Committee responsible for approving the policy*
Date of implementation	
Monitoring and audit	*State which bodies will be responsible for monitoring the progress against the implementation plan*

DOCUMENT CONTROL AND HISTORY				
Version No	**Date Approved**	**Date of Implementation**	**Next Review Date**	**Reason for Change** e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.
X	DD-MM-YYYY	DD-MM-YYYY	DD-MM-YYYY	

Contents page – mandatory

Introduction – mandatory: introduces the topic and includes reference and applicability of relevant legislation, definitions and context.

Objectives – mandatory: Sets out the purpose of the policy.

Scope – mandatory: the target audience for the policy must be clearly stated. Example wording: 'This policy applies to all Trust staff in all locations including temporary employees, locums, agency staff, contractors and visiting clinicians'.

Definitions – mandatory: this clarifies the language used within the policy to reduce any chance of misinterpretation.

Roles and responsibilities – mandatory: expectations of staff as a whole and any specific duties associated with particular posts.

Body of the policy
The standards to be achieved (policy) and how the policy standards will be met through working practices (procedure)

Equality and Diversity – mandatory: it is important that the Trust recognises the need for equality in all aspects of its work. This must be reflected in its policy development. As a result, equality must be included in polices and procedures, with suggested text as follows: 'The Trust recognises the diversity of the local community and those in its employ. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced and Equality Policy Statement to reflect this. All policies are assessed in accordance with the Equality impact assessment tool, the results for which are monitored centrally'.

Review – mandatory: 'This policy will be reviewed in two years time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation of guidance'.

Training and awareness – mandatory: this section must detail how staff will be made aware of the policy and what training will be provided to ensure compliance. Specialists in the area covered may provide training.

Key Performance Indicators/Process for Monitoring Effectiveness – mandatory: this section should outline the tangible evidence that may be sought to gain assurance that the policy has been embedded in the Trust. Include details of how the implementation and application of the policy will be monitored and may include details on how compliance will be audited.

Discipline – optional: 'Breaches of this policy will be investigated and may result in the matter being treated as a disciplinary offence under the Trust's disciplinary procedure.

References – mandatory: a list of documents referred to in the main body of the text. A reference document is any piece of printed material to which the author refers or quotes directly or any other policy that has been referred to.

Bibliography – optional: a list of works that the author has used as a source of information evidence or inspiration, but is not referred to directly in the text.

Glossary – optional: consisting of definitions of technical or specialised terminology used with the policy.

Appendices – mandatory where applicable: additional material necessary to the delivery of the policy.

Further enquiries – mandatory: details of the individual(s) to whom questions about the policy should be directed.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Initial Equalities Screening Checklist (To be replaced by new Toolkit under development)

POLICY TITLE/SERVICE:	
ACCOUNTABLE DIRECTOR:	
MANAGER RESPONSIBLE FOR COMPLETION:	
DATE:	

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

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

CHECKLIST
Step 1 – What is the purpose of the policy/service proposal? **How will the outcomes be measured?** **Who are the key stakeholders?**

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

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

Step 3 – Impact of the Policy, process or service

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

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

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

Name of EIA Lead : _____ **Date:** _____

Signed: _____

Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	
ACCOUNTABLE DIRECTOR:	
POLICY AUTHOR:	
APPROVED BY:	
DATE OF APPROVAL:	

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

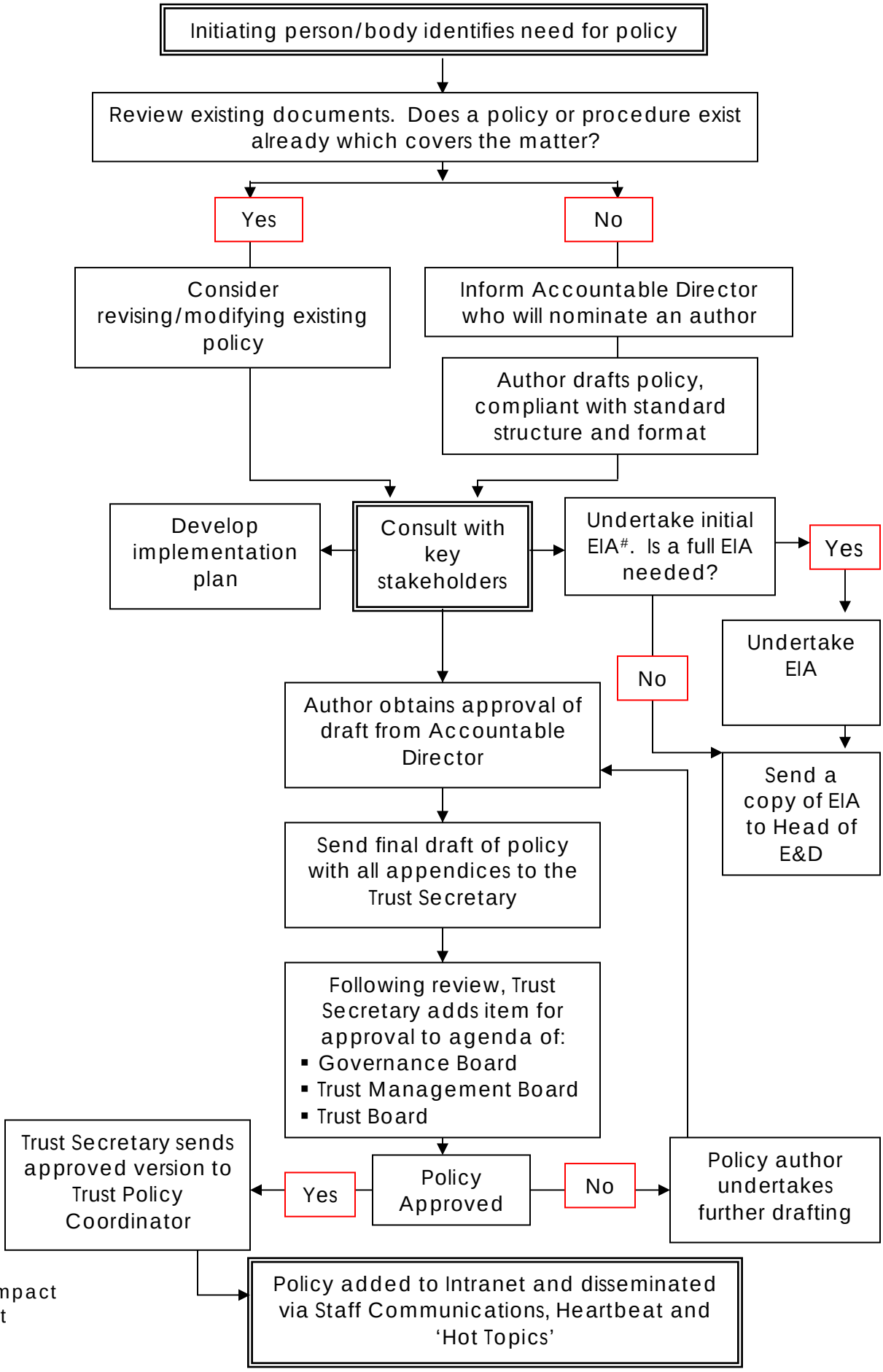
The following template provides a list of activities to consider as a starting point for thinking about implementation in a systematic manner.

KEY ACTIVITY	ACTIONS PLANNED TO DELIVER ACTIVITY	PLANNED COMPLETION DATE
Coordination of Plan		
Identify an individual to oversee the implementation plan		
Communication and Engagement		
Identify the key messages to communicate to the different stakeholder.		
Consider how these messages will be disseminated.		
Identify which groups or members of staff are affected by the policy, either directly or indirectly.		
Identify which groups of service users are affected by the policy, either directly or indirectly		
Update or produce new patient information regarding the policy		
Identify any service users who could contribute to the implementation of the policy		
Arrange an appropriate engagement exercise where appropriate		
Training		
Identify the training needs arising from the implementation of the policy		
Identify the skills and knowledge needed to deliver the training		
Ensure that the corporate induction and other mandatory training programmes incorporate any changes required as a result of implementing the policy		
Resources		
Determine the financial impacts of any changes arising from the introduction of the policy		
Identify any other resource implications arising from the implementation of the policy		
Monitoring and Evaluating		
Determine the main changes you would expect to see once the policy is embedded		
Devise a means of confirming that the changes		

KEY ACTIVITY	ACTIONS PLANNED TO DELIVER ACTIVITY	PLANNED COMPLETION DATE
expected have occurred		
Devise a means of evaluating the effectiveness of the changes resulting from the policy introduction		
Arrange for an evaluation of the policy introduction to be presented to an appropriate monitoring body after the latest activity completion date		
Consider how lessons learned from the implementation of the policy may be fed back into the organisation		

Appendix 6

Flowchart for the Policy Approval Process



#Equality Impact Assessment

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Initial Equalities Screening Checklist

POLICY TITLE/SERVICE:	Policy on the Development, Approval and Management of Policies
ACCOUNTABLE DIRECTOR:	Kam Dhami, Director of Governance
MANAGER RESPONSIBLE FOR COMPLETION:	Simon Grainger-Payne, Trust Secretary
DATE:	12 August 2009

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

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

CHECKLIST

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

To ensure that policies are developed in a systematic and consistent manner and that they are directed for approval through appropriate channels, having undergone a robust consultation and equality impact assessment process. The policy also ensures that communication of changes from previous versions or a summary of what the policy means to staff is undertaken in a systematic manner.

How will the outcomes be measured?

Policies submitted for approval will be monitored for compliance with the policy, particularly for evidence of appropriate consultation, completion of the correct proformas and the undertaking of an equality impact assessment.

Who are the key stakeholders?

All staff in the Trust responsible for the development, approval and management of policies

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

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

Step 3 – Impact of the Policy, process or service

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

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

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

Name of EIA Lead : Simon Grainger-Payne Date: 12 August 2009

Signed: *Simon Grainger-Payne*

Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Policy on the Development, Approval and Management of Policies
ACCOUNTABLE DIRECTOR:	Kam Dhami, Director of Governance
POLICY AUTHOR:	Simon Grainger-Payne, Trust Secretary
APPROVED BY:	Trust Management Board
DATE OF APPROVAL	18 August 2009

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

The following template provides a checklist to be used as a starting point for thinking about implementation in a systematic manner.

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
Co-ordination of implementation ▪ How will the implementation plan be co-ordinated and by whom? *Clear co-ordination is essential to monitor and sustain progress against the implementation plan and resolve any issues that may arise.*	Implementation of the policy will be undertaken by the Trust Secretary Staff will need to be made aware of the new proformas and additional activities within the policy ready for an implementation date of 1 October 2009	Communication of the changes will be disseminated via staff communications, Heartbeat and 'Hot Topics' All Trustwide policies submitted for approval will need to be monitored for compliance with the new policy and assistance given where required	Trust Secretary and Trust Policy Co-ordinator	September 2009 onwards
Engaging staff ▪ Who is affected directly or indirectly by the policy? ▪ Are the most influential staff involved in the implementation? *Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made.*	All staff responsible for the development of policies will need to be engaged with the new policy	The policy has been revised in line with feedback received at various corporate meetings, together with informal feedback received on an ad-hoc basis The revised policy has been sent to ALL MAILBOXES to ensure as wide a consultation exercise as possible	Trust Secretary	August 2009
Involving service users and carers ▪ Is there a need to provide information to service users and carers regarding this policy? ▪ Are there service users, carers, representatives or local organisations who could contribute to the implementation? *Involving service users and carers will ensure that any actions taken are in the best interests of the service users and carers and that they are better informed about their care.*	There are no external parties that require to be consulted on the policy directly.	The Equality Impact Assessment process has been strengthened to ensure that staff are awre of the need to conduct a full impact equality assessment where required and the EIAs are reviewed by the Head of Equality and Diversity	Trust Secretary and Head of Equality and Diversity	October 2009 onwards
Communication ▪ What are the key messages to communicate to the different stakeholders? ▪ How will these messages be	All staff responsible for the development of policies will need to be made aware of the need to use the revised template and complete additional templates	Policy to be distributed via Hot Topics Staff bulletin to notify staff of new policy	Trust Policy Co-ordinator	Following Trust Board on 27 August 2009

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
▪ communicated? *Effective communication will ensure that all those affected by the policy are kept informed thus smoothing the way for any changes. Promoting achievements can also provide encouragement to those involved.*	where required	Policy will be placed on the Intranet		
Training ▪ What are the training needs related to this policy? ▪ Are the people available with the skills to deliver the training? *All stakeholders need time to reflect on what the policy means to their current practice and key groups may need specific training to be able to deliver specific requirements.*	There are no specific training needs identified	Support and guidance will be given by the Trust Secretary to those responsible for developing policies where required	Trust Secretary	October 2009 onwards
Resources ▪ Have the financial impacts of any changes been established? ▪ Are other resources required to enable the implementation of the policy e.g. new documentation, increased staffing? *Identification of resource impacts is essential at the start of the process to ensure action can be taken to address issues that may arise at a later stage.*	There are no financial implications arising from the introduction of the policy	Existing resources will be adequate to manage the implementation of the policy	Trust Secretary	October 2009 onwards

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
Securing and sustaining change ▪ Have the likely barriers to change and realistic ways to overcome them been identified? ▪ Who needs to change and how do you plan to approach them? ▪ Have arrangements been made with service managers to enable staff to attend briefing and training sessions? ▪ Are arrangements in place to ensure the induction of new staff reflects the policy? *Initial barriers to implementation need to be addressed as well as those that may affect the on-going success of the policy.*	There will potentially be a number of policies submitted to the TMB, Governance Board or Trust Board which will be in the previous format.	Staff developing policies will be asked to use the new format and complete all accompanying appendices. The previous version of the policies template will be removed from the intranet to ensure that it is not available to download for use	Trust Secretary and Trust Policy Co-ordinator	October 2009 onwards
Evaluation ▪ What are the main changes in practice that should be seen from the policy? ▪ How might these be evaluated? ▪ How will lessons learned from implementation of this policy be fed into the organisation? *Evaluating and demonstrating the benefits of new policy is essential to promote the achievements of those involved and justify changes that have been made.*	The main changes involve a more robust approvals process, additional responsibilities involving the Trust Secretary and the Trust Policy Co-ordinator; strengthened need to complete an EIA; and revised/new appendices required to accompany the policy when presented for approval	Adherence to the changes will be monitored through a robust checking of all policies submitted for approval The KPIs detailed within the policy will be used to monitor effectiveness of implementation	Trust Secretary	October 2009 onwards
Other consideration ▪	None			

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Whistleblowing Policy
SPONSORING DIRECTOR:	Colin Holden, Director of Workforce
AUTHOR:	Sarah Heaton, Human Resources Manager
DATE OF MEETING:	27 August 2009

SUMMARY OF KEY POINTS:

The policy has been revised, the main points of the revised policy are noted below:

- The Procedure for Raising Concerns Internally now includes a further option for raising concerns within divisions, i.e. with Divisional General Managers, Divisional Directors or Clincal Directors
- For safeguarding concerns the policy now details route to take, i.e. referral to Policy for the Management and Protection of Vulnerable Adults
- For Fraud and/or corruption concerns the policy now details the route to take via the Trusts Local Counter Fraud Specialist
- In line with current policy format requirements, Roles and Responsbillities section has been included
- Further clarity re scope of policy
- Greater clarity re the difference between concerns that come under this policy compared to personal concerns which fall under the remit of the Trusts grievance policy.
- Greater clarity re conditions required to make external/wider disclosures
- Details re trade union bodies whistleblowing helplines

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

It is recommended that the Board approves the attached policy.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA: None

Strategic objectives	None specifically
Annual priorities	None specifically
NHS LA standards	2.5.2 – Raising concerns
Core Standards	Core standard C7b Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources. Core standard C8a Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.
Auditors' Local Evaluation	As part of the evidence to support compliance with the Internal Control dimension, the Trust is required to show that it has a Whistleblowing Policy in place

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

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

PREVIOUS CONSIDERATION:

The policy has been previously been considered at the August 2009 TMB. One minor amendment has been made:

Sections 7.5/7.6 where it refers to DGM and Div Director, can you also add 'Clinical Director'.

This has been amended and included in the policy attached.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

WHISTLEBLOWING POLICY

PROFILE	
REFERENCE NUMBER:	HR\008
VERSION:	4
STATUS:	
ACCOUNTABLE DIRECTOR:	Director of Workforce
AUTHOR:	Human Resources Manager
DATE OF LAST REVIEW/ ORIGIN DATE:	November 2006
DATE OF THIS REVIEW:	August 2009
APPROVED BY:	
DATE OF APPROVAL:	
IMPLEMENTATION DATE:	
DATE NEXT REVIEW DUE:	
REVIEW BODY:	Trust Board
CATEGORISATION:	Human Resources
DATE OF EQUALITY IMPACT ASSESSMENT:	October 2007
APPLICATION:	Trust Wide
PRINCIPAL TARGET AUDIENCE:	All Professionally Registered Staff
ASSOCIATED TRUST DOCUMENTS:	Counter Fraud and Corruption Policy Policy for the Management and Protection of Vulnerable Adults

Whistleblowing Policy

CONTENTS

1. Introduction

1.1 The Public Interest Disclosure Act 1998 (PIDA) provides legal protection for workers from dismissal, victimisation or other detrimental treatment when they raise genuine concerns at work in relation to 'protected disclosures'. Protected disclosures are disclosures alleging:

- Criminal offences or failure to comply with legal obligations
- Fraud and Corruption
- Miscarriages of justice
- Dangers to health and safety
- Damage to the environment
- Any attempt to deliberately conceal any of the above

Disclosures are protected whether they concern:

- An act or omission that took place in the past
- Improper conduct occurring in the present, or
- The prospect of likelihood of an act or omission occurring in the future

1.2 In addition, the Trust recognises that all employees have both a right and a responsibility to express any concerns that they may have relating to the delivery of patient care and the overall provision of health services.

1.3 This policy provides the basis by which legitimate concerns can be fairly, effectively and speedily aired and responded to by the use of internal mechanisms. The policy sets out that concerns should initially be raised at a local level with the facility for employees to register concerns directly with a designated Non Executive Director if necessary. This provides the Trust with the opportunity to address concerns and for remedial action to be taken where appropriate.

1.4 In cases of suspected fraud and/or corruption, concerns should be reported to the Trusts Local Counter Fraud Specialists (LCFS) and/or the Trusts Director of Finance and performance Management.

1.5 Where whistleblowers have concerns regarding the safeguarding of vulnerable adults within their care, the Policy for the Management and Protection of Vulnerable Adults (Pt Care/011) should be followed.

2. Objectives

2.1 To ensure that the Trust meets its legal obligations under the Public Interest Disclosure Act 1998.

2.2 To encourage a culture where individual employees can speak out freely and report any genuine concerns at the earliest possible opportunity in the confidence that they will be taken seriously and will not be victimised as a result.

2.3 To define the process by which employees can report genuine concerns and to set out a clear procedure for investigating concerns.

2.4 To ensure that all genuine concerns reported are treated seriously and appropriately.

2.5 To ensure that action, where appropriate, is taken and improvements made.

2.6 To direct potential whistleblowers to the Trusts Local Counter Fraud Specialist should they have any concerns which may involve potential fraudulent activity and/or corrupt activity.

2.7 To direct potential whistleblowers regarding the safeguarding of vulnerable adults from abuse to the Policy for the Management and Protection of Vulnerable Adults (Pt Care/011).

3. Scope

This policy applies to any person who undertakes work for the Trust including employees and workers, e.g. agency staff, temporary staff, trainees and bank staff.

4. Definitions

Whistleblowing is the disclosure by a member of staff of information that relates to some danger, criminal activity, failure to comply with a legal duty, standards of care, unethical conduct, miscarriage of justice, danger to health and safety or the environment, be it of the Trust or fellow employees.

5. Roles And Responsibilities

5.1 Chief Executive

Overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

5.2 Trust Board

5.2.1 To create an environment and culture in which individuals can speak out freely and report any genuine concerns at the earliest possible opportunity in the confidence that they will be taken seriously and will not be victimised as a result.

5.2.2 Designated Non executive and Executive Directors should be aware of their responsibilities in line with this policy.

5.2.3 To ensure that all concerned are aware of this policy and of sources of available support; that managers and employees are aware of the expectations that flow from this policy.

5.3 Designated Non Executive Director

5.3.1 To be aware of their responsibilities in line with this policy and to attend any relevant training as deemed appropriate.

5.3.2 Treat concerns raised seriously and sensitively, recognising the difficulty employees may have in raising concerns. Give the employee an unequivocal guarantee that where they raise concerns responsibly and reasonably they will be protected against victimisation.

5.3.3 Seek advice from other healthcare professionals where appropriate.

5.3.4 If the concerns are fraud related contact must be made with the Trusts Local Counter Fraud Specialist before any further action is taken.

5.4 Director of Workforce

5.4.1 To be aware of their responsibilities in line with this policy.

5.4.2 To be responsible for ensuring that the policy is implemented appropriately and that the numbers of complaints and associated outcomes made in line with this policy are monitored (refer to section 12 Monitoring).

5.5 Trust Managers

5.5.1 To be aware of their responsibilities in line with this policy and to attend any relevant training as deemed appropriate.

5.5.2 Treat concerns raised seriously and sensitively, recognising the difficulty employees may have in raising concerns. Give the employee an unequivocal guarantee that where they raise concerns responsibly and reasonably they will be protected against victimisation.

5.5.3 Seek advice from other healthcare professionals where appropriate.

5.5.4 If the concerns are fraud and/or corrupt related contact must be made with the Trusts Local Counter Fraud Specialist before any further action is taken.

5.5.5 If concerns are regarding the safeguarding of vulnerable adults within their care, referral must be made to the Policy for Management and Protection of Vulnerable Adults.

5.6 Local Counter Fraud Specialists (LCFS)

5.6.1 Treat concerns raised seriously and sensitively, recognising the difficulty employees may have in raising concerns. Give the employee an unequivocal guarantee that where they raise concerns responsibly and reasonably they will be protected against victimisation.

5.6.2 The LCFS's role is to ensure that all cases of actual or suspected fraud and corruption are notified to the Director of Finance and reported accordingly.

5.6.3 Be responsible for the day-to-day implementation of the seven generic areas of counter fraud and corruption activity and investigate all cases/suspicions of fraud reported to them. Report any cases to the police or NHS CFS as appropriate and ensure that other relevant parties are informed where necessary, e.g. Human Resources.

5.6.4 LCFS contact details:
Email: paul.westwood@cwaudit.org.uk
Address: Room S37, Second floor, Arden House, City Hospital, Dudley Road, Birmingham, B18 7QH.
Tel: 0121 5075087 / 07811 408224 Fax: 0121 5074440

5.7 All staff

5.7.1 Raise any genuine concerns in a reasonable and responsible way, acting in good faith.

5.7.2 Follow the procedure as detailed within this policy when raising concerns within the Trust.

5.7.3 To recognise that the Trust will not tolerate harassment or victimisation of any individual who decides to whistleblow.

5.7.4 To recognise that if a disclosure is found to have been made for malicious or vexatious reasons this could lead to disciplinary action.

5.8 Trade Unions

To support employees as appropriate and to treat all complaints in line with this policy seriously and sensitively.

6. Basic Principles

6.1 All employees have a responsibility to report any genuine concerns in a reasonable and responsible way.

6.2 An employee who raises a genuine concern in accordance with this policy will not be at risk of any form of retribution as a result provided that they acted in good faith. The Trust will not tolerate harassment or victimisation of any individual who does decide to whistleblow. Any such action will be dealt with in line with the Trust's Disciplinary Policy (HR/003).

6.3 This policy is intended to provide a mechanism for individual employees to raise matters of concern (about danger or illegality) that they may have about other people within the Trust or the way in which the Trust is run. The concern will have a public interest aspect to it, usually because it threatens others, for example patients and the public. It is not intended to replace the Trust's Grievance and Disputes Policy (HR/007), which should be referred to when employees have concerns relating to themselves, that have no additional public interest dimension.

6.4 If an investigation confirms that an employee has made a disclosure for malicious or vexatious reasons this could lead to disciplinary action.

6.5 All employees are encouraged to consult and seek guidance from their professional organisation, statutory bodies such as the Nursing and Midwifery Council or the General Medical Council or their local trade union. This will complement existing professional or ethical rules/guidelines and codes of conduct on freedom of speech including the NMC Code of Professional Conduct for Registered Nurses and the General Medical Council Guidance on Contractual Arrangements in Healthcare. A number of Trade Union bodies have their own whistleblowing helplines, details of which can be obtained from local trade union representatives (for further details see appendix A).

6.6 Safeguarding concerns involving a member of staff as the perpetrator must be referred to the Independent Safeguarding Authority (ISA). If concerns are in relation to medical staffing, the Medical Director will be responsible for the referral. For Nursing and Midwifery staff, this will be the responsibility of the Chief Nurse and for all other staff this will be the responsibility of the Director of Workforce.

6.7 Advice may be obtained from the independent charity Public Concern at Work (PCaW), an organisation which provides free, confidential advice to people concerned about crime, danger or wrongdoing at work. There is a specific helpline for NHS staff. PCaW can be contacted by telephone on 020 7404 6609 or via e-mail helpline@pcaw.co.uk. Further information can be obtained via the organisation's website - www.pcaw.co.uk.

6.7 The Trust recognises that there may be circumstances when an employee feels that it is necessary to report their concerns to an external body (see section 7). The appropriate regulatory bodies prescribed by legislation are listed in Appendix A. Wider disclosures to the police, media, MPs and non-prescribed regulatory bodies are protected if they are reasonable and not made for personal gain (see section 7.)

7. Procedure For Raising Concerns

7.1 In the first instance the employee should raise their concerns with their line manager (for alternative internal options see section 7.5) unless the issue relates to potential fraud and/or corruption, in which case the matter should be raised with the Trusts Local Counter Fraud Specialist. The line manager should always:

- take all concerns seriously and investigate them UNLESS they are in respect of potential fraudulent activity or in respect to safeguarding of vulnerable adults. If the concerns are fraud and/or corruption related the Trusts Local Counter Fraud Specialist must be contacted. Failure to do so could have serious implications in any potential investigation. For example, the confidentiality of the investigation could be breached which may alert the individual under suspicion, which in turn could result in the tampering or removal of evidence. If concerns are in respect of to safeguarding of vulnerable adults, the Policy for the Management and Protection of Vulnerable Adults should be followed. Failure to do so could potentially put vulnerable adults at risk of abuse. Advice regarding

safeguarding procedures can be obtained via the Trusts Adult Safeguarding Nurse, 0121 507 5174.

- recognise the difficulty the employee may have in raising them. Offer support measures , e.g. Occupational health, Counselling.
- give the employee an unequivocal guarantee that where they raise concerns responsibly and reasonably they will be protected against victimisation.
- seek advice from other healthcare professionals where appropriate

(Contact details for the Trusts Local Counter Fraud Specialist are detailed in section 5.6.4. Alternatively whistleblowers are able to report suspicions anonymously by calling the NHS National Fraud and Corruption Reporting Line, which is 0800 028 40 60).

7.2 The line manager should make every effort to meet with the employee within 2 working days of the matter being raised. If this is not possible, the meeting should be held as soon as is reasonably possible.

7.3 The line manager should notify the individual of the outcome within 5 working days of their meeting. Where action is not considered appropriate, the employee should be given an explanation of the reasons behind this decision. Details of the complaint and a copy of the outcome letter must also be sent to the Director of Workforce for monitoring purposes.

7.4 If a member of medical staff wishes to raise an issue of concern about a colleague's performance they have a duty under their General Medical Council registration to raise it in the first instance with the Trust's Medical Director. (See Procedure for Doctors to Report Concerns about the Conduct, Performance or Health of Medical Colleagues SHC/HR/032).

7.5 If an employee does not feel it is appropriate to raise their concerns with their line manager or continues to feel concerned after feedback from their line manager he/she has the option of either escalating their concerns within the division, i.e. with the Divisional General Manager, Divisional Director or Clinical Director (see section 7.6) or to write to the designated Non-Executive Director via the Director of Governance (see section 7.7).

7.6 If a complaint is raised with the Divisional General Manager, Divisional Director, or Clinical Director the procedure as detailed within sections 7.1 to 7.3 should be followed. The Divisional General Manager, Divisional Director or Clinical Director may investigate the concerns themselves or allocate an appropriate manager to investigate.

7.7 If a complaint is raised with the Non-Executive Director, the Non-Executive Director will acknowledge their letter within 7 days of receipt and make arrangements to meet with the employee to discuss their concerns. If the Non-Executive Director decides that it would be appropriate for an investigation to take place, he/she will decide who is to investigate. This will normally be an appropriate Executive Director. The Non-Executive Director will be responsible for deciding on the time scales for the investigation and will keep the employee regularly informed of progress in writing. On completion of the investigation, the Non Executive Director should advise the employee in writing of the outcome. A copy of this letter must be sent to the Chief Executive for information and for appropriate follow up action. For

monitoring purposes details of the complaint and a copy of this letter must also be sent to the Director of Workforce.

7.8 Where the matter in question is of a particularly serious nature (for example in relation to criminal or unlawful behaviour) it may be necessary to inform the appropriate external body, for example Nursing and Midwifery Council or Health Professions body (see also Appendix A for list of prescribed regulatory bodies). Where this is necessary the Trust will support the employee throughout the process and maintain their anonymity within the Trust as far as is possible. Issues of concern relating to the safeguarding and safety of children/vulnerable adults must be referred to the Independent Safeguarding Authority (ISA) as detailed in section 6.6.

8. External and Wider Disclosures

8.1 The Trust hopes that this policy and procedure will give employees the confidence to raise concerns internally and therefore encourages employees to raise their concerns under this procedure in the first instance. However, it is recognised that there may be circumstances where they can properly report matters to external bodies. This includes circumstances where employees are dissatisfied with the outcome of the internal investigation.

8.2 Providing disclosures are made in good faith and the worker reasonably believes that the allegations of wrongdoing are substantially true, external routes of disclosure that are protected are:

- To a legal advisor, if made in the course of obtaining legal advice
- To a minister of the crown, where the worker is engaged in crown or public employment
- To a 'prescribed person (body)'. For example HM Revenue & Customs; the Health & Safety Executive (see appendix A for list of bodies that have been prescribed for this purpose)
- Elsewhere in defined circumstances, subject to certain conditions (see section 8.3)
- Elsewhere in exceptionally serious cases (subject to certain conditions (see section 8.3)

8.3 A disclosure made elsewhere, for example to the police, the media, an MP or a ` non-prescribed regulator, may qualify for a protected disclosure providing certain conditions are met. These conditions are that the disclosure is made in good faith and not for personal gain. That the person making the disclosure must reasonably believe that the information disclosed is substantially true and it must be reasonable in the circumstances for the person to have made the disclosure in that way. The worker must also:

- Reasonably believe that he or she would be subjected to a detriment by the employer if they had raised the matter internally or to a prescribed body
- If there is no prescribed body, he or she reasonably believes the employer would react to the disclosure by concealing or destroying evidence OR

- Have already raised the concern with the employer or a prescribed body to no avail

8.4 Employees need to be aware that such action, if entered unjustifiably could result in disciplinary action.

9. Equality

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

10. Review

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

11. Training And Awareness

11.1 Reference to this policy will be made during the Trust Corporate Induction course and is contained within the Trusts Staff Handbook.

11.2 Copies of this policy will be made available to all staff via the Trusts intranet site and in any local policy folders.

12. Monitoring

The Trusts Workforce Director will be responsible for monitoring the number of complaints made in line with this policy, how they have been handled and their outcome. An annual report will be made to the Trust Board.

13. References

13.1 Trust policies and procedures

Disciplinary Policy HR/003
Grievance and disputes Policy HR/007
Policy for the Management and Protection of Vulnerable Adults Pt Care/011

13.2 Legislation

The Public Interest Disclosure Act 1998

14. Further Enquiries

Further information relating to this policy can be obtained from the Trust Human Resources Department.

15. Appendices

Appendix A – List of prescribed persons/bodies
Trade Union bodies whistleblowing helplines

1. PRESCRIBED PERSONS/BODIES

Prescribed persons are statutory bodies – or people within them – who have the authority to receive disclosures relevant to the role of that particular body.

Health and safety dangers – Health and Safety Executive, Local Authority, Foods Standards Agency

Environmental dangers – The Environment Agency

Financial Services – Financial Services Authority, Serious Organised Crime Agency

Public sector finance & fraud and fiscal irregularities – Serious Fraud Office, Her Majesty's Revenue and Customs (HMRC), National Audit Office, Audit Commission

Others – Charity Commission, Civil Aviation Authority, The Pensions Regulator, Information Commission, National Care Standards Commission

The above list is not exhaustive. A full list can be obtained via the Department for Business and Regulatory Reform (BERR) www.berr.gov.uk

2. TRADE UNION BODIES WHISTLEBLOWING HELPLINES

A number of Trade Union bodies have their own whistleblowing helplines, details of which can be obtained from local trade union representatives.

Examples include:

RCN Whistleblowing helpline 0845 772 6300

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Initial Equalities Screening Checklist

POLICY TITLE/SERVICE:	Whistleblowing Policy
ACCOUNTABLE DIRECTOR:	Director of Workforce
MANAGER RESPONSIBLE FOR COMPLETION:	Sarah Heaton – Human Resources Manager
DATE:	9th July 2009

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

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

CHECKLIST

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

Timed procedure review.

To encourage a culture where individuals can speak out and report any genuine concerns at the earliest opportunity in confidence they will be taken seriously and not victimised.

To provide a clear internal procedure for addressing concerns.

To ensure the Trust meets its legal obligations under the Public Interest Disclosure Act 1998.

How will the outcomes be measured?

Monitoring of any investigations/disciplinaries undertaken in relation to this procedure.

Who are the key stakeholders? Employees/individuals working for the Trust.		
Step 2 – Gather information and data (evidence)	**YES**	**NO**
Will the proposed policy/service involve or have consequences for the patients or staff of the Trust on racial grounds in the context of their gender, disability, sexuality, age, religion and language? • If yes, please explain, identifying those likely to be affected and detailing evidence sources.		x
Is there any reason to believe that people from the different equality strands, taking into account of interaction between strands, could be affected differently, by the proposed policy/service • If yes, please state reason and those likely to be affected and evidence sources...		x
Is there evidence to suggest that any part of the proposed policy/service could discriminate unlawfully, directly or indirectly? • If yes, please specify • If no, please explain The procedure is based on best practice and legislation regarding whistleblowing. Applicable equally to all groups.		x
Is there any evidence that some people may have different expectations of the policy/service in question due to their race, gender, disability, sexuality,		x

age, religion and language? • If yes, please specify • If no, please explain		
Is the proposed policy/service likely to affect relations between some people due to their race, gender, disability, sexuality, age, religion and language, for example if is seen as favouring a particular group or denying opportunities for another? • If yes, please state reason/evidence and information on those likely to be affected.		x

Step 3 – Impact of the Policy, process or service

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

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

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

Name of EIA Lead : Sarah Heaton – Human Resources Manager

Date: 9th July 2009

Signed:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Whistleblowing Policy
ACCOUNTABLE DIRECTOR:	Colin Holden, Director of Workforce
POLICY AUTHOR:	Sarah Heaton, Human Resources Manager
APPROVED BY:	
DATE OF APPROVAL	

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

The following template provides a checklist to be used as a starting point for thinking about implementation in a systematic manner.

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
Co-ordination of implementation • How will the implementation plan be co-ordinated and by whom? *Clear co-ordination is essential to monitor and sustain progress against the implementation plan and resolve and issues that may arise.*	That the procedure has been revised – times review.	Communication to be planned/timed in line with final approval.	HR Manager (Sarah Heaton)	From date of final approval.
Engaging staff • Who is affected directly or indirectly by the policy? • Are the most influential staff involved in the implementation? *Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made.*	All levels of employee and workers.	HR team for comments Wider consultation – trust wide comment, eg. Trust Executives, DGM's, Divisional Directors, Diversity Groups PPAC TMB Trust Board	HR Manager (Sarah Heaton)	July – Sept 2009
Involving service users and carers • Is there a need to provide information to service users and carers regarding this policy? • Are there service users, carers, representatives or local organisations who could contribute to the implementation? *Involving service users and carers will ensure that any actions taken are in the best interests of the service users and carers and that they are better informed about their care.*	N/A			
Communication • What are the key messages to communicate to the different stakeholders?	That the policy has been revised as a timed review and the key differences.	Communication via - Team Brief - Staff comms – email system	HR Manager (Sarah Heaton)	To coincide with final approval

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
• How will these messages be communicated? *Effective communication will ensure that all those affected by the policy are kept informed thus smoothing the way for any changes. Promoting achievements can also provide encouragement to those involved.*	Detail key areas of change.	- Policy to be placed on intranet. - The availability of the Trusts Whistleblowing policy is signposted on the local counter fraud specialist staff induction where all new starters are briefed on the role of LCFS and arrangements to whistleblow		
Training • What are the training needs related to this policy? • Are the people available with the skills to deliver the training? *All stakeholders need time to reflect on what the policy means to their current practice and key groups may need specific training to be able to deliver specific requirements.*	No direct training required. Advice can be provided as required via HR team			
Resources • Have the financial impacts of any changes been established? • Are other resources required to enable the implementation of the policy e.g. new documentation, increased staffing? *Identification of resource impacts is essential at the start of the process to ensure action can be taken to address issues that may arise at a later stage.*	N/A			

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
Securing and sustaining change • Have the likely barriers to change and realistic ways to overcome them been identified? • Who needs to change and how do you plan to approach them? • Have arrangements been made with service managers to enable staff to attend briefing and training sessions? • Are arrangements in place to ensure the induction of new staff reflects the policy? *Initial barriers to implementation need to be addressed as well as those that may affect the on-going success of the policy.*	N/A	.		
Evaluation • What are the main changes in practice that should be seen from the policy? • How might these be evaluated? • How will lessons learned from implementation of this policy be fed into the organisation? *Evaluating and demonstrating the benefits of new policy is essential to promote the achievements of those involved and justify changes that have been made.*	Greater clarity in terms of role responsibilities and processes to follow			
Other consideration •				

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT JULY 2009

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 July 2009.

This report is in three sections:

a) Overview of the work of the Right Care Right Here Programme
b) Programme Director's report as presented to the Right Care Right Here Partnership and the Boards of Sandwell and HoB PCTs (Appendix 1)
c) Right Care Right Here Exemplar Project Performance for April – May 2009 (Appendix 2 – separate spreadsheet)

OVERVIEW

This section provides an overview of the work of the Right Care Right Here Programme. This work is set out in more detail in the Programme Director's report in Appendix 1. The work of the Right Care Right Here Programme and involvement of the Trust in this is also discussed on a monthly basis at the Right Care Right Here Implementation Board meetings. The most significant issues arising this month are as follows:

Project Performance – Appendix 2 shows the performance of exemplar projects (first and second wave) for the period April – May 2009. Two of the projects are over performing in all activity areas and therefore rated as 'green' (ENT and Gynaecology). A number of projects are rated as amber (Urgent Care – HoB, Ophthalmology and Dermatology) because of an underperformance against target which is being investigated by Project Leads. Several other projects are rated as amber because there are some residual concerns about data completeness and quality (Rehab Beds, Sheldon, Musculoskeletal, Respiratory, Diabetes and Cardiology). One project, Urgent Care – Sandwell, is rated as red because of an underperformance resulting from the decision to reduce expenditure on the project.

Service Redesign Activity - The Strategic Model Of Care Steering (SMOCS) Groups continue to make progress and are now developing the three key deliverables (Clinical Strategy, Overall Model of Care and Priorities for Service Redesign) for presentation to the Clinical Group through the autumn, starting with the Maternity and Newborn group in September. A review of progress was undertaken within the Programme Team in early July and identified some further areas for action including user engagement, wider clinical engagement and the involvement of public health.

A further clinical review of the Map of Medicine has been undertaken and whilst the number of responses were limited these supported use of the Map. The Clinical Group have therefore decided that the use of Map of Medicine would assist considerably the maintenance, development and amendment of care pathways across the LHE. The need for administrative support has been identified and the process for funding and providing this is now being considered by the Strategy Group.

Activity and Capacity Model Version 5 – The development of the Activity and Capacity Model Version 5 has now been completed. The outputs will be available by the beginning of August to help to inform the significant areas for service redesign to be targeted in the near future to move towards an affordable solution. Based on the assumptions developed so far, the total increased cost to the health economy, driven mainly by activity increases, HRG 4 implementation and demographic changes, is an additional £25m (£16m in Sandwell PCT and £9m in Heart of Birmingham PCT). Development work has now stopped on the Model Version 5, awaiting decisions on the approach to be taken in the Review of the

Programme. As broad assumptions are made based on an affordable future proposed pattern of care, the assumptions is that following the Review the model will be updated to Version 5.1.

Review of the Programme - There is a growing view that the size, shape and affordability of the Programme needs to be reviewed in the light of changed economic circumstances facing the NHS. A Joint Board meeting was held on Monday 20th July to agree principles and the process for the review.

Update on CLAHRC Research Project - Following a period of building up the research team, the CLAHRC (Collaborations for Leadership in Applied Health Research and Care) Project Team is now undertaking a series of interviews with a range of colleagues to establish its baseline report. This will then enable the identification of the tracker conditions which will be used and followed as part of the project.

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
13th August 2009

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, 27th July 2009**

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 the content of the report.

2. Project Performance

2.1 April to May 2009

The information system issues which prevented a report being provided in May and June have been resolved. Given at Appendix 1 is the Project Performance report for April and May 2009.

As can be seen, all but one of the projects have submitted reports, and the issue of Cardiology reporting is compounded by the fact the Project Lead is leaving after her summer break. Sandwell PCT is identifying a replacement, with progress being monitored through the Programme Delivery.

In terms of performance, there are two projects rated as 'green' (ENT and Gynaecology), where the projects are overperforming in all elements. It is clear from several projects rated 'amber' that there are some residual concerns about data completeness and quality (Rehab Beds, Sheldon, Musculoskeletal – Community Orthopaedics, Respiratory and Diabetes). For Rehab Beds Rowley, the target needs to be adjusted to take account of the work undertaken by the Assessment and Rehabilitation Unit.

Concerns over performance arise from the projects for Urgent Care – HoB, Ophthalmology and Dermatology – Community Outpatients in which Project Leads are investigating the underperformance. For Urgent Care Sandwell, the underperformance is the result of the decision to reduce spend on this project.

3. Service Redesign Activity

3.1 SMOCS Update

Progress continues to be made with all the SMOCS Groups and they are now developing the three key deliverables (Clinical Strategy, Overall Model of Care and Priorities for Service Redesign) for presentation to the Clinical Group in the autumn. A review of progress was undertaken within the Programme Team in early July and this identified some further areas for action, which are now being pursued:

- It has been agreed to establish a process to ensure the Directors of Public Health and their staff link with the relevant SHA Clinical Lead to review the evidence base underpinning the strategy, model of care and priorities for service redesign and ensure the proposals made are well-founded in evidence and best practice
- The level of engagement from Heart of Birmingham is not as high nor as consistent as other partner organizations

- User involvement varies between SMOCS Groups and this has been impacted by Communications and Engagement Leads not being able to contribute as had been agreed. This is being pursued through further debates with the leads assigned to support each SMOCS Group.
- It is also clear that there is more work to do to ensure appropriate clinical engagement for all SMOCS.
- A timetable has been agreed for presentation of the three key deliverables to the Clinical Group. The Group has decided that SMOCS Chairs should be provided with a checklist to ensure all the issues they wish to see included are covered. This will be discussed with SMOCS Chairs at my meeting with them on 31st July.
- The Clinical Group has now decided to review the SMOCS Groups' deliverables in the scheduled Clinical Group meetings, with the SMOCS Chairs being asked to present to them. A proposed timetable for presentations and discussion has been suggested as below and is now being confirmed with SMOCS Chairs:

Wednesday, 5th August	Trial run: Maternity and Newborn
Wednesday, 2nd September	Maternity and Newborn, Staying Healthy
Wednesday 7th October	Children's Services, Planned Care, End of Life, Dementia
Wednesday, 4th November	Mental Health, Acute Care, Long Term Conditions

3.2 Activity and Capacity Model Version 5

As previously reported, work has been continuing on the Activity and Capacity Model Version 5 and this is now an important part of the process developing around the Review of the Programme. At the Strategy Group on 15th July, Richard Kirby reported that the development of Version 5 had now been completed and the outputs will be available by the beginning of August. These will help to inform the significant areas for service redesign to be targeted in the near future to move towards an affordable solution.

Based on the assumptions developed so far, the total increased cost to the health economy, driven mainly by activity increases, HRG 4 implementation and demographic changes, is an additional £25m (£16m in Sandwell PCT and £9m in Heart of Birmingham PCT).

Development work has now stopped on the Model Version 5, awaiting decisions on the approach to be taken in the Review of the Programme. As broad assumptions are made based on an affordable future proposed pattern of care, the assumptions in the model can be updated. This will be labelled Version 5.1.

3.3 Map of Medicine

3.3.1 Background

Members will recall that I brought the issue of the Map of Medicine and its potential use to the Partnership Board on 26th May 2009. It was agreed that the Clinical Group was best placed to take a view on the potential use of Map of Medicine and reach a decision on this, with a recommendation to the Strategy Group, should additional resources be required.

At its May meeting, the Clinical Group received a presentation on Map of Medicine from the SHA and discussed its potential use in the local health economy and the Programme in some detail.
Several issues were raised, on which clarification was sought from the SHA. These were reported back to the Clinical Group on 1st July 2009.

In addition, the Clinical Group felt that it would be sensible to give a range of clinicians across the LHE the opportunity to comment of the usefulness of the Map of Medicine. The Programme Team therefore circulated an example of a care pathway held on Map of Medicine to 23 clinical colleagues across several partner organisations, with a short proforma to complete for comments. Unfortunately, only four of these were returned, with a further clinician commenting that she supported the use of the Map but would not complete the proforma. An evaluation report was prepared which is available should colleagues wish to see this.

3.3.2 Review by and Conclusions of the Clinical Group

Having reviewed the SHA responses and the evaluation report, the Clinical Group decided that the use of Map of Medicine would assist considerably the maintenance, development and amendment of care pathways across the LHE. The group is particularly interested in developing local care pathways of direct relevance to clinicians working across Heart of Birmingham and Sandwell. In addition, the Group felt that the Map would have a significant role to play assisting the development of care pathways, to include referral thresholds and triggers across the primary care/secondary care interface. Their view was that having colleagues from primary and secondary care using the Map of Medicine pathways as a means of reviewing current practice, improving upon it, offering standard approaches and prompting debate on the best locations of services in the future, would all greatly assist the processes of service redesign and will lead to more efficient, cost effective and clinically safe working. There was also some interest in working with the SHA and the Map of Medicine company to develop the Map to be used in social care as well as NHS organisations.

The Clinical Group discussed how the Map of Medicine, which is free to the NHS through a Department of Health contract with a commercial company, would be maintained and managed. It was recommended that this should be managed as a project within the Right Care Right Here Programme, with project management coming from the Programme Team. The Clinical Group identified that administrative management of the processes of maintaining, changing and uploading local care pathways would be required. They suggested that co-ordination across the seven partner organisations would be enabled most cost effectively by the appointment of a full time administrative manager post, to provide access to the Map, to manage the establishment of Heart of Birmingham and Sandwell –specific care pathways, either through amending currently available pathways or by generating new pathways. This recommendation was made to the Strategy Group on 15th July, who support the development in principle and each organisation is now identifying how the resource requirement can be met. It is hoped to resolve this at the next meeting on 29th July 2009.

3.4 Third Wave Projects

As discussed at the last meeting, the Programme Delivery Group has been advised that the further definition of projects to be established as a third wave should be suspended for a period until the further development of the Review of the Programme. I believe that, for many of the proposals, the valuable work that has been undertaken in developing ideas for changing services will be incorporated into the service redesign workstreams that may emanate from current discussions.

4. Review of Programme

4.1 General

As members will be aware from the presentation and the discussion at the last meeting, there is a growing view that the size, shape and affordability of the Programme has to be reviewed in the light of changed economic circumstances facing the NHS. This is taking up the majority of my time currently, as discussions continue between the Chief Executives and Finance Directors of the two PCTs and SWBH. This will culminate in the Joint Board meeting to be held on Monday 20th July. I have provided a paper suggesting some principles to be discussed and several significant areas of service where redesign can yield substantial change and reduction in both activity and costs.

I will provide a verbal report to the meeting on the outcome of this discussion and how it is proposed to move forward.

4.2 Terms of Reference of Partnership Board and Programme Groups

As members will be aware, July is the month at which the terms of reference of the Partnership Board and the Programme Groups is scheduled to be undertaken. I have agreed with the Chair and Chief Executives

that this should be delayed until any implications for our governance arrangements from the Review of the Programme are known.

5. Skills and Competency Project Manager for the Programme – Chris Lawson

I am delighted to announce the arrival of Chris Lawson on Monday 13th July to undertake the role of Skills and Competency Project Manager. This project, which is jointly funded with Skills for Health, aims to utilise their methodology working across the Projects and Care Pathways.

Chris has worked in the NHS over the last five years prior to which he worked in community education. Chris has previously project managed work in relation to the Skills Escalator and has a strong understanding of Skills for Health methodology. Over the next few weeks he will be familiarising himself with local meetings before providing awareness sessions for colleagues on the proposed methodology.

Chris can be contacted on chris.lawson@sandwell-pct.nhs.uk or by phone on 0121 612 3513.

6. Update on CLAHRC Research Project

Following a period of building up the research team, the CLAHRC (Collaborations for Leadership in Applied Health Research and Care) Project Team is now undertaking a series of interviews with a range of colleagues to establish its baseline report. This will then enable the identification of the tracker conditions which will be used and followed as part of the project.

In addition, arrangements are being made with SWBH for the trust to offer honorary contracts to researchers, along with the standard pre-employment, occupational health and CRB checks, as it is expected that some patient survey work will be undertaken.

The Project Team is currently developing a proposal to engage with wider clinical, professional and all other staff groups which will be piloted at Walsall Hospitals before being extended to SWBH and UHB.

The Project Leads have been provided with the details of a number of meetings where redesign issues are discussed, within the Programme and the partner organisations and they will notify colleagues direct prior to attending any of them to observe how service redesign is addressed.

A communications strategy is being developed.

The CLAHRC is currently advertising a Surgical Research Fellow jointly with SWBH to work half time on service and half time on the CLAHRC project.

The CLAHRC will hold its annual conference on Friday 23rd October, 2009 in the Post Graduate Medical Centre, QEMC.

The CLAHRC Steering Group, involving the Chief Executives of the two PCTs and SWBH will be held at the end of July. Presentations will be made to Trust Board and the Partnership Board when there are findings to report.

7. Recommendation

The Partnership Board is recommended to:

- Note the content of the report.

Les Williams
Programme Director

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-May 09/10

PROJECT	MONTH (2009/10) April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2008/09 Yearend Target	Status	PROJECT LEAD	Comments
URGENT CARE - SANDWELL																		
Target (Attendances)	976	976	0	0	0	0	0	0	0	0	0	0	1,952		11,710		Matthew Dodd	Activity is below target.
Actual	842	855	0	0	0	0	0	0	0	0	0	0	1,697				SWBH	Reduction in funding for the scheme has led to the reduction in hours provided by Mrs Bannerjee &
Variance													**-255**	**-13**				hours provided by Prime Care at weekends has been removed.
URGENT CARE - HoB																		
Targets:																		
City	2,500	2,500	0	0	0	0	0	0	0	0	0	0	5,000		30,000		Mark Curran	Activity just below target - Project Lead seeking explanation from SWBH
Actual	2,424	2,433	0	0	0	0	0	0	0	0	0	0	4,857				HOB PCT	
Variance													**-143**	**-3**				
Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0		13,000			
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
REHAB BEDS - SHELDON																		
Targets:																		
Community - D43 (OBDs)	647	647	0	0	0	0	0	0	0	0	0	0	1,294		7,760		Angela Young	D43 activity is just exceeding target. Care Centre activity has exceeded target in month. Both
Actual	638	659	0	0	0	0	0	0	0	0	0	0	1,297				HOB PCT	elements of the project to be considered for project closure - Project Lead has submitted
Variance													**3**	**0**				Project Review & Closure Report to the Programme Delivery Group July 2009.
Care Centres (OBDs)	571	571	0	0	0	0	0	0	0	0	0	0	1,142		6,850			
Actual	595	657	0	0	0	0	0	0	0	0	0	0	**1,252**					
Variance													**110**	**10**				
Comm. Alternatives Sub-Acute D47 (?)	0	0	0	0	0	0	0	0	0	0	0	0	0		2625*			Community alternatives activity information only available for Rehabilitation element, the
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					currency described as a count of patients receiving a package of care comprising one or
Variance													**0**	**n/a**				more contacts by a healthcare professional e.g. district nurse, physiotherapist, occupational
Comm. Alternatives Rehabilitation (Patient Package)	292	292	0	0	0	0	0	0	0	0	0	0	584		3,500			therapist. Programme proposing an Intermediate Care Project be established.
Actual	835	977	0	0	0	0	0	0	0	0	0	0	**1,812**					
Variance													**1,228**	**210**				
Note: Target for Community Alternatives Sub-Acute D47 is HoBPCT only - Sandwell target to be agreed.																		
REHAB BEDS - ROWLEY																		
Targets:																		
Community Step Up - ET Ward (OBDs)	317	317	0	0	0	0	0	0	0	0	0	0	634		3,800		Wendy Godwin	Community step-up activity is significantly below target and is being investigated by Project
Actual	48	231	0	0	0	0	0	0	0	0	0	0	279				SPCT	Lead.
Variance													**-355**	**-56**				
Community Step Down - Mc Ward (OBDs)	642	624	0	0	0	0	0	0	0	0	0	0	1,266		7,700			Community step-down activity now includes Assessment and Rehabilitation (ARU) activity,
Actual	1,526	1,663	0	0	0	0	0	0	0	0	0	0	3,189					hence the significant overperformance - target needs to be revised to take account of ARU.
Variance													**1,923**	**152**				
STAR (Av Admits)	83	83	0	0	0	0	0	0	0	0	0	0	166		1,000			Admissions avoided owing to the STAR service are lower than anticipated - Project Lead
Actual	60	77	0	0	0	0	0	0	0	0	0	0	137					investigating
Variance													**-29**	**-18**				Project 9 bid submitted to develop re-ablement skills for HCAs in the community/trained and
																		untrained staff at Rowley
MUSCULOSKELETAL (includes Orthopaedic beds & outpatients, Rheumatology outpatients & Pain Managemen																		
Targets:																		
HoB Orthopaedics Triage (Atts)	545	545	0	0	0	0	0	0	0	0	0	0	1,090		6,535		Paul Hazle	Orthopaedic triage in the community is exceeding target overall but Sandwell service is
Actual	641	556	0	0	0	0	0	0	0	0	0	0	1,197				SWBH	below target by 5% at month 2.
Variance													**107**	**10**				
Sandwell Orthopaedics Triage (Atts)	574	574	0	0	0	0	0	0	0	0	0	0	1,148		6,885			
Actual	585	508	0	0	0	0	0	0	0	0	0	0	1,093					
Variance													**-55**	**-5**				
Community Rheumatology (OPs)	381	381	0	0	0	0	0	0	0	0	0	0	762		4,564			Community Rheumatology just exceeding target.
Actual	387	397	0	0	0	0	0	0	0	0	0	0	784					
Variance													**22**	**3**				
Primary Care Rheumatology (OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		140			HoB Primary Care Rheumatology service pilot commenced 1st July. IT issues i.e. full access
Actual	n/a	n/a	0	0	0	0	0	0	0	0	0	0	0					to ICM hindering roll-out of community activity and Choose & Book system influencing referrals
Variance													**0**	**n/a**				
Community Orthopaedics (OPs)	74	74	0	0	0	0	0	0	0	0	0	0	148		889			Project lead investigating accuracy of activity data with Information Department owing to
Actual	50	4	0	0	0	0	0	0	0	0	0	0	54					significant underperformance being reported to date. Venue funding issue to be resolved to
Variance													**-94**	**-64**				enable community orthopaedic clinic to start at Handsworth Wood.
Community Pain Management (OPs)	59	59	0	0	0	0	0	0	0	0	0	0	118		702			New service with HoB pilot service to commence 26th July. Funding issue in relation to
Actual	11	13	0	0	0	0	0	0	0	0	0	0	24					Community Pilot Clinician for HoB pilot threatens start date.
Variance													**-94**	**-80**				
Note; Community Pain Management actual activity only includes Lyng activity																		Project 9 bid submitted for Sandwell PCT Extended Scope Practitioner development.

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-May 09/10

PROJECT	MONTH (2008/09) April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2008/09 Yearend Target	Status	PROJECT LEAD	Comments
OPHTHALMOLOGY																		
Target (Outpatients)	1,273	1,273	0	0	0	0	0	0	0	0	0	0	2,546		15,274		Wendy Godwin	Activity below target at Month 2 - Rowley service unlikely to commence before April 2010.
Actual	1,162	973	0	0	0	0	0	0	0	0	0	0	2,135				SPCT	VFM discussions on-going. HoB decision re capital including equipment purchase awaited.
Variance													**-411**	**-16**				Audit of emergency attendances underway. Adult Social Services to develop recommendations to support the Eye Liaison Officer role. LOC/LMC to discuss possible support of optometrist direct referral for Glaucoma.
DERMATOLOGY																		
Targets:																		
Community Outpatients)	267	267	0	0	0	0	0	0	0	0	0	0	534		3,198		Kayode	Community outpatients below target but GPwSI activity exceeding target.
Actual	182	220	0	0	0	0	0	0	0	0	0	0	402				Odetayo	
Variance													**-132**	**-25**			HOB PCT	
Community - GPwSI (Outpatients)	134	134	0	0	0	0	0	0	0	0	0	0	268		1,602			HoB GPwSI has taken some referrals from SWBH owing to capacity shortfalls at SWBH.
Actual	178	187	0	0	0	0	0	0	0	0	0	0	365					4 Consultant vacancies - one appointment made but cannot commence for 12 months
Variance													**98**	**36**				locums being considered and re-advertising to fill. Oldbury clinic has temporarily re-located back to hospital site owing to venue being used as Swine Flu Centre.
RESPIRATORY																		
Targets:																		
Community - Nurse-led (Attendances)	80	80	0	0	0	0	0	0	0	0	0	0	160		1,034		Sally Sandel	Actual activity has exceeded target (includes clinics being undertaken at Sandwell that have
Actual	295	281	0	0	0	0	0	0	0	0	0	0	576				SPCT	been redesigned).
Variance													**416**	**260**				
Primary Care - GP/Nurse/GPwSI (Attendances)	0	0	0	0	0	0	0	0	0	0	0	0	0		432			All funding applications made via HoB LDP process in relation to the project have not been
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					supported which Project Lead has highlighted may impact upon primary care target and
Variance													**0**	**n/a**				future years' activity. Concern has also been raised by Project Board members regarding
	Note: Primary Care service planned to commence in October																	engagement of HoB.
ENT																		
Target (Outpatients)	822	822	0	0	0	0	0	0	0	0	0	0	1,644		9,860		Jane Clark	Target exceeded. On-going supervision of 8 nurses who have completed the Diploma in
Actual	852	883	0	0	0	0	0	0	0	0	0	0	1,735				SWBH	Ear Care course - competency completion by September 2009. Provisional training
Variance													**91**	**6**				programme agreed for GPs who wish to develop their skills in ENT - 2 GPs will participate initially. Operational policy complete for new Hearing Services Centre & work underway to translate this into a project brief.
CARDIOLOGY																		
Targets:																		Report not submitted by Project Lead - Project Lead is leaving the PCT and as works on a
Community (Outpatients)	0	0	0	0	0	0	0	0	0	0	0	0	0		782			term-time only contract no report expected until September. Confirmation of future
Actual - Rowley & Neptune	n/a	n/a	0	0	0	0	0	0	0	0	0	0	0				Ruth Westerby	arrangements for this project being sought via the Programme Delivery Group.
Variance													**0**	**n/a**		TBC	SPCT	
Community (Attendances)	0	0	0	0	0	0	0	0	0	0	0	0	0		1,867			
Actual	n/a	n/a	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
GYNAECOLOGY																		
Target (Outpatients)	88	88	0	0	0	0	0	0	0	0	0	0	176		1,053		Therese	Target exceeded. Clinics commenced at Aston Health Centre in May and initial patient/staff
Actual	89	100	0	0	0	0	0	0	0	0	0	0	189				McMahon	feedback is positive. Feasibility of converting a room at Aston for plain film x-ray is being
Variance													**13**	**8**			HOB PCT	investigated by SWBH Radiology Department to increase number of patients who can be seen in this location.
DIABETES																		
Targets:																		Target exceeded.
Community (Outpatients)	553	553	0	0	0	0	0	0	0	0	0	0	1,106		6,635		Olivia Amartey	
Actual	355	796	0	0	0	0	0	0	0	0	0	0	1,151				HOB PCT	Workforce planning group has re-started and are working on developing an interim workforce
Variance													**45**	**4**				plan.
Primary Care (Outpatients)	0	0	0	0	0	0	0	0	0	0	0	0	0		361			Project Lead to confirm position with regard to primary care activity.
Actual	n/a	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	RCRH Acute Hospital Development: Project Director's Report
SPONSORING DIRECTOR:	Graham Seager, New Hospital Project Director
AUTHOR:	Andrea Bigmore, New Hospital Project Manager
DATE OF MEETING:	27 August 2009

SUMMARY OF KEY POINTS:

The Project Director's report includes reference to:

- Review of the Outline Business Case (OBC) approval process
- Press coverage of OBC approval
- Land acquisition
- Due diligence process

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

For information.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to deliver new hospital as planned
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial	**X**	
Business and market share	**X**	
Clinical	**X**	
Workforce	**X**	
Environmental	**X**	
Legal & Policy	**X**	
Equality and Diversity	**X**	
Patient Experience	**X**	
Communications & Media	**X**	
Risks		Risks identified in project risk register and where appropriate included in Trust risk register

PREVIOUS CONSIDERATION:

Not previously considered.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

right care right here

RIGHT CARE, RIGHT HERE PROGRAMME
Acute Hospital Development

Report to:	Trust Board
Subject:	Project Director's Report
Report by:	Andrea Bigmore
Date:	September 2009

1.0 Review of the Outline Business Case (OBC) Approval Process

OBC approval has been a very demanding process. It required a well developed design, which was to test affordability, and very detailed financial modelling.

The OBC was developed by the Project Team during the second half of last year. The Team worked to a strict project plan and met deadlines at each stage. The OBC was presented to Trust Board on 4th December 2008 to agree submission of the document to the formal approvals process.

The Right Care, Right Here Partnership Board and Sandwell and Heart of Birmingham Teaching Primary Care Trusts also endorsed the scheme in December 2008.

The Project Team worked closely with the Strategic Health Authority (SHA) and the Department of Health (DH) to ensure that the OBC and appendices were good documents and would meet approval criteria. Their confidence in the scheme was strong enough for them to agree to a parallel approvals process.

Rapid progress was made and the SHA approved the OBC on 27th January 2009.

The Trust received notification from the DH that the OBC was approved in late July 2009 and a confirmatory letter of approval was received on 14th August 2009.

Lessons learnt from the process indicate that the Project Team developed a good set of documents and managed the approvals process effectively.

2.0 Press Coverage of OBC Approval

Press releases were issued to accompany the announcement of approval at the last Trust Board meeting.

Subsequent review of press coverage has shown very positive reports. For example: the Halesowen News (Wednesday 5th August 2009), quotes Halesowen and Rowley Regis MP, Sylvia Heal, as saying: "I am really pleased the Government has given the go-ahead to the new Sandwell and West Birmingham hospital development. The new healthcare facilities will make a real difference to local people and the construction will also hopefully have a positive effect on local employment as building gets underway".

3.0 Land Acquisition

Work continues on the acquisition of the Grove Lane site. A letter to seek approval for the activation of an NHS Compulsory Purchase Order (CPO) has been sent to the Department of Health (DH).

4.0 Project Plan

The project plan will be updated following approval of the NHS CPO. The plan will include all the activities required to acquire the land and to prepare for the procurement process.

5.0 Due Diligence Process

A due diligence process is underway to test the new hospital specifications at this stage.

This involves the following activities:

- Documents have been sent out for review by the clinical teams, departmental managers and relevant Trust committees
- The specifications and policies are being reviewed to check consistency with facilities management, IM&T and equipping assumptions
- The Trust leads for infection control, moving and handling, health and safety and security are reviewing the documents to ensure compliance with best practice and Trust standards
- An approach to equality impact assessment (EIA) of the operational policies has been proposed, which integrates the work for the project with the wider Trust EIA process
- The Core Team has reviewed the scheme at high level with the Medical Director and Chief Nurse

Reviews like this will be repeated regularly throughout the life of the project to ensure that the hospital will be fit for purpose and best value for money.

Graham Seager
Project Director

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 August 2009

SUMMARY OF KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – July 2009.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Financial Management Board, Trust Management Board and Finance and Performance Management Committee.

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - JULY 2009

SWBTB (8/09) 163 (a)

EXECUTIVE SUMMARY

<table>
<tr><th>Note</th><th>Comments</th></tr>
<tr><td>a</td><td>Operational Standards for Cancer Waiting Times have been published and are incorporated within the report. Actual performance during the month of June, and for the period to date, is favourable, and exceeds the thresholds for each of the 3 principal cancer targets.</td></tr>
<tr><td>b</td><td>Cancelled Operations during July expressed either as a percentage or numerically are similar to those reported in June. Numerically almost 70% of cancellations occurred within General Surgery, Ophthalmology and Trauma & Orthopaedics.</td></tr>
<tr><td>c</td><td>Overall Delayed Transfers of Care (2.5%) remain essentially stable, although during the month of July equalised across sites. Delays predominantly (84%) are attributable to Social Services.</td></tr>
<tr><td>d</td><td>Stroke Care - during the month of June 61.1% of stroke patients spent at least 90% of their hospital stay on a Stroke Unit. Early in July a modified patient pathway was introduced whereby wherever possible patients are transferred from A/E to a Stroke Unit directly, rather than initial admission to an Assessment Unit. It is anticipated that this change will improve performance against this indicator.</td></tr>
<tr><td>e</td><td>Accident & Emergency 4-hour waits - performance during the month of July was 99.1%, with performance for the first 4 months of the year 99.3%. This compares with performance for the same 4-month period last year of 98.5%, when 3,500 fewer attendances were experienced.</td></tr>
<tr><td>f</td><td>Cases of C Diff increased to 14 across the Trust during July, with 5 reported at Sandwell and 9 reported at City. 1 case of MRSA Bacteraemia was recorded. The Trust continues to meet National and Local performance trajectories.</td></tr>
<tr><td>g</td><td>Referral to Treatment Time targets for Admitted and Non-Admitted patient care were both met during July. Audiology data completeness (84%), a data quality test, fell outside of the 90 - 100% range for achievement. Work to assertain the reason for this is underway.</td></tr>
<tr><td rowspan="7">h</td><td>CQUIN:</td></tr>
<tr><td>Outpatient source of Referral - Performance remains well within the trajectory set for this target.</td></tr>
<tr><td>Caesarean Section Rate - The overall rate across the Trust for July reduced to 20.5%, with both sites showing in-month reductions. The year to date rate has reduced to 22.4%.</td></tr>
<tr><td>Brain Imaging - During the month of July, 55.3% of patients admitted as an emergency following a stroke received a brain scan within 24 hours of admission. Year to date performance is 64.1%, currently below the January - March 2009 baseline of 72%.</td></tr>
<tr><td>Hip Fracture - During the period to date 85% of patients have received an operation within 48 hours of admission with a fracture of the hip. Performance during July was 86.7%.</td></tr>
<tr><td>Smoking Cessation Referrals - A range of initiatives designed to improve performance against this target have recently been introduced. Early indications suggest a demonstrable increase in the number of referrals made.</td></tr>
<tr><td>Inpatient Patient Satisfaction Survey - The initial survey as reported previously has as intended informed the future composition of this indicator, with formal assessment against coverage of a further survey scheduled to be conducted later in the year.</td></tr>
<tr><td>i</td><td>There is a favourable variance of 1.2% between income per spell and cost per spell during the month of July, this in month improvement, increases the year to date variance to a favourable 0.7%.</td></tr>
<tr><td>j</td><td>Activity to date is compared with the contracted activity plan for 2009 / 2010.
<table>
<tr><th></th><th>Sandwell</th><th>City</th><th>Trust</th></tr>
<tr><td>IP Elective</td><td>-6.3%</td><td>13.2%</td><td>5.2%</td></tr>
<tr><td>Day case</td><td>9.3%</td><td>4.6%</td><td>6.8%</td></tr>
<tr><td>IPE plus DC</td><td>6.3%</td><td>6.5%</td><td>6.4%</td></tr>
<tr><td>IP Non-Elective</td><td>5.0%</td><td>2.6%</td><td>3.6%</td></tr>
<tr><td>OP New</td><td>-1.9%</td><td>-0.6%</td><td>-1.1%</td></tr>
<tr><td>OP Review</td><td>-2.7%</td><td>6.9%</td><td>3.2%</td></tr>
</table>
Overall performance against the various components of the contracted activity plan is similar to that reported last month, and is reflected in the table opposite.

When activity to date is compared with 2008 / 09 for the corresponding period
<table>
<tr><th></th><th>Sandwell</th><th>City</th><th>Trust</th></tr>
<tr><td>IP Elective</td><td>-10.1%</td><td>4.0%</td><td>-1.6%</td></tr>
<tr><td>Day case</td><td>7.5%</td><td>1.0%</td><td>4.0%</td></tr>
<tr><td>IPE plus DC</td><td>4.1%</td><td>1.7%</td><td>2.8%</td></tr>
<tr><td>IP Non-Elective</td><td>7.0%</td><td>1.5%</td><td>3.8%</td></tr>
<tr><td>OP New</td><td>7.8%</td><td>6.5%</td><td>7.0%</td></tr>
<tr><td>OP Review</td><td>3.2%</td><td>13.6%</td><td>9.6%</td></tr>
</table>
Overall Elective, Non-Elective and Outpatient activity delivered during the first 4 months exceeds that delivered during the corresponding period last year by the level indicated.</td></tr>
<tr><td>k</td><td>Ambulance turn around data for the month of July is awaited.</td></tr>
<tr><td>l</td><td>Nurse Bank and Agency Shifts and Costs remain within the profile set for the period to date. The Nurse Bank Fill Rate (>86%) remains in excess of 2008 / 09 outturn. Overall Agency spend is largely influenced by Medical and Other Agency costs, although actual spend on Medical & Other Agency and Medical Locums reduced by £75K in month.</td></tr>
<tr><td>m</td><td>Almost 25% of staff have received a PDR (as reported to Learning and Development) during the first 4 months of the year. Actual numbers have shown demonstrable improvement over the last 2 months.</td></tr>
</table>

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - JULY 2009

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS			March	April	May	June			July			To Date	TARGET		Exec Summary Note	THRESHOLDS			06/07 Outturn	07/08 Outturn	08/09 Outturn
				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	09/10							
RW	Net Income & Expenditure (Surplus / Deficit (-))		£000s	-117 ■	162 ■	357 ▼	→		-5 ■	→		364 ■	876	1066	2269		0%	0 - 1%	>1%	3399	6547	2535
RK	Cancer	2 weeks	%	96.0 ▲	93.2 ▼	92.9 ■	→		93.3 ■	→			93.1	=>93	=>93	a	No variation		Any variation	100	97.1	98.6
		31 Days	%	100 ■	100 ■	100 ■	→		99.4 ▼	→			99.8	=>96	=>96		No variation		Any variation	99.9	99.9	100
		62 Days	%	93.0 ▼	92.6 ▼	91.4 ▼	→		88.1 ▼	→			90.6	=>85	=>85		No variation		Any variation	99.3	99.7	98.6
RK	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.9 ■	0.5 ■	0.8 ■	1.2 ■	1.0 ■	1.1 ■	0.8 ■	1.1 ■	1.0 ■	0.8	<0.8	<0.8	b	<0.8	0.8 - 1.0	>1.0	0.9	0.9	1.0
		28 day breaches	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0		3 or less	4 - 6	>6	4	0	0
	Delayed Transfers of Care	Total	%	1.5 ▲	2.2 ▼	3.2 ■	1.7 ■	3.4 ■	2.6 ■	2.3 ▼	2.6 ■	2.5 ▲	2.6	<3.0	<3.0	c	<3.0	3.0 - 4.0	>4.0	4.0	2.7	3.1
RK	Coronary Heart Disease	Primary Angioplasty (<90 mins)	%	62 ▲	53 ▼	82 ■	100 ▲	86 ▲	93 ▲				75	80	80		>80	75-80	<75	n/a	63.0	70.5
		Rapid Access Chest Pain	%	100 ■	100 ■	98.4 ▼	100 ■	100 ■	100 ■	100 ■			99.5	=>98	=>98		>99	98 - 99	<98	99.7	99.6	100.0
		Revascularisation >13 weeks	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0		0		>0	0	0	0
		Thrombolysis (60 minutes)	%	no pts	no pts	no pts	no pts	no pts	no pts				no pts	80	80		>80	75-80	<75	57	50	0
DO'D	Stroke Care	>90% stay on Stroke Unit	%	32.4 ▼	52.6 ▲	47.6 ▼	→		61.11 ▲	→			53.5	66	70	d	+>70	65 - 70	<65	n/a	n/a	36.5
RK	A/E 4 Hour Waits		%	99.6 ▲	99.3 ▼	99.5 ▲	99.0 ▼	99.4 ▲	99.2 ▼	99.2 ▲	99.1 ▼	99.1 ▼	99.30	=>98	=>98	e	=>98		<98	98.20	98.28	98.16
	GUM 48 Hours	Patients seen within 48 hours	%	85.2 ▲	90.2 ■	81.8 ■	→		89.6 ▲	→		89.6 ■	88.0	=>95	=>95		No variation	0 - 10% variation	>10% variation	n/a	n/a	81.0
		Patients offered app't within 48 hrs	%	100 ■	99.8 ■	100 ■	→		99.1 ■	→		100 ■	99.7	100	100		No variation	0 - 10% variation	>10% variation	35.8	80.7	98.3
R0	Infection Control	C. Diff - EXTERNAL (DH) TARGET	No.	15 ■	14 ▲	11 ▲	3 ■	4 ▲	7 ▲	5 ▼	9 ▼	14 ▼	46	92	264	f	No variation		Any variation	n/a	355	163
		C. Diff - INTERNAL (LHE) TARGET	No.	15 ■	14 ▲	11 ▲	3 ■	4 ▲	7 ▲	5 ▼	9 ▼	14 ▼	46	76	220		No variation		Any variation	n/a	355	163
		MRSA - EXTERNAL (DH) TARGET	No.	2 ▼	2 ■	1 ▲	0 ■	2 ■	2 ▼	0 ■	1 ■	1 ■	6	12	33		No variation		Any variation	61	43	15
		MRSA - INTERNAL (LHE) TARGET	No.	2 ▼	2 ■	1 ▲	0 ■	2 ■	2 ▼	0 ■	1 ■	1 ■	6	8	23		No variation		Any variation	61	43	15
RK	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	94 ■	94 ■	94 ■	→			→			94	90	90		>/=90	89.0-89.9	<89	90.0	89.0	87.0
RO	Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	100 ▲	→	→	→		96.9 ■	→			96.9	=>99.0	=>99.0		>99	98 - 99	<98	99.9	99.5	99.9
		Breast Feeding Status Data Complete	%	100 ■	→	→	→		99.1 ■	→			99.1	=>99.0	=>99.0		>99	98 - 99	<98	98.3	99.8	97.8
		Maternal Smoking Rates	%	10.6	→	→	→		12.3 ■	→			12.3	<12.0	<12.0		<12.0	12-14	>14.0	13.2	13.1	12.6
		Breast Feeding Initiation Rates	%	57.7	→	→	→		62.9 ■	→			62.9	>57.0	>57.0		>57.0	55-57	<55.0	52.5	55.0	54.2
RK	Patient Access	Inpatients >26 weeks	%	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0.000	0	0		<0.03		>0.03	1	0	0
		Outpatients >13 weeks	%	0 ■	0 ■	1 breach ■	→		0 ■	→		0 ■	0.002	0	0		<0.03		>0.03	4	0	5
RK	RTT Milestones	Admitted Care (RTT <18 weeks)	%	98.6 ▲	98.2 ▼	98.5 ▲	→		97.2 ▼	→		97.7 ▲	97.7	=>90.0	=>90.0	g	=>90.0		<90.0	52.0	90.6	98.6
		Admitted Care - Data Completeness	%	100.4 ■	102.5 ■	101.3 ■	→		101.7 ■	→		101.1 ■	101.1	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	100.4
		Non-Admitted Care (RTT <18 weeks)	%	98.8 ▲	98.2 ▼	98.7 ▲	→		98.6 ▼	→		97.9 ▼	97.9	=>95.0	=>95.0		=>95.0		=<95.0	n/a	95.5	98.8
		Non-Admitted Care - Data Completeness	%	98.1 ■	96.2 ■	108.0 ■	→		101.0 ■	→		109.6 ■	109.6	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	98.1
		Audiology Direct Access Waits (<18 wks)	%	99 ▼	100 ▲	99.7 ▼	→		100 ▲	→		100 ■	100	=>95	=>95		=>95		<95	n/a	n/a	99.0
		Audiology Data Completeness	%	96.0 ■	102.0 ■	97.0 ■	→		91.0 ■	→		84.0 ■	84.0	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	96.0
		Diagnostic Waits greater than 6 weeks	No.	26 ▲	23 ▲	18 ▲	→		23 ▼	→		21 ▲	21	0	0		0		>0	996	25	26
DO'D	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	103.5 Dec '08	104.2 Jan '09	96.8 Feb '09	→		89.1 March '09	→		82.0 April '09	82.0	Rate only	Rate only					101.1	100.2	99.0
		Peer (SHA) HSMR	HSMR	102.6	101.1	95.5	→		88.7	→		88.4	88.4	Rate only	Rate only					110.7	106.1	96.5
RK	CQUIN	OP Source of Referral Information	%		0.93 ■	0.87 ▲	→		1.77 ▼	→		1.17 ▲	1.21	8.5	5.0	h	No variation		Any variation	n/a	n/a	10.0
DO'D		Caesarean Section Rate	%	22.1 ▼	22.5 ▼	22.7 ▼	21.2 ▼	25.5 ▼	23.9 ▼	16.9 ▲	23.2 ▲	20.5 ▲	22.4	26.6	26.0		=<26.0		>26.0	n/a	27.7	27.0
		Brain Imaging for Em. Stroke Admissions	%		61.7 ■	74.2 ■	→		66.2 ■	→		55.3 ▼	64.1	72.0	72.0		=>72.0		<72.0	n/a	n/a	72.0
		Hip Fracture Op's <48 hours of admission	%	85.2 ▲	89.7 ▲	74.9 ■	→		91.7 ■	→		86.7 ▼	85.0	80.0	87.0		No Variation	0 - 2% Variation	>2% Variation	63.6	70.1	77.8
		Smoking Cesssation Referrals	No.	→			39	128	167 ■	40	45	85 ■	252	333	1000		=>83	per month	<83	n/a	n/a	7
RO		IP Patient Satisfaction (Survey Coverage)	%														=>90		<90	n/a	n/a	n/a

Exec Lead	CLINICAL QUALITY			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	Readmission Rates	(Within 28 days of discharge)	%	11.3	12.0	12.3	11.6	10.4	10.9				11.5	No. Only	No. Only					10.1	n/a	11.6
		(Within 14 days of discharge)	%	8.0	8.6	9.1	8.8	7.7	8.1				8.4	No. Only	No. Only					n/a	n/a	7.3
R0	Infection Control	Savings Lives Compliance	%	99 ■	99 ■	99 ■	→		99 ■	→		99 ■	99	>95	>95		< YTD target		> YTD target	n/a	n/a	99.0
		Phlebitis Rate	%		1.08 ■	0.97 ▲	→		0.43 ▲	→		0.54 ▼	0.54	<5	<5		< YTD target		> YTD target	n/a	1.77	
		Phlebitis Compliance	%		76.6 ■	80.7 ▲	→		84.9 ▲	→		86.1 ▲	86.1	>95	>95		>95%	75-95%	<75%	n/a	78	
		MRSA Screening (Elective)	No.	1184 ▲	1822	1692	→		2007	→		1782	7303	No. Only	No. Only		0 - 10%	10 - 15%	>15%	n/a	n/a	6495
		MRSA Screening (Non-Elective)	No.		1074	527	→		678	→		595	2874	No. Only	No. Only		0 - 10%	10 - 15%	>15%	n/a	n/a	n/a
DO'D	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	1 ▼	1 ■	3 ▼	0 ▲	1 ▲	1 ▲	0 ■	0 ▲	0 ▲	5	16	48		=<2	3 - 4	>4	n/a	n/a	
		Admissions to Neonatal ICU	%	6.5 ▼	6.6 ▼	6.3 ▲	6.2 ▼	7.0 ■	6.7 ▼	3.7 ▲	6.3 ▲	5.2 ▲	6.2	=<10	=<10		=<10	10.0-12.0	>12.0	n/a	9.6	
		Adjusted Perinatal Mortality Rate	/1000	9.8 ▼	9.5 ■	7.5 ■	25.3 ■	12.2 ■	17.1 ■	8.0 ■	9.1 ■	8.6 ■	8.6	<8.0	<8.0		<8	8.1 - 10.0	>10	n/a	n/a	
FINANCE & FINANCIAL EFFICIENCY																						
RW	Gross Margin		£000s	1267 ■	2361 ■	2569 ▼	→		2206 ■	→		2565 ■	9700	9864	29805		0%	0 - 1%	>1%	26429	33250	26436
	CIP		£000s	829 ■	2542 ■	949 ■	→		949 ■	→		1060 ■	5577	5878	15075		0 - 2.5%	2.5 - 7.5%	>7.5%	19679	14027	11084
	In Year Monthly Run Rate		%	-202 ▼	9.5 ■	0.3 ▼	→		-102 ■	→		1.11 ■	-17.8	0	0		NO or a + variation	0 - 5% variation	>5% variation	329	45	1.4
RK	Income / WTE		£s	5521 ▲	4955 ■	4991 ▲	→		4908 ▼	→		4998 ▲	4958	5127	5127	i	No variation	0 - 5% variation	>5% variation	5460	4924	5014
	Income / Open Bed		£s	34214 ■	29321 ■	32944 ■	→		32662 ▼	→		32615 ▼	32304	31184	31184		No variation	0 - 5% variation	>5% variation	24774	29065	30498
	Income per Spell	Total Income	£s	2858 ▼	2714 ■	2836 ■	→		2719 ■	→		2649 ■	2733	2762	2762		No Variation	0 - 4% Variation	>4% Variation	2635	2740	2701
		Clinical Income	£s	2402 ■	2456 ■	2561 ▲	→		2448 ■	→		2389 ▼	2467	2454	2454		No Variation	0 - 4% Variation	>4% Variation	2317	2449	2400
		Non-Clinical Income	£s	456 ▲	258 ■	275 ▲	→		272 ▼	→		260 ▼	266	308	308		No Variation	0 - 4% Variation	>4% Variation	318	291	301
	Cost per Spell	Total Cost	£s	2868 ■	2700 ▲	2803 ■	→		2720 ■	→		2618 ▲	2713	2742	2742		No Variation	0 - 4% Variation	>4% Variation	n/a	2643	2682
		Total Pay Cost	£s	1904 ▲	1788 ■	1882 ■	→		1834 ▲	→		1751 ■	1816	1825	1825		No Variation	0 - 4% Variation	>4% Variation	1772	1737	1785
		Medical Pay Cost	£s	556 ▲	517 ■	547 ■	→		515 ■	→		506 ▲	522	544	544		No Variation	0 - 4% Variation	>4% Variation	543	517	532
		Nursing Pay Cost (including Bank)	£s	676 ▲	619 ■	666 ■	→		648 ■	→		605 ■	635	639	639		No Variation	0 - 4% Variation	>4% Variation	609	615	625
		Non-Pay Cost	£s	963 ■	912 ■	921 ■	→		886 ■	→		867 ▲	897	917	917		No Variation	0 - 4% Variation	>4% Variation	n/a	906	897
		Mean Drug Cost / IP Spell	£s	123 ▼	114 ■	110 ▲	→		107 ▲	→		114 ▼	111	123	123		No Variation	0 - 4% Variation	>4% Variation	n/a	95	120
		Mean Drug Cost / Occupied Bed Day	£s	49 ▼	56 ■	44 ■	→		44 ■	→		42 ▲	43	48	48		No Variation	0 - 4% Variation	>4% Variation	n/a	35	47
PATIENT EXPERIENCE																						
KD	Complaints	Number Received	No.	206	→	→	→			→				No. Only	No. Only					673	697	789
		Response within 25 days	%	75 ■	→	→	→			→				85	85		80%+	70 - 79%	<70%	77.4	81.2	81.1
	Thank You Letters		No.	328	→	→	→			→				No. Only	No. Only					6026	3491	2912
RK	Elective Access Contact Centre	Number of Calls Received	No.	13245	11985	11244	→		13516	→		12366	49111	No. Only	No. Only					n/a	n/a	190434
		Average Length of Queue	mins	0.44 ■	1.14 ■	0.39 ■	→		0.50 ▼	→		1.03 ■	1.03	0.5	0.5		No variation	0 - 10% variation	>10% variation	n/a	n/a	0.44
		Maximum Length of Queue	mins	17.4 ▲	20.5 ▼	13.4 ▲	→		22.5 ▼	→		17.5 ▲	17.5	6.0	6.0		No variation	0 - 10% variation	>10% variation	n/a	n/a	17.4
RK	Telephone Exchange									→										n/a	n/a	n/a
STRATEGY																						
RK	Referrals	Total By Site	No.	16975 ▲	16506 ■	15730 ■	→		17048 ▼	→			49284	44161	178070		No Variation	0 - 2% Variation	>2% Variation	138580	151755	178070
		Total GP Referrals	No.	11309 ▲	10583 ▼	9984 ▲	→		11101 ▲	→			31668	29674	120138		No Variation	0 - 2% Variation	>2% Variation	98476	95857	120138
		Total Other Referrals	No.	5666 ▲	5923 ■	5746 ■	→		5947 ▼	→			17616	14487	57932		No Variation	0 - 2% Variation	>2% Variation	40104	55898	57932
		By PCT - Heart of B'ham	No.	4854 ▲	4627 ▼	4343 ▲	→		4558 ▼	→			13528	12215	49859		No Variation	0 - 2% Variation	>2% Variation	40394	41628	49859
		By PCT - Sandwell	No.	8283 ▲	8407 ■	7899 ■	→		8754 ▲	→			25060	21681	87779		No Variation	0 - 2% Variation	>2% Variation	72580	77592	87779
		By PCT - Other	No.	3842 ▲	3472 ■	3488 ■	→		3736 ▼	→			10696	10264	40453		No Variation	0 - 2% Variation	>2% Variation	25606	32535	40453
		Conversion (all referrals) to New OP Att'd	%	83.0	84.5	79.6	→		84.1	→			82.8	No. Only	No. Only					91.5	87.0	85.9

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Exec Lead	ACTIVITY			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	Spells	Elective IP	No.	1167	1084	1080	387	817	1204	435	750	1185	4555	4328	13077	j	No Variation	0 - 2% Variation	>2% Variation	13887	13395	13106
		Elective DC	No.	4468	4393	4062	2099	2352	4451	2243	2472	4715	17542	16430	49636		No Variation	0 - 2% Variation	>2% Variation	45831	46304	50873
		Total Elective	No.	5635	5477	5142	2486	3169	5655	2678	3222	5900	22097	20758	62713		No Variation	0 - 2% Variation	>2% Variation	59718	59699	63979
		Non-Elective - Short Stay	No.	988	1584	1323	708	698	1406	712	787	1499	6265	4499	13745		No Variation	0 - 2% Variation	>2% Variation	12414	11575	12770
		Non-Elective - Other	No.	5051	4255	4453	1693	2645	4338	1973	2460	4433	16982	17926	54971		No Variation	0 - 2% Variation	>2% Variation	52662	55163	56226
		Total Non-Elective	No.	6039	5839	5776	2401	3343	5744	2685	3247	5932	23247	22425	68716		No Variation	0 - 2% Variation	>2% Variation	65076	66738	68996
	Outpatients	New	No.	14094	13948	12521	4996	9337	14333	5197	9208	14405	53885	54478	159666		No Variation	0 - 2% Variation	>2% Variation	127449	131941	152923
		Review	No.	34697	37057	33914	12808	22825	35633	12762	22821	35583	137341	132288	385680		No Variation	0 - 2% Variation	>2% Variation	370970	361113	374867
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	17110	16650	14984	7578	10406	17984	7091	9228	16319	68086	68953	197122		No Variation	0 - 2% Variation	>2% Variation	200561	195093	191141
	A/E Attendances	Type II (BMEC)	No.	3079	2885	3197	→	2923	2923	→	2854	2854	11902	10756	30749		No Variation	0 - 2% Variation	>2% Variation	31373	29803	30800
PATIENT ACCESS & EFFICIENCY																						
RK	Length of Stay	Average Length of Stay	Days	4.9	4.6	4.4	4.7	4.4	4.5				4.5	5.0	5.0		No Variation	0 - 5% Variation	>5% Variation	5.7	5.0	5.0
		All Patients with LOS > 14 days	No.	312	306	305	119	138	257	143	179	322	322	No. Only	No. Only					n/a	345	312
		All Patients with LOS > 28 days	No.	152	179	161	62	83	145	71	83	154	154	No. Only	No. Only					190	174	152
		Min. Stay Rate (Electives (IP/DC) <2 days)	%	91.8	92.2	92.4	95.2	89.9	92.2	93.8	91.3	92.44	92.3	92.0	92.0		No Variation	0 - 5% Variation	>5% Variation	88.3	90.5	91.6
	Admissions	Day of Surgery (IP Elective Surgery)	%	82.3	82.4	82.6	88.8	84.8	86.1	87.0	85.4	86.0	84.0	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	63.2	76.5	79.4
		Day of Surgery (IP Non-Elective Surgery)	%	73.2	72.6	66.2	62.6	74.2	69.8	63.86	63.72	63.78	67.9	No. Only	No. Only					n/a	68.3	70.2
		With no Procedure (Elective Surgery)	%	7.6	9.2	9.2	13.7	8.5	10.2				9.7	No. Only	No. Only					10.6	n/a	10.6
		Per Bed (Elective)	No.	5.23	6.07	4.89	4.78	5.74	5.27	5.90	7.00	6.47	5.68	5.90	5.90		No Variation	0 - 5% Variation	>5% Variation	4.66	4.87	5.33
	Discharges	Pt's Social Care Delay	No.	8	15	14	4	6	10	6	10	16	16	<18	<18	c	No Variation	0 - 10% Variation	>10% Variation			
		Pt.'s NHS & NHS plus S.C. Delay	No.	6	8	12	0	8	8	2	1	3	3	<10	<10		No Variation	0 - 10% Variation	>10% Variation			
	Beds	Occupied Bed Days	No.	29282	23098	27186	12523	15216	27739	14024	17066	31912	117105	112976	342000		No Variation	0 - 5% Variation	>5% Variation	378060	348676	342793
		Occupancy Rate	%	88.5	86.2	83.57	84.31	87.22	85.71	86.0	84.5	85.2	85.2	86.5 - 89.5	86.5-89.5		86.5 - 89.5	85.5-86.4 or 89.6-90.5	<85.5 or >90.5	88.6	90.8	90.3
		Open at month end (exc Obstetrics)	No.	975	986	940	461	488	949	465	496	961	961	975	975		No Variation	0 - 2% Variation	>2% Variation	1039	1007	975
	Day Case Rates	All Procedures	%	78.8	78.7	79.0	83.3	70.9	76.3	82.2	75.4	78.5	77.9	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	76.0	76.9	79.0
		BMEC Procedures	%	78.3	76.4	79.5		80.2	80.2		80.74	80.74	79.1	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	71.5	77.2	79.7
	Non-Admitted Care	New : Review Rate	Ratio	2.46	2.66	2.71	2.56	2.44	2.49	2.46	2.48	2.47	2.55	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	2.91	2.74	2.45
		DNA Rate - New Referrals	%	11.7	11.8	16.3	15.0	15.5	15.3	13.5	15.2	14.6	13.6	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	10.8	10.9	12.0
		DNA Rate - Reviews	%	12.4	14.5	14.5	14.1	13.6	13.8	13.7	12.7	13.1	12.6	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	12.8	13.5	13.5
	Pathology	Cervical Cytology Turnaround	Weeks	2.7	3.8	4.3	→		4.3	→		3.3	3.3	<4.0	<4.0		<4.0	4.0-6.0	>6.0	1.7 - 4.0	1.5 - 2.9	2.7
	Ambulance Turnaround	In Excess of 30 minutes	%	19	17	17	18	17	17	n/a	n/a	n/a	17	<10.0	<10.0		<10	10 - 12.5	>12.5	n/a	29.1	19.0
		(West Midlands average)	%	21	20	20	→		19	→		n/a	19	No. Only	No. Only	k				n/a	31.1	21.0
		In Excess of 60 minutes	No.	13	7	9	15	11	26	n/a	n/a	n/a	26	0	0		0	1 - 5	>5	n/a	n/a	
THEATRE UTILISATION																						
RK	Sitrep Declared Late **Cancellations** by Specialty	General Surgery	No.	2	6	5	16	0	16	8	5	13	40	20	60	b	0-5% variation	5 - 15% variation	>15% variation	n/a	75	104
		Urology	No.	1	3	1	0	2	2	1	3	4	10	16	48		0-5% variation	5 - 15% variation	>15% variation	n/a	67	102
		Vascular Surgery	No.	0	0	0	0	1	1	0	0	0	1	1	3		0-5% variation	5 - 15% variation	>15% variation	n/a	1	7
		Trauma & Orthopaedics	No.	13	3	0	1	4	5	3	8	11	19	24	72		0-5% variation	5 - 15% variation	>15% variation	n/a	100	75
		ENT	No.	2	0	0	0	3	3	0	2	2	5	4	12		0-5% variation	5 - 15% variation	>15% variation	n/a	19	23
		Ophthalmology	No.	14	9	19	0	14	14	6	6	12	54	36	108		0-5% variation	5 - 15% variation	>15% variation	n/a	139	153
		Oral Surgery	No.	5	2	0	0	6	6	0	0	0	8	3	8		0-5% variation	5 - 15% variation	>15% variation	n/a	10	19
		Cardiology	No.	0	0	1	1	0	1	1	0	1	3	7	21		0-5% variation	5 - 15% variation	>15% variation	n/a	28	31
		Gynaecology	No.	6	3	1	4	2	6	3	1	4	14	18	54		0-5% variation	5 - 15% variation	>15% variation	n/a	69	71
		Plastic Surgery	No.	1	1	0	1	0	1	1	4	5	7	4	12		0-5% variation	5 - 15% variation	>15% variation	n/a	17	21
		Dermatology	No.	8	0	10	0	1	1	0	0	0	11	8	24		0-5% variation	5 - 15% variation	>15% variation	n/a	4	24
		TOTAL	No.	52	27	37	23	33	56	23	29	52	172	141	422		0-5% variation	5 - 15% variation	>15% variation	n/a	529	630

Exec Lead	WORKFORCE			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	WTE in Post	Total	No.	6042 ▼	6178 ▲	6232 ▼	→		6315 ▼	→		6271 ▲	6271	6385	6241		No Variation	0 - 1% Variation	>1% Variation	6000	5875	6042
		Medical and Dental	No.	755 ▲	759 ▼	756 ▲	→		744 ▲	→		739 ▲	739	776	761		No Variation	0 - 1% Variation	>1% Variation	822	736	755
		M'ment, Admin. & HCAs	No.	1852 ▼	1966 ▼	1972 ▲	→		2015 ▼	→		2016 ▼	2016	2017	1952		No Variation	0 - 1% Variation	>1% Variation	1806	1765	1852
		Nursing & Midwifery (excluding Bank)	No.	2259 ■	2317 ▼	2346 ▼	→		2355 ▼	→		2344 ▲	2344	2585	2547		No Variation	0 - 1% Variation	>1% Variation	2481	2255	2259
		Scientific and Technical	No.	913 ▲	935 ▲	942 ▼	→		935 ▲	→		949 ▼	949	1003	981		No Variation	0 - 1% Variation	>1% Variation	891	869	913
		Bank Staff	No.	260	201	216	→		266	→		223	223	No. Only	No. Only					n/a	250	260
		Gross Salary Bill	£000s	22232 ▼	20168 ■	20556 ■	→		20906 ▼	→		20724 ▲	82351	81138	243342		No Variation	0 - 1% Variation	>1% Variation	220244	219667	238674
RK	Bank & Agency	Nurse Bank Fill Rate	%	84.3	86.3	87.7	→		82.8	→		86.4	86.1	No. Only	No. Only	l				n/a	87.6	81.8
		Nurse Bank Shifts covered	No.	6524 ▼	5199 ■	5225 ▼	→		5134 ▲	→		5250 ▼	20808	20612	61836		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	67330	68707	69675
		Nurse Agency Shifts covered	No.	362 ▲	299 ▲	264 ▲	→		459 ■	→		455 ▲	1477	1657	4972		0 - 5% Variation	5 - 10% Variation	>10% Variation	2879	5524	4765
		Nurse Bank AND Agency Shifts covered	No.	6524 ▼	5498 ■	5489 ▲	→		5593 ▼	→		5705 ▼	22285	22269	66808		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	70209	74231	74440
		Nurse Bank Costs	£000s	699 ▼	472 ■	536 ▼	→		529 ▲	→		530 ▼	2067	2141	6423		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	6883	6980	6844
		Nurse Agency Costs	£000s	106 ■	66 ■	24 ▲	→		24 ■	→		103 ■	217	331	992		0 - 5% Variation	5 - 10% Variation	>10% Variation	474	1078	832
KD		Medical Agency Costs	£000s	309 ▼	119 ▲	109 ■	→		277 ■	→		174 ▲	679	397	1192		0 - 5% Variation	5 - 10% Variation	>10% Variation	693	1296	2026
RK		Other Agency Costs	£000s	773 ▼	239 ▲	198 ▲	→		331 ▼	→		240 ▲	1008	470	1410		0 - 5% Variation	5 - 10% Variation	>10% Variation	1661	2223	3759
KD		Medical Locum Costs	£000s	225 ■	256 ▼	200 ▲	→		174 ■	→		293 ■	923	750	2250		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	2566	2445	2747
RK/KD		Agency Spend cf. Total Pay Spend	%	5.35 ▼	2.10 ■	1.61 ■	→		3.02 ■	→		2.49 ▲	2.31	<2.00	<2.00		<2	2 - 2.5	>2.5	1.50	2.15	2.77
CH	Sickness Absence	Long Term	%	2.85 ■	2.50 ▲	2.58 ▼	→		2.60 ▼	→			2.56	<3.00	<3.00		<3.0	3.0-3.35	>3.35	2.50	3.52	3.16
		Short Term	%	1.10 ▲	1.09 ▲	1.10 ▼	→		1.26 ■	→			1.15	<1.25	<1.25		<1.25	1.25-1.40	>1.40	2.17	1.26	1.22
		Total	%	3.95 ■	3.59 ▲	3.68 ▼	→		3.86 ▼	→			3.71	<4.25	<4.25		<4.25	4.25-4.75	>4.75	4.67	4.78	4.38
	Recruitment & Retention	Permission to Recruit	wte	87	83	72	→		91	→		79	325	No. Only	No. Only					n/a	1143	1124
		New Starters	wte	102	85	69	→		56	→		54	264	No. Only	No. Only					n/a	855	1066
		Leavers	wte	82	36	57	→		35	→		53	181	No. Only	No. Only					n/a	1004	999
		Inductions	No.	72	59	88	→		72	→		71	290	No. Only	No. Only					n/a	442	896
	Learning & Development	PDRs (includes Junior Med staff)	No.	248 ▲	219 ▼	313 ▲	→		379 ▲	→		384 ▲	1295	1780	5341	m	0-5% variation	5 - 15% variation	>15% variation	n/a	1963	4518
		Mandatory Training	No.	341 ▲			→			→					5163		0-5% variation	5 - 15% variation	>15% variation	4313	2770	4044
		Conflict Resolution Training	No.	87 ■	159 ■	298 ▲	→		270 ▼	→		253 ▼	980	667	2000		0-5% variation	5 - 15% variation	>15% variation	1441	1712	1050

KEY TO PERFORMANCE ASSESSMENT SYMBOLS

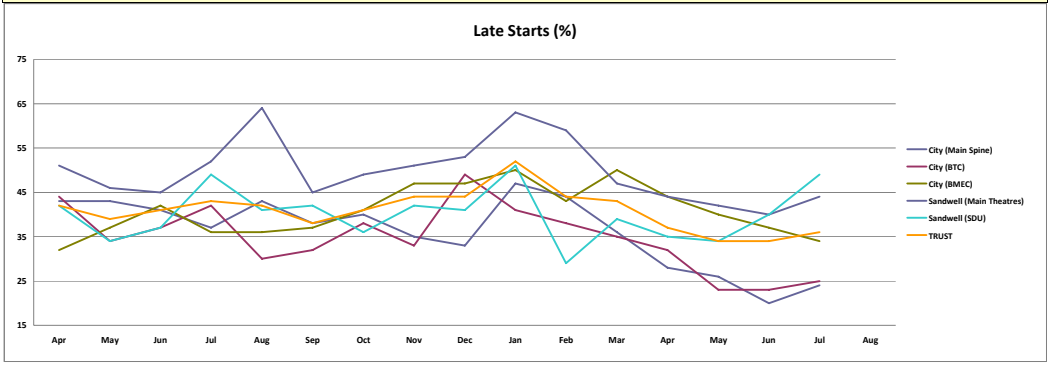
▲	Fully Met - Performance continues to improve
■	Fully Met - Performance Maintained
▼	Met, but performance has deteriorated
▲	Not quite met - performance has improved
■	Not quite met
▼	Not quite met - performance has deteriorated
▲	Not met - performance has improved
■	Not met - performance showing no sign of improvement
▼	Not met - performance shows further deterioration

Please note: Although actual performance within the period may have improved, this may not always be reflected by a symbol which reflects this, if the distance from trajectory has worsened

SUPPLEMENTARY DATA THEATRE UTILISATION

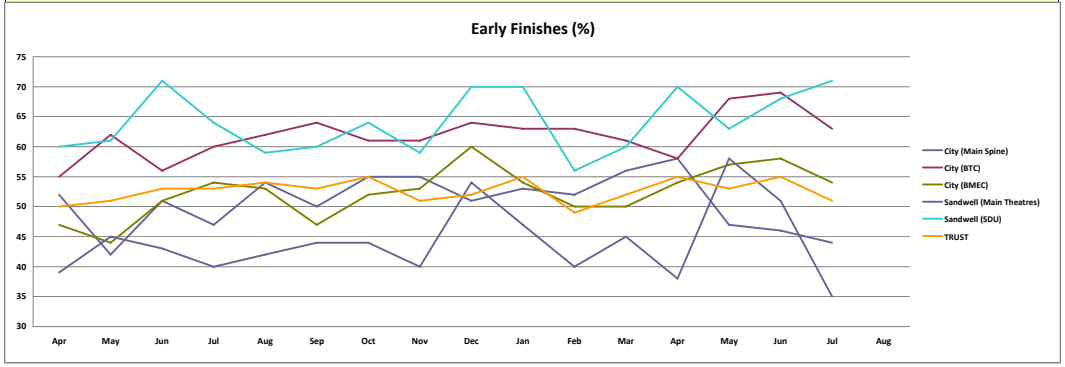
LATE STARTS (%)	2008 / 2009												2009 / 2010				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	43	43	41	37	43	38	40	35	33	47	44	36	28	26	20	24	
City (BTC)	44	34	37	42	30	32	38	33	49	41	38	35	32	23	23	25	
City (BMEC)	32	37	42	36	36	37	41	47	47	50	43	50	44	40	37	34	
Sandwell (Main Theatres)	51	46	45	52	64	45	49	51	53	63	59	47	44	42	40	44	
Sandwell (SDU)	42	34	37	49	41	42	36	42	41	51	29	39	35	34	40	49	
TRUST	42	39	41	43	42	38	41	44	44	52	44	43	37	34	34	36	

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



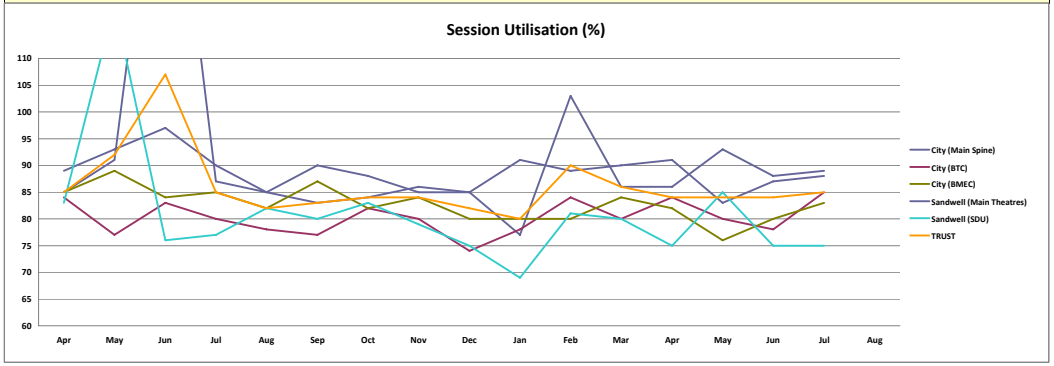
EARLY FINISHES (%)	2008 / 2009												2009 / 2010				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	52	42	51	47	54	50	55	55	51	53	52	56	58	47	46	44	
City (BTC)	55	62	56	60	62	64	61	61	64	63	63	61	58	68	69	63	
City (BMEC)	47	44	51	54	53	47	52	53	60	54	50	50	54	57	58	54	
Sandwell (Main Theatres)	39	45	43	40	42	44	44	40	54	47	40	45	38	58	51	35	
Sandwell (SDU)	60	61	71	64	59	60	64	59	70	70	56	60	70	63	68	71	
TRUST	50	51	53	53	54	53	55	51	52	55	49	52	55	53	55	51	

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



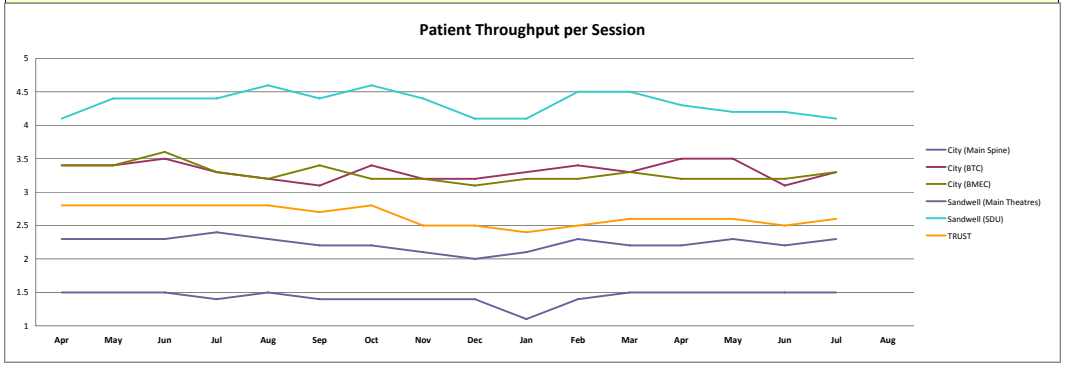
SESSION UTILISATION (%)	2008 / 2009												2009 / 2010				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	85	91	165	87	85	83	84	86	85	77	103	86	86	93	88	89	
City (BTC)	84	77	83	80	78	77	82	80	74	78	84	80	84	80	78	85	
City (BMEC)	85	89	84	85	82	87	82	84	80	80	80	84	82	76	80	83	
Sandwell (Main Theatres)	89	93	97	90	85	90	88	85	85	91	89	90	91	83	87	88	
Sandwell (SDU)	83	120	76	77	82	80	83	79	75	69	81	80	75	85	75	75	
TRUST	85	92	107	85	82	83	84	84	82	80	90	86	84	84	84	85	

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



THROUGHPUT / SESSION	2008 / 2009												2009 / 2010				
Theatre Location	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	1.4	1.5	1.4	1.4	1.4	1.4	1.1	1.4	1.5	1.5	1.5	1.5	1.5	
City (BTC)	3.4	3.4	3.5	3.3	3.2	3.1	3.4	3.2	3.2	3.3	3.4	3.3	3.5	3.5	3.1	3.3	
City (BMEC)	3.4	3.4	3.6	3.3	3.2	3.4	3.2	3.2	3.1	3.2	3.2	3.3	3.2	3.2	3.2	3.3	
Sandwell (Main Theatres)	2.3	2.3	2.3	2.4	2.3	2.2	2.2	2.1	2.0	2.1	2.3	2.2	2.2	2.3	2.2	2.3	
Sandwell (SDU)	4.1	4.4	4.4	4.4	4.6	4.4	4.6	4.4	4.1	4.1	4.5	4.5	4.3	4.2	4.2	4.1	
TRUST	2.8	2.8	2.8	2.8	2.8	2.7	2.8	2.5	2.5	2.4	2.5	2.6	2.6	2.6	2.5	2.6	

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance – Month 4
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	27 August 2009

SUMMARY OF KEY POINTS:

The report is provided to update the Trust Board on financial performance for the four months to 31st July 2009.

In-month surplus is £364k against a target surplus of £360k; £4k above plan with significant improvement in patient related income.

Year to date surplus is £876k against a plan of £1,066k, £190k below plan.

In-month WTEs are 114 below plan.

Cash balance is £2.2m below plan at 31st July.

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

Approval	Receipt and Noting	Discussion
X	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

- To receive and note the monthly finance report.
- To endorse any actions taken to ensure that the Trust remains on target to achieve its planned financial position.
- To approve the amendment to the capital programme in relation to estates statutory standards and risk related expenditure.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Deliver the financial plan including achieving a financial surplus of £2.269m and a CIP of £15m.
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	Reporting and management of financial position.

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

Financial		Potential to fail to meet statutory financial targets.
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		Potential to fail to meet statutory financial targets.

PREVIOUS CONSIDERATION:

Previously considered at Financial Management Board and Trust Management Board meetings on 18 August 2009 and at the Finance and Performance Management Committee meeting on 20 August 2009.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2009

EXECUTIVE SUMMARY

• For the first four months of the financial year, the Trust generated an overall I&E surplus of £876k which is £190k less than the planned position. In month, the Trust generated a net surplus of £364k which is £4k better than planned and reverses the deficit position seen in the previous month although the Trust still has a year to date shortfall against plan.

• Fully coded and priced activity information is available for June and patient related SLA income included within this report is based on this position.

• At month end WTE's (whole time equivalents) were 114 below plan but total pay expenditure was £225k above plan. This includes £516k of agency expenditure during July.

• The cash balance is equal to the revised plan at the month end but £2.2m lower than the original plan.

• There has been a small relative improvement in performance across a number of divisions in month, primarily driven by improved SLA income performance although there are still a number of operational divisions where financial performance has worsened notably in month.

Financial Performance Indicators

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	4	-190	> Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	6	-164	> Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	-225	-1,213	< Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	-376	-606	< Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	114	120	< Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	0	0	> = Plan	> = 95% of plan	< 95% of plan
CIP Actual v Plan £000	-80	-301	> 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	1,066	876
Capital Resource Limit	0	887
External Financing Limit	---	13,516
Return on Assets Employed	3.50%	3.50%

2009/2010 Summary Income & Expenditure Performance at July 2009	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
Income from Activities	329,419	27,545	28,265	720	110,007	111,835	1,828
Other Income	36,973	3,191	3,078	(113)	12,257	12,084	(173)
Operating Expenses	(337,729)	(28,177)	(28,778)	(601)	(112,400)	(114,219)	(1,819)
EBITDA	28,663	2,559	2,565	6	9,864	9,700	(164)
Interest Receivable	150	13	7	(6)	50	24	(26)
Depreciation & Amortisation	(17,246)	(1,437)	(1,433)	4	(5,749)	(5,749)	0
PDC Dividend	(9,258)	(772)	(772)	0	(3,086)	(3,086)	0
Interest Payable	(40)	(3)	(3)	0	(13)	(13)	0
Net Surplus/(Deficit)	**2,269**	**360**	**364**	**4**	**1,066**	**876**	**(190)**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2009

Divisional Performance

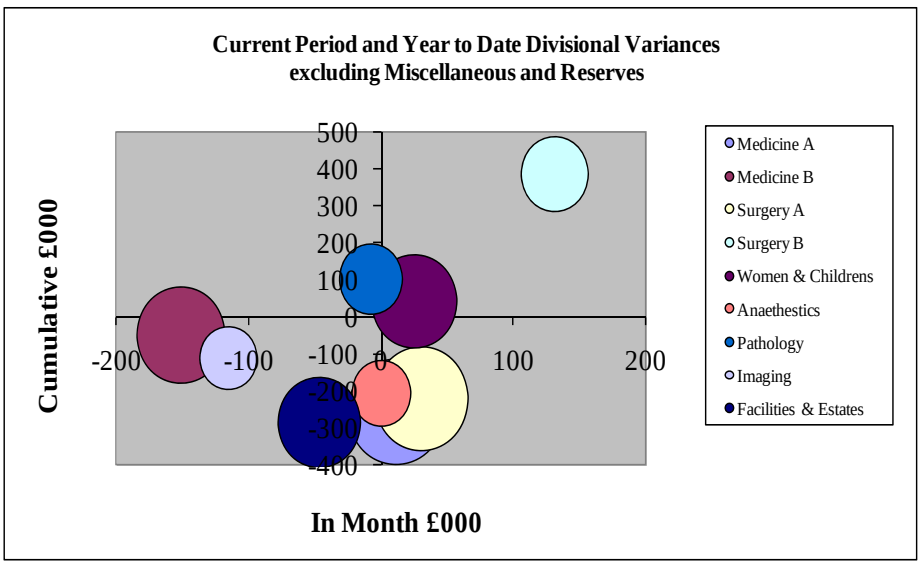
• Compared with the previous month, the overall position of the Trust has improved with an in month bottom line performance which has now returned to a surplus marginally better than the planned position for the month. This improvement has primarily been driven by better than planned SLA income resulting from higher levels of patient related activity. Pay performance has continued to deteriorate, albeit at a slower rate than experienced earlier in the year. There has also been a significant downward shift in non pay performance with an in month performance £376k worse than planned. However, much of this relates to medical equipment and consumables which has a close link with levels of patient activity.

•In month, Imaging, Medicine B and Nursing – Facilities have all generated significant deficits. Imaging performance is driven primarily by a combination of income shortfalls (both direct patient related income and krypton sales) and increased expenditure on consumables. Medicine B also has a patient related income shortfall coupled with ongoing high levels of bank and agency spend. Facilities performance continues to be mainly the result of ongoing pay costs linked with higher levels of cleaning and infection control measures.

•The significant improvement in patient related income has benefited a number of divisions, primarily Surgery A and surgery B and, to a lesser extent, Medicine A although performance does remain variable across divisions.

•The performance for the Trust overall is assisted by favourable budget positions within corporate divisions with a year to date performance £191k better than plan.

• An additional £141k expenditure was incurred on specific pandemic flu related issues (primarily in Medicine A and Operations) bringing the year to date total to £314k. This expenditure has been funded from Trust reserves.

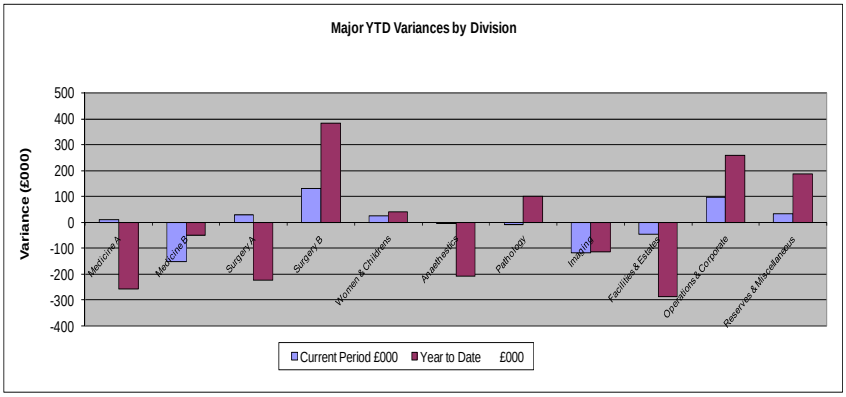


The tables adjacent and overleaf show a mixed position across divisions. A general improvement in performance in July has brought more divisions into or closer to a break even position.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

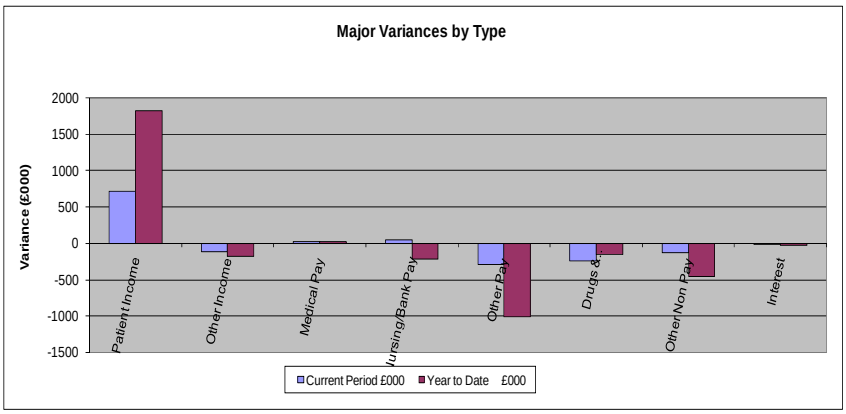
Financial Performance Report – July 2009

Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine A	11	-258
Medicine B	-152	-49
Surgery A	30	-222
Surgery B	131	385
Women & Childrens	25	40
Anaethestics	0	-206
Pathology	-8	101
Imaging	-116	-112
Facilities & Estates	-47	-286
Operations & Corporate	96	257
Reserves & Miscellaneous	35	187



The tables below illustrate that overall income has performed better than plan for the year to date, driven by patient related SLAs. The worsening position of pay expenditure against plan has continued in month with ongoing high levels of spend on bank and agency staff. In month non pay expenditure is also significantly in excess of plan although some of this expenditure can be attributed to higher levels of patient activity as well as some irregularity in spend patterns.

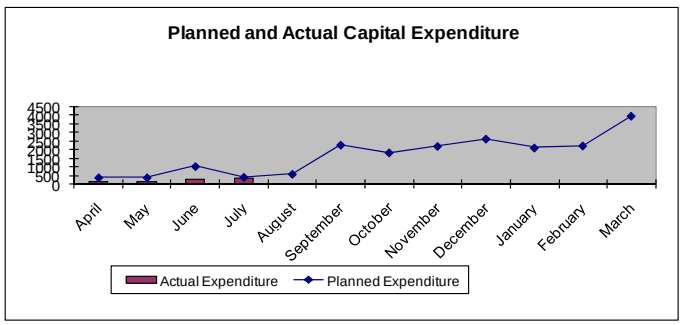
Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	720	1828
Other Income	-113	-173
Medical Pay	20	20
Nursing/Bank Pay	51	-222
Other Pay	-296	-1011
Drugs & Consumables	-246	-157
Other Non Pay	-130	-449
Interest	-6	-26



Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Expenditure of £363k was incurred in July mainly relating to the Urgent Care Centre and mixed sex accommodation This brings total capital expenditure for the year to date up to £887k.

•As the anticipated phasing of land purchases has changed, SIRG is in the process of updating the Trust's capital programme. To date approvals have been given for schemes detailed overleaf. The remainder of the programme has been held as earmarked but not formally committed. This will be updated at the next meeting of SIRG.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2009

Updates to Capital Programme

Additions to the capital programme have been made by SIRG as follows:

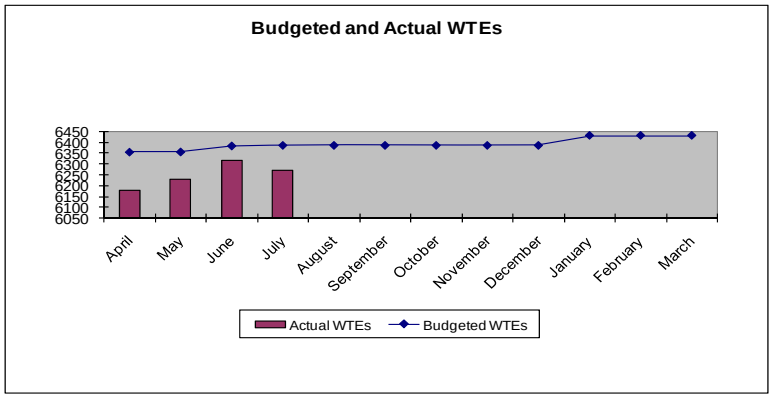
- Additional IT expenditure £100k
- Telecoms equipment £220k
- Additional mixed sex related work on Priory 2 (medical gases) £14k
- City CBRN facility £60k
- HSSU/medical records racking £45k

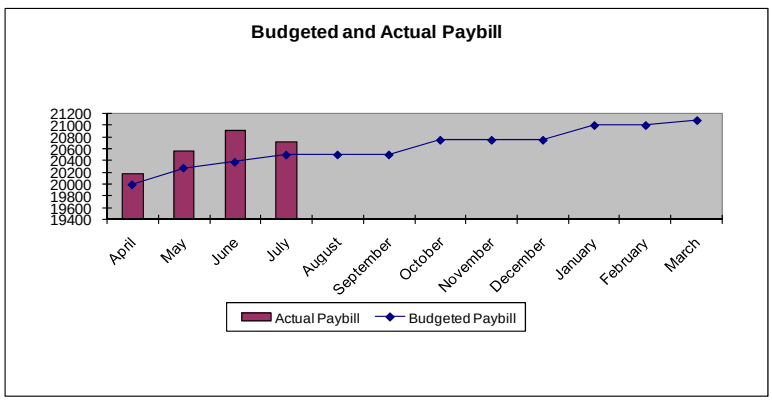
Paybill & Workforce

• Overall workforce numbers (wtes) are 114 below plan for July, an improvement on the position for June of approximately 47 wte's.

•Paybill (including agency staff) is £225k above budgeted levels for the month and £1,213k for the year to date. This is a significant (£305k) improvement on performance in June, primarily driven by a reduction in nursing and midwifery spend as well as lower agency expenditure.

•In month expenditure on agency staff was £516k compared with an average for April to June of £462k. Excluding agency spend, actual pay expenditure would be approximately £200k better than plan. Although this is an improved position compared with June, agency expenditure is still running at high levels which can no longer be accommodated by under spending elsewhere.





Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2009

Pay Variance by Pay Group

• The table below provides an analysis of all pay costs by major pay group by removing both bank and agency costs and allocating these into the appropriate main pay group.

•The table demonstrates that the major areas of pay overspend 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.

Analysis of Total Pay Costs by Staff Group

	Year to Date to July					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	23,765	23,657		679	24,336	-571
Management	4,627	4,326			4,326	301
Administration & Estates	9,111	8,928		407	9,335	-224
Healthcare Assistants & Support Staff	3,981	3,943	625	501	5,069	-1,088
Nursing and Midwifery	28,609	26,727	1,454	216	28,397	212
Scientific, Therapeutic & Technical	11,022	10,778		99	10,877	145
Other Pay	23	11			11	12
Total Pay Costs	81,138	78,370	2,079	1,902	82,351	-1,213

Balance Sheet

• The opening balance sheet for the year at 1st April reflects the final audited accounts for 2008/2009.

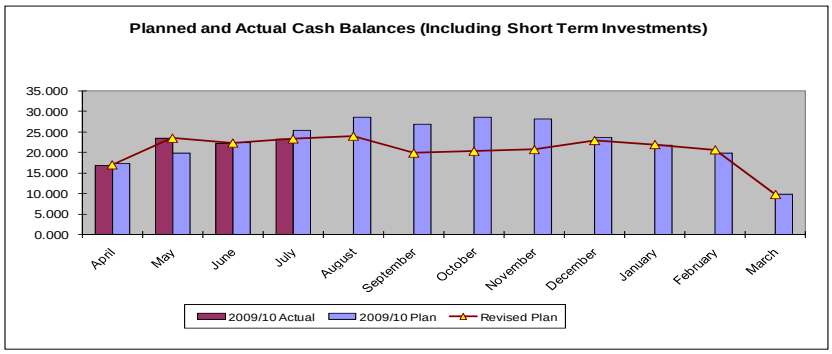
•Cash balances at 30th July are approximately £2.2m lower than the original plan, primarily driven by higher than planned levels of creditor payments. The cash plan for the remainder of the year has been updated to reflect actual cash movements to 31st July and known or expected changes to the position in future months. The Trust is still planning to hold the same year end cash balance as included in its original financial plan for the year.

Sandwell & West Birmingham Hospitals NHS Trust
BALANCE SHEET

		Opening Balance as at March 2009 £000	Balance as at July 2009 £000	Forecast at March 2010 £000
Fixed Assets	Intangible Assets	547	500	522
	Tangible Assets	255,007	250,145	260,039
	Investments	0	0	0
Current Assets	Stocks and Work in Progress	3,295	3,317	3,300
	Debtors and Accrued Income	20,242	17,952	18,500
	Investments	0	0	0
	Cash	8,752	23,261	9,750
Current Liabilities	Creditors and Accrued Expenditure Falling Due In Less Than 1 Year	(27,328)	(36,226)	(24,752)
	Loan Repayments Due in Less Than 1 Year	0	0	(2,049)
Long Term Liabilities	Creditors Falling Due in More Than 1 Year	0	0	(2,049)
Provisions for Liabilities and Charges		(7,633)	(5,191)	(5,500)
		252,882	253,758	257,761
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,661
	Revaluation Reserve	60,699	60,699	63,199
	Donated Asset Reserve	2,531	2,531	2,391
	Government Grant Reserve	1,985	1,985	1,805
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	18,378	19,254	20,647
		252,882	253,758	257,761

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – July 2009



Cash Flow

• The table below shows actual cash receipts and payments for July 2009 and a forecast of expected flows for the following 12 months.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT July 2009

ACTUAL/FORECAST	July-09 £000s	Aug-09 £000s	Sept-09 £000s	Oct-09 £000s	Nov-09 £000s	Dec-09 £000s	Jan-10 £000s	Feb-10 £000s	March-10 £000s	April-10 £000s	May-10 £000s	Jun-10 £000s	Jul-10 £000s
Receipts													
SLAs: Sandwell PCT	**13,013**	13,040	13,040	13,040	13,040	13,040	13,040	13,040	13,040	13,236	13,236	13,236	13,236
HoB PCT	**7,155**	7,198	7,198	7,198	7,198	7,198	7,198	7,198	7,198	7,306	7,306	7,306	7,306
South Birmingham PCT	**1,320**	1,264	1,264	1,264	1,264	1,264	1,264	1,264	1,264	1,282	1,282	1,282	1,282
BEN PCT	**1,733**	1,732	1,732	1,732	1,732	1,732	1,732	1,732	1,732	1,757	1,757	1,757	1,757
Pan Birmingham LSCG	**1,213**	1,213	1,213	1,213	1,213	1,213	1,213	1,213	1,213	1,231	1,231	1,231	1,231
Other PCTs	**2,251**	2,496	2,496	2,496	2,496	2,496	2,496	2,496	2,496	2,534	2,534	2,534	2,534
Over Performance Payments	**0**	0	750	0	0	750	0	0	0	1,000			
Education & Training	**1,814**	1,501	1,501	1,501	1,501	1,501	1,501	1,501	1,501	1,523	1,523	1,523	1,523
Loans	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Interest	**6**	6	7	6	6	6	6	7	6	11	8	8	8
Other Receipts	**4,326**	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,090	2,090	2,090	2,090
Total Receipts	**32,831**	30,861	31,611	30,861	30,860	31,610	30,861	30,861	30,861	31,971	30,968	30,968	30,968
Payments													
Payroll	**12,036**	12,272	12,272	12,311	12,350	12,350	12,520	12,520	12,520	12,673	12,673	12,673	12,673
Tax, NI and Pensions	**8,296**	8,402	8,402	8,429	8,456	8,456	8,571	8,571	8,571	8,677	8,677	8,677	8,677
Non Pay - NHS	**2,613**	2,465	2,773	2,465	2,465	2,157	2,465	2,465	3,096	3,127	3,127	3,127	3,127
Non Pay - Trade	**8,163**	6,035	6,789	6,035	6,035	5,281	6,035	6,035	7,579	5,940	5,940	5,940	5,940
Non Pay - Capital	**360**	617	462	771	771	771	1,850	2,158	4,932	500	500	500	501
PDC Dividend	**0**	0	4,629	0	0	0	0	0	4,629	0	0	0	0
Repayment of Loans	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Interest	**0**	0	0	0	0	0	0	0	0	0	0	0	0
BTC Unitary Charge	**319**	325	325	325	325	325	325	325	325	335	335	335	335
Other Payments	**51**	70	70	70	70	70	70	70	70	355	355	356	357
Total Payments	**31,838**	30,186	35,723	30,406	30,472	29,409	31,835	32,144	41,722	31,606	31,606	31,607	31,609
Cash Brought Forward	**22,268**	23,261	23,936	19,824	20,279	20,667	22,869	21,894	20,612	9,750	10,115	9,476	8,837
Net Receipts/(Payments)	**993**	675	(4,112)	455	389	2,201	(975)	(1,283)	(10,861)	364	(639)	(640)	(642)
Cash Carried Forward	**23,261**	23,936	19,824	20,279	20,667	22,869	21,894	20,612	9,750	10,115	9,476	8,837	8,195

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2009

SLA Performance

•The table below shows a summary of both activity and financial performance for major patient types across the Trust's SLA's. This demonstrates that the majority of the financial gain is the result of higher than planned levels of out-patient activity. Final SLA performance remains subject to data challenges generated via the CBSA. These challenges could significantly worsen performance against SLAs if they are upheld. The Trust has made some provision in its overall income position to cover the effect of any upheld challenges.

Year to Date Key Performance Against SLA

PERFORMANCE UP TO JUNE	Activity			Finance		
	Planned	Actual	Variance	Planned £000	Actual £000	Variance £000
Accident & Emergency	60,008	60,703	695	4,421	4,360	-62
Admitted Patient Care - Elective	15,066	16,005	939	13,651	14,208	557
Admitted Patient Care - Non Elective	14,153	14,892	739	22,460	22,160	-300
Excess Bed Days	8,843	9,243	400	1,831	1,842	12
Other	0	0	0	19,184	19,262	78
Out-Patients First Attendance	38,948	39,840	892	6,540	6,748	208
Out-Patients Follow Up	92,741	98,816	6,075	8,061	8,671	610
Out-Patients With Procedure	1,845	5,398	3,553	384	1,223	839
Unbundled Activity	3,349	13,896	10,547	2,635	2,635	0
Total				**79,166**	**81,108**	**1,942**

Note: This analysis does not cover all services provided under SLAs

SLA Performance by Commissioner

• The table adjacent shows overall financial performance by commissioner for the Trust's major commissioners. This demonstrates that over performance is spread over a large number of commissioners including specialised service agencies.

Year to Date SLA Performance for Major Commissioners

PERFORMANCE UP TO JUNE	Finance		
	Planned £000	Actual £000	Variance £000
SANDWELL PCT	38,170	38,473	303
HEART OF BIRMINGHAM TEACHING PCT	21,248	21,487	238
BIRMINGHAM EAST & NORTH PCT	5,110	5,230	120
SOUTH BIRMINGHAM PCT	3,735	4,105	370
PAN BIRMINGHAM LSCG	3,571	3,904	332
WALSALL PCT	1,585	1,491	-94
WEST MIDLANDS SCT	1,314	1,335	21
DUDLEY PCT	1,111	1,195	84
WORCESTERSHIRE PCT	663	782	119
SOLIHULL CARE TRUST	580	689	109
TOTAL	**77,086**	**78,691**	**1,604**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2009

SLA Performance by Specialty

• The table adjacent shows overall financial performance by specialty for the Trust's largest specialties. This is a summary of all types of activity within any given specialty and includes both admitted patient care and out-patients. It therefore needs to be considered only as broad indication of performance within each area as there may be different issues affecting different patient types within a specialty.

Year to Date SLA Performance for Major Specialties

PERFORMANCE UP TO JUNE	Finance		
	Planned £000	Actual £000	Variance £000
General Medicine	9,187	6,660	-2,527
Trauma & Orthopaedics	6,273	5,859	-414
Maternity	6,062	6,092	30
Ophthalmology	5,688	5,995	308
A&E	5,273	4,853	-420
General Surgery	4,995	4,668	-327
Elderly Care	4,826	5,139	313
Oncology	3,177	3,327	150
Cardiology	2,506	3,322	816
Paediatrics	2,461	2,676	216
Critical Care	2,420	2,419	-1
Gynaecology	2,148	2,279	131
Urology	1,696	2,083	387
Neonatology	1,276	1,302	26
ENT	1,250	1,442	192
Dermatology	1,163	1,208	45
Gastroenterology	1,123	1,835	712
Clinical Haematology	967	1,294	328
Rheumatology	901	937	36
Plastic Surgery	811	922	112
TOTAL	**64,202**	**64,312**	**111**

Note: the performance of general medicine needs to be viewed alongside other medical specialties with planned general medicine activity actually delivered within medical sub specialties.

Risk Ratings

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	8.5%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	98.3%	4
Return on Assets	Surplus before dividends over average assets employed	1.7%	2
I&E Surplus Margin	I&E Surplus as % of total income	0.7%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	5.7	1
Overall Rating			**2.2**

Risk Ratings

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

•The only significantly weak area remains liquidity which will only be substantially corrected with the introduction of a working capital facility.

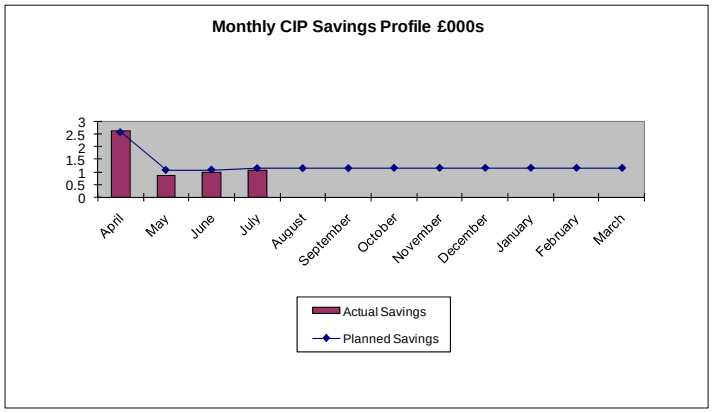
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2009

Cost improvement Programme

•The adjacent graph shows the monthly profile of the Trust's cost improvement programme and actuals achieved up to July.

•As at July, there is a shortfall against planned levels of £301k or 5.1% which is a slight improvement on the position for June.



External Focus and Forward Look

• The overall economic climate and public sector financial position remains largely unchanged and the Trust and wider Health Economy must prepare for the well documented reduced health spending after 2010/11.

• For 2011/2012, the first year following the end of the current Comprehensive Spending Review, it is expected there will be a significant tightening in the financial position of the NHS with minimal, if any, scope for growth. This will clearly have a significant impact on the local health economy and preparations for this period need to occur over the next 12-18 months.

•Based on performance up to June, Sandwell and West Birmingham Hospitals is also forecasting fairly significant over performance against its Service Level Agreements with PCTs and this over performance has grown sizeably in month. Although there are still outstanding data challenge issues, this over performance will impact on the financial position of PCTs, particularly if they are experiencing over performance elsewhere in the acute sector. In addition, the Right Care, Right Here proposals are based upon a common understanding and agreement of expected activity levels and the extent to which actual activity, if sustained, is out of line with these assumptions, there may be a knock on effect both operationally and financially to the RCRH schemes.

• Clearly, if the Trust is to meet its Income and Expenditure target at the end of the year, it is imperative that performance is sustained and improved for the remainder of the year. This particularly applies to pay expenditure which is generally more difficult to control in the shorter term.

• Given the expectation of a very tight financial settlement, particularly from 2011/2012 onwards, it is essential that the Trust is in the best possible financial position to move forward over the next few years. Part of this process will need to be to ensure that underlying financial performance is sound.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2009

Conclusions

•For the year to 30th July 2009, the Trust has generated an overall income and expenditure surplus of £876k which is £190k below plan. For the current month, the actual surplus of £364k was £4k above plan.

•Capital expenditure for the year to date remains low and amendments to the capital programme are being considered by SIRG to recover any potential under spending. Some proposed amendments are included within this report, others are expected to be confirmed at next month's SIRG meeting.

•At 31st July, cash balances are approximately £2.2m lower than originally planned. A revised cash forecast has been developed reflecting actual performance to 31st July and known or expected changes from the original plan for future months.

• A number of key divisions remain in significant year to date deficit although there have been some improvements in month, primarily driven by better than planned patient related income.

•Although the rate of over spending against pay budgets has improved in month, the issues raised in the previous report remain valid . Previous years under spending on substantive staff has significantly reduced and it is imperative that staff costs, and particularly the use of agency staff, are realigned to budgeted levels.

•Although some of the higher spending levels may be attributed to higher activity levels, it cannot be assumed that a positive contribution will be forthcoming in all areas.

• Initial meetings between key divisions and the Chief Operating Officer and Director of Finance have taken place to consider financial and operational performance and agree action plans to rectify any problems, e.g. CIP shortfalls and a further round of performance reviews is planned following submission of divisional rectification plans. In addition, the actions previously take to slow down expenditure remain in place, specifically strengthening vacancy approval procedures, evaluation of non contracted payments, selective establishment review and an assessment of use of bank and agency staff in targeted areas.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report;

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

iii. APPROVE the amendments to the capital programme outlined above.

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Annual Plan 2010/11 – Process and Timetable
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer/ Robert White, Director of Finance and Performance Management
AUTHOR:	Ann Charlesworth, Head of Corporate Planning
DATE OF MEETING:	27 August 2009

SUMMARY OF KEY POINTS:

The paper presents the proposed timetable for developing the Trust's Annual Plan for 2010/11.

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 process and timetable for the production of the Annual Plan 2010/11.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	Required to produce Annual Plan for the year ahead
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Previously considered and approved by the Trust Management Board on 18 August 2009.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST ANNUAL PLAN 2010/11
PROCESS AND TIMETABLE

INTRODUCTION

This paper presents the proposed timetable for developing the Trust's Annual Plan for 2010/11 for approval by the Trust Board.

PROCESS AND TIMETABLE

The proposed process and timetable for the production of the Trust's Annual Plan for 2010/11 by the beginning of April 2010 is set out below. This mirrors that for 2009/10 with minor variations. Detailed financial planning will proceed in parallel.

Stage	**Dates**
Annual Planning Process & Timetable report • to Trust Management Board (TMB) • to Trust Board	 18th Aug 09 27th Aug 09
Initial Cost Improvement Programme (CIP) proposals	tbc
Annual Planning Framework -Trust Board discussion (Propose use FT Seminar slot)	TBC
Issue Annual Planning Framework to Divisions	w/c 5th Oct 09
Divisions engage with Clinical Directorates	Mid Oct – Mid Nov 09
Planning meetings with each Division to review plans	w/c 16th /23rd Nov 09
First Cut Divisional Plans inc. CIP	27th Nov 09
Financial Plan – High level I&E assumptions 2010/11 • Finance and Performance Committee (F&PC) • Trust Board	 19th Nov 09 26th Nov 09
Review of Divisional submissions	Dec 09
National Operating Framework issued	Dec 09
Update of Planning Assumptions	Early Jan 10
Annual Plan Monthly updates to Trust Board	Jan-Mar 10
Financial Plan Update • F&PC • Trust Board	 21st Jan 10 28th Jan 10
Second Cut Divisional Plans	1st Feb 10

Stage	Dates
Financial Plan Draft • F&PC • Trust Board	 18th Feb 10 25th Feb 10
Draft Trust Annual Plan issued	w/c 22nd Feb 10
Local Delivery Plan Sign Off (assumed date)	end Feb 10
Consultation on draft Trust Annual Plan /Updating	From issue to 8th Mar 10
Annual Plan to TMB	16th Mar 10
Financial Plan – Final Sign Off • F&PC • Trust Board	 18th Mar 10 25th Mar 10
Annual Plan presented to Trust Board for approval	25th Mar 10
Printed version of Annual Plan completed	Mid May 10
Divisional Annual Plans Signed	By end May 10

It is proposed that the Trust Board should consider the initial Annual Planning Framework at the end of September. The Annual Planning Framework will then be issued to Divisions early in October setting out the corporate assumptions relating to our objectives, targets, patient activity and financial position for 2010/11. Divisions will be expected to return their draft Divisional Plan proformas by 27th November 2009.

The national Operating Framework containing planning assumptions and guidance is not expected to be issued until December. The timetable therefore allows for any update required to the Annual Planning Framework to be made and circulated in early January. The aim is to complete any adjustments to Divisional Plans and to produce the Trust's Annual Plan 2010/11 for Trust Board approval at the end of March 2010.

RECOMMENDATIONS

The Trust Board is recommended to:

1. APPROVE the process and timetable for the production of the Annual Plan 2010/11.

Ann Charlesworth
August 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Briefing on Staff Engagement
SPONSORING DIRECTOR:	Colin Holden, Director of Workforce
AUTHOR:	Sally Fox, LIA Facilitator
DATE OF MEETING:	27 August 2009

SUMMARY OF KEY POINTS:

The Trust has been using the 'Listening into Action' approach since April 2008. There are 48 established teams using the LiA approach.

There are plans to include a further 8 wards in the 'Optimal Ward' programme over the coming months. Facilities Division now has events planned for staff working within Transport, Catering and Security and Portering Services.

At a corporate level LiA is increasingly being used to address specific challenges with events planned for September and October.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The paper is presented to brief the Board.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to spread staff engagement through Listening into Action including delivery of the LiA 'Enabling our People' projects
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Considered at Trust Management Board on 18 August 2009

Briefing on Staff Engagement

Introduction

The Trust has been using the ‘Listening into Action’ approach since April 2008 as the principal means of engaging with staff about improving services for patients and also their own daily experience of working within this Trust..

There are 48 established teams using the LiA approach including 13’Optimal Wards’, 22 clinical teams, 5 teams from non-clinical areas and 8 teams working on the broader corporate ‘enabling’ projects.

This number is increasing all the time, and there are encouraging signs that engaging with staff in this way is increasingly becoming part of the normal way of working.

Current position

There are plans to include a further 8 wards in the ‘Optimal Ward’ programme over the coming months. In addition, the Facilities Division now has events planned for staff working within Transport, Catering and Security and Portering services which are scheduled to take place before Christmas. This will significantly increase the number of non-clinical staff involved in LiA.

The principles of LiA are being gradually incorporated in to situations where change is necessary and it is crucial to engage with staff. A recent example was the Maternity service, where the approach was used to gather staff’s views about a range of possible options. The same approach is being used to inform the reconfiguration of gynaecology services.

At a corporate level LiA is increasingly being used to address specific challenges-from identifying more environmentally sustainable ways of working (event planned for the 22 October), developing a cycling strategy for the Trust as part of the overall approach to transport (event planned for the 28 September) or improving our performance on the provision of mixed sex accommodation.

Where next?

The Executive Sponsor Group continues to monitor progress and receives reports on a quarterly basis from the Divisions. It will be considering the future development of ‘Listening into Action’ at its next meeting on the 18 August.

The Trust will also be taking part in an academic study evaluating the effectiveness of the LiA approach which is being led by the Strategic Health Authority.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Quarterly Infection Prevention and Control Report – April-June 2009
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Dr Beryl Oppenheim, Director of Infection Prevention and Control
DATE OF MEETING:	27 August 2009

SUMMARY OF KEY POINTS:

Organisational structures continue to work well although a significant new workload related to Influenza A H1N1 has resulted in delays to some aspects of joint working with community partners

Numbers of cases of MRSA bacteraemia and Clostridium difficile infections remain low and within our threshold levels, the focus now remains on sustaining these over time.

Audit and directed training continue to be prioritised as a means of delivering continuous improvements. The revision of the ten key infection control rules is an important aspect of ensuring that staff understand their own responsibilities and will be linked to induction and mandatory training.

PURPOSE OF THE REPORT:

☐ **Approval** ☉ **Noting** ☐ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive and note the Quarterly Report for April-June 2009.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to reduce hospital infection rates, and achievement of national and local targets
Annual priorities	
NHS LA standards	2.4.9 Infection Control
Core Standards	C21 - Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.
Auditors' Local Evaluation	Continue to reduce hospital infection rates, and achievement of national and local targets

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

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

PREVIOUS CONSIDERATION:

Not previously considered.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUARTERLY INFECTION PREVENTION AND CONTROL REPORT APRIL-JUNE 2009

Management and Organisation

Overall, management arrangements within the Trust continue to work well, although unfortunately some meetings and proposals for joint working with community partners have been postponed or cancelled because of pressure of influenza related work.

MRSA

Mandatory Reporting of MRSA bloodstream infections

These were a total of 5 MRSA bacteraemias during this quarter (Figure 1), with our threshold for that period being 6. Four of these were in samples taken within 48 hours of admission and 1 was from a patient who had been an in-patient for some time.

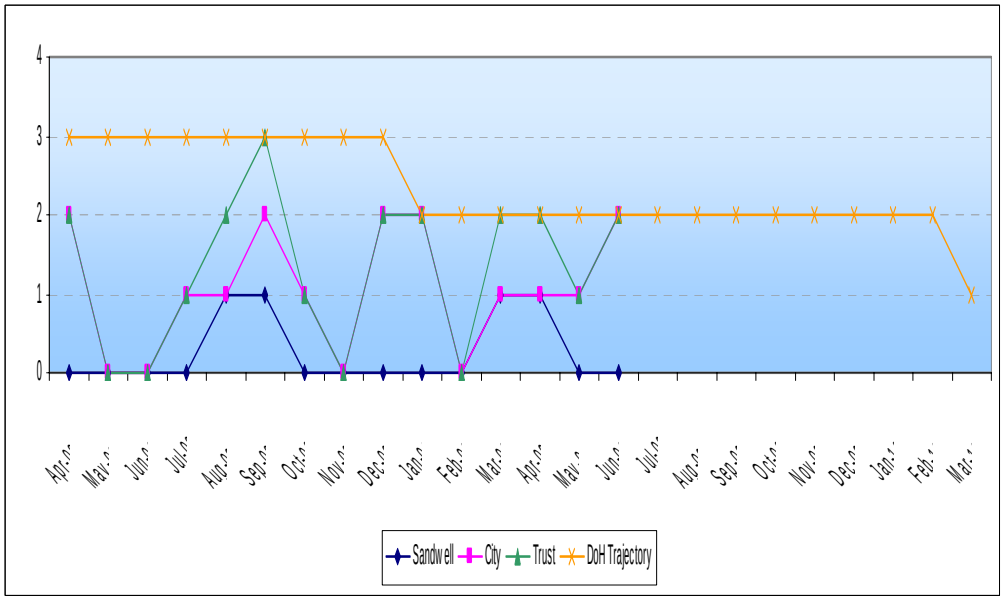
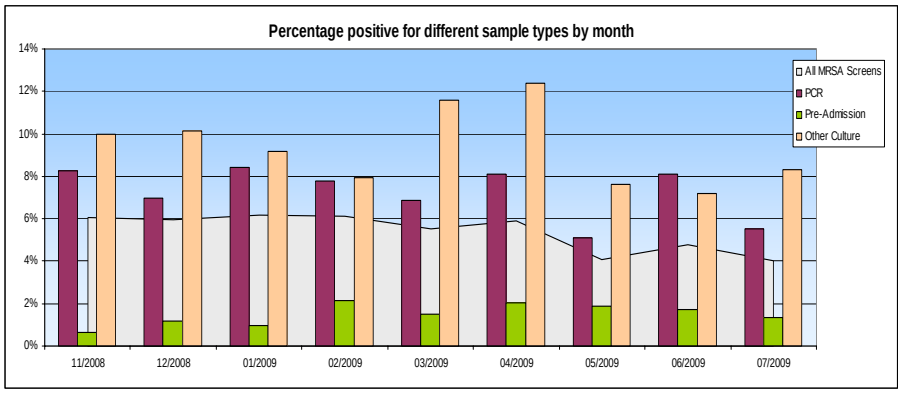


Figure 1. Total MRSA bacteraemias during quarter Apr-June 2009

MRSA Screening and Decolonisation Therapy

Many aspects of the MRSA screening programme are bedding down well, but we feel that there is still room for education and training on all aspects of the programme, particularly for those staff who are not directly involved with screening of elective and non-elective admissions.

We continue to monitor overall numbers of patients screened and positivity rates.



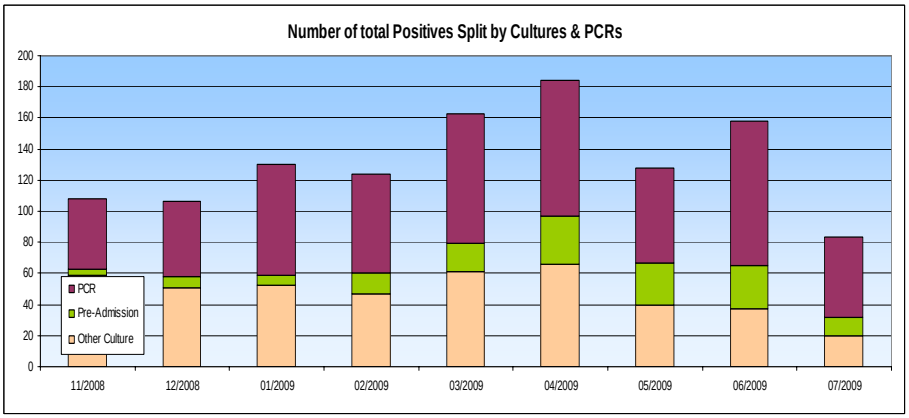


Figure 2.

Clostridium difficile infections (CDI)

There were 53 cases of CDI in patients admitted to the Trust during the period April to June 2009, of which 32 were diagnosed after 48 hours and are attributable to our trajectory (Figure 2). This compares with 48 cases in the comparable period of the previous financial year, showing that we have continued to reduce hospital acquired cases year on year.

Of particular note was the month of June, where the number of cases diagnosed was 7, the lowest number for a single month which we have recorded since collecting data in this way.

We feel that the reasons for this further reduction in cases are multifunctional but an important intervention does appear to be the use of the new highly sensitive testing algorithm which allows us to diagnose cases at a very early stage, giving an improved outcome to individual patients and also preventing ongoing spread to others within the hospital.

The timing of the new testing regimen in relation to the further decreaser on cases diagnosed after 48 hours is shown in the rolling 30 day graph (Figure 3).

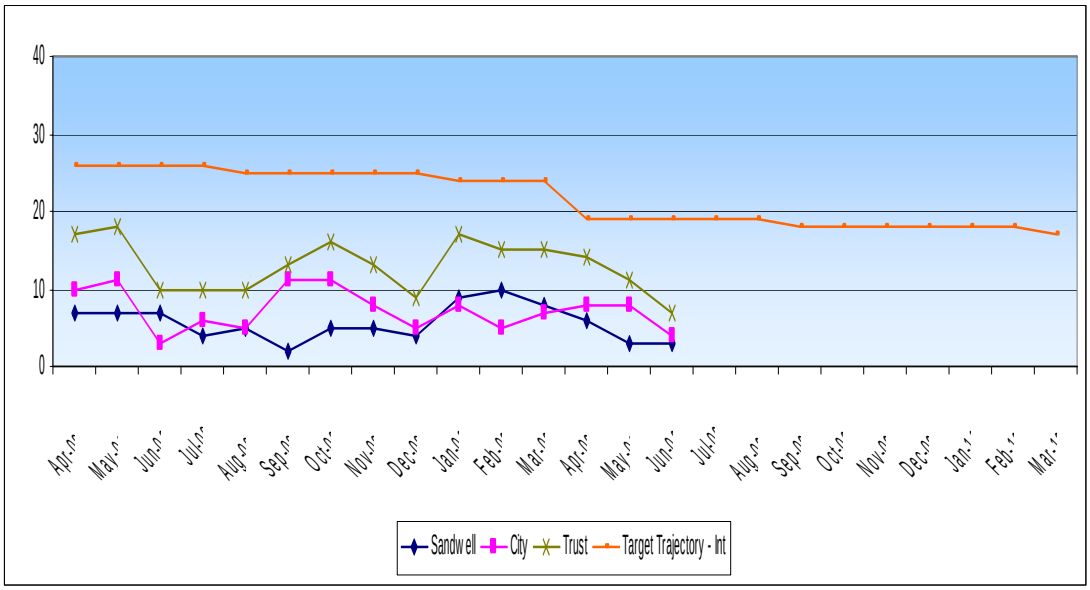


Figure 3.

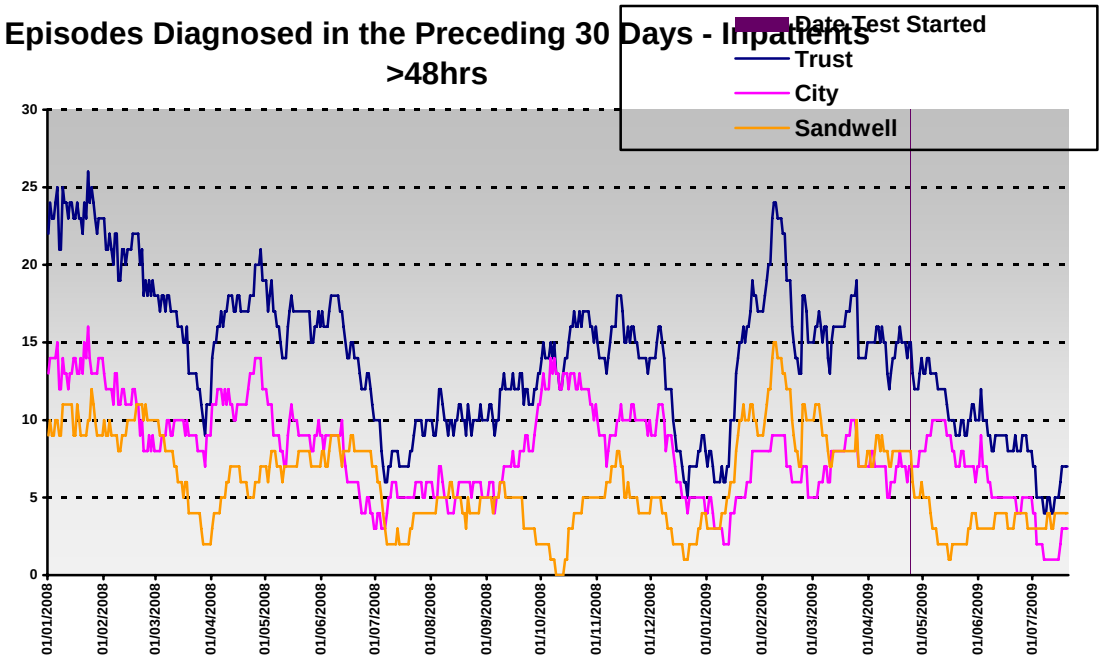


Figure 4.

Antibiotic stewardship

Work on all aspects of improving antibiotic prescribing is progressing well. We have been particularly pleased to see what appears to be a sustained fall in overall antibiotic usage across the Trust over recent months (Figure 4).

Ensuring that all antibiotic prescriptions are accompanied by the required documentation, particularly a stop or review date, remains a challenge and is forming a key part of the regular audits undertaken by medical staff within the Infection Control team.

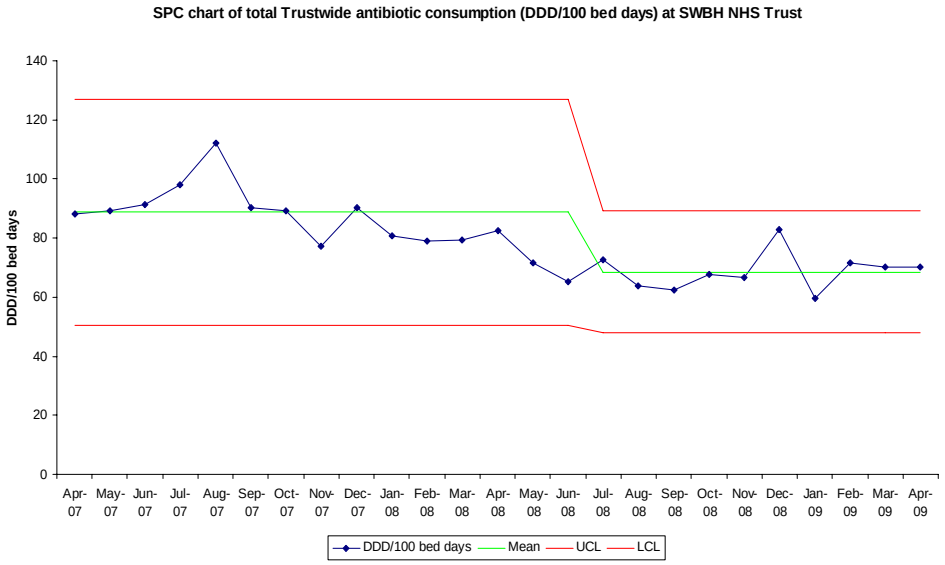


Figure 5.

Influenza A H1N1

In common with many other NHS organisations, the infection control team have been heavily involved with all aspects of dealing with the increased numbers of cases of influenza H1N1, developing protocols for investigation, treatment and containment of cases. Figure 5 shows the number of confirmed H1N1 admitted to the Trust until end June 2009. To date, we do not believe we have had any cases acquired in patients who were already hospitalised for other causes.

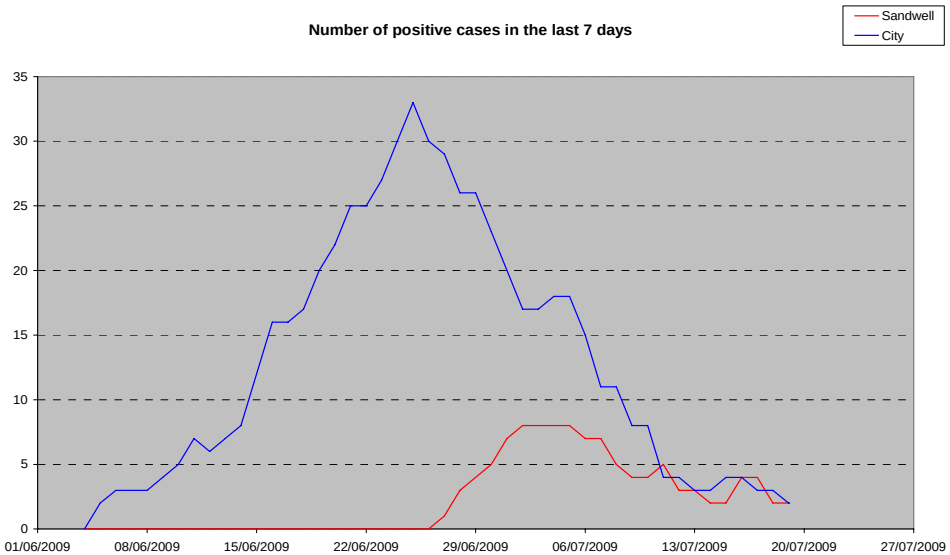


Figure 6.

Audit and training

We feel that the emphasis on the 10 key infection control rules has been successful in clarifying to staff their own responsibility with regard to infection prevention. Over time, details of policies and priorities do change, so that it was felt appropriate to re-launch these at the end of June 2009. The layout and wording of the rules was discussed with a group of junior doctors within the Trust who had volunteered to give ideas on the best methods of disseminating infection control messages and we hope that the resulting document is memorable and easy to understand.

The rules have also been used as the basis for a major update of our mandatory training programme, both for induction and for regular updates. They have been divided into those required for all staff and those which apply particularly to staff who deliver direct clinical care to patients.

A series of workshops on infection control was delivered to Foundation Trust members and once again, these were well attended and enthusiastically received. It is extremely helpful for the team to receive feedback on the public's concerns and priorities.

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 August 2009

SUMMARY OF KEY POINTS:

The Infection Control Assurance Framework was produced in response to the 2006 Health Act – Code of Practice for the Prevention and Control of HCAI.

The attached is the revised assurance framework for this quarter.
Amber items:

2e – Relates to the patient environment. Whilst we are confident that cleaning standards are satisfactory, the age of the buildings and backlog maintenance mean that some areas remain in a poor state of repair or decoration.

2g – Additional handwash stations have been installed at Sandwell as part of the Privacy and Dignity at work.
A plan is agreed for City site and should commence within the next quarter.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to receive and note the report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to reduce hospital infection rates, and achievement of national and local targets
Annual priorities	
NHS LA standards	2.4.9 Infection Control
Core Standards	C21 - Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Not previously considered.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

27th August 2009

Infection Control and Cleanliness Trust Board Assurance Framework – Version 10

The following provides a framework in which assurance can be gained that the Trust understands the risks associated with infection control and cleanliness: has actions in place or planned to mitigate risk: assigned individuals and expected outcomes from each action and appropriate monitoring structures.

The document takes into account standards from the following key documents:

- Health Act 2008 – Code of Practice for the prevention and control of healthcare associated infections.

The document is overseen by the Executive Infection Control Committee and owned by the Trust Executive Lead, Chief Nurse.

Status	
Green	Complete/compliant
Light Green	On track/compliant
Amber	Some delay/partial compliance
Red	Significant delay/non compliance

Compliance Criteria	Outcome required		Action required/to have in place	Who By/Exec Lead	Status
1 *Have in place and operate effective management systems for the prevention and control of HCAI which are informed by risk assessments and analysis of infection incidents* Overall Status: 'MEETS'	1a	A Board level agreement outlining the boards collective responsibility for minimizing the risks of infection and the general means by when it prevents and controls such risks.	• Board level agreement • Risk assessment and incorporation of risks into the Trust Risk Register • System of risk and incident reporting and investigation • Appropriate structures in place for managing risk.	Chief Nurse	Green
	1b	The designation of an individual as Director of Infection Prevention and Control, accountable to the Chief Executive and the Board.	• Appoint a DIPC • Provide system for reporting to TB	Chief Executive	Green
	1c	A mechanism that ensures sufficient resources are available to secure the effective prevention and control of HCAIs.	• Trust Assurance Framework • Infection Control Action Plan • Infection Control Programme • Infection Control team and information infrastructure • Infection Control Operational Committee and Executive Committee	Chief Nurse	Green
	1d	Ensuring that relevant staff, contractors and others who are directly or indirectly concerned with patient care receive suitable and sufficient information on infection prevention and control.	• Training programmes for all staff and evidence of attendance. • Specific induction for contractors.	Director of Workforce	Green
	1e	A programme of audit to ensure key policies and practices are being implemented appropriately.	• Develop a programme of audit against all key policies • Identify resources and timescales • Identify reporting cycle	DIPC	Green
	1f	A policy addressing the admission, discharge, transfer and movement of patients between departments and health care facilities.	• Develop an all encompassing bed management policy • Develop and deliver relevant training and awareness raising	Chief Operating Officer	Green

	1g	Designation of Decontamination Lead	• Appoint a Decontamination Lead	Chief Nurse	Green
2 *Provide and maintain a clean and appropriate environment which facilitates the prevention and control of HCAI.* Overall Status: 'PARTLY MEETS'	2a	The Trust has policies for the environment that make provision for liaison between members of the ICT and facilities management.	• Senior Nurse Forum and Facilities • Chief Nurse role • PEAT visits • Infection Control Operational Committee and Executive Committee	Chief Nurse	Green
	2b	The Trust designates lead managers for cleaning and decontamination of equipment.	• Appoint Decontamination Manager • Establish a Decontamination Committee • Regular reports against a work plan	Director of Estates	Green
	2c	Chief Nurse, Matrons and ICT involve in all aspects of cleaning	• Chief Nurse role to include facilities management • Joint Forums • PEAT • Infection Control Operational Committee • Executive Infection Control Committee	Chief Nurse	Green
	2d	Matrons have personal responsibility for delivering safe and clean care environment and the nurse in charge of a shift is responsible for standards throughout the shift.	• Job Descriptions for Matrons and shift leaders • Matrons report • PEAT visits • Environment audits • Cleaning audits • Cleaning matrix	Chief Nurse	Green
	2e	All parts of the premises in which the Trust provides care are suitable for purpose, clean and well maintained	• Cleaning standards • Maintenance programme • PEAT • Cleaning audits • Environmental audit • TB reports	Chief Nurse and Director of Estates	Amber
	2f	Cleaning arrangements detail the standards of cleanliness required in each part of the premises	• Cleaning schedules detailing the frequency of cleans • Cleaning audits • Cleanliness TB report	Chief Nurse	Green
	2g	There is adequate provision of suitable hand-washing facilities and antibacterial handrubs	• Handwash facilities at entrance to the wards • Sufficient handwash facilities throughout the wards • Handwash facilities in sluices	Chief Nurse and Director of Estates	Amber

			• Handwash facilities in siderooms • Hand gel at entrance to the wards and siderooms • Hand gel at the end of beds • Appropriate policies		
	2h	There are effective arrangements for the decontamination of instruments and other equipment.	• Decontamination and disinfectant policy • Decontamination work plan • Decontamination Committee	Director of Estates	Green
	2i	The supply and provision of linen and laundry reflects the HSG (95) 18	• Linen and laundry contract compliant with the HSG standards • Report to Executive Infection Control Committee quarterly. • Linen and laundry policy in place	Chief Nurse	Green
	2j	Uniform policies ensure that clothing worn by staff is clean and fit for purpose.	• Uniform policy in place • Uniform audits take place twice a year • Included in PEAT	Chief Nurse	Green
3 *Provide suitable and sufficient information on HCAI to the patient, the public and other service providers when patients move between health and social care providers* Overall status: 'MEETS'	3a	Provides information on prevention and control of HCAI and key asopects of the providers policy on infection prevention and control.	• Infection control policy widely published • Various leaflets available • Posters and signage • Visitors Policy	DIPC	Green
	3b	Information on the role and responsiblities of individuals in the prevention and control of HCAI to support them when visiting patients.	• As per 3a	DIPC	Green
	3c	Information to support vigilance in patients.	• As per 3a	DIPC	Green
	3d	Information to stress the importance of compliance by visitors with hand hygiene and visiting restrictions.	• As per 3a	Chief Nurse	Green
	3e	Information on how to report breeches in hygiene and cleanliness	• As per 3a	Chief Nurse	Green
	3f	Information re incident/outbreak management	• Policy widely available • As per 3a	DIPC	Green
	3g	Feedback that is focused on the patient pathway.	• Bed Management Policy • Divisional reports • Ward review process	Chief Nurse	Green
	3h	Information is provided across boundaries	• Health economy wide committee • Screening action plan	DIPC	Green
4		Prevention and control of HCAI should be	• Job descriptions of all staff include control	Chief Nurse	Green

Ensure that patients presenting with an infection or who acquire an infection during care are indentified promptly and receive appropriate management and treatment to reduce the risk of transmission. Overall Status: 'MEETS'		such as to demonstrate responsibility is devolved to: • All professional groups • All specialties	and prevention of infection • Division performance reviews • Division governance groups • Division reports to Infection Control Operational Committee • Ward reviews • Incidence reports by Division • Saving Lives/Hand Hygiene audits by ward		
5 *Gain the co-operation of staff, contractors and others involved in the prevention and control of infection.* Overall Status: 'MEETS'		Providers should ensure that staff, contractors and others co-operate to meet obligations under this code.	• PDR's • Performance reviews • Infection Control and Prevention included in SLA's and contracts with others	Chief Nurse	Green
6 *Provide or secure adequate isolation facilities.* Overall Status: 'MEETS'		Providers should ensure that adequate isolation facilities are provided including facilities for day care. Policies should be in place for risk assessment and allocation of isolation facilities. Sufficient staff should be available to care for patients in isolation.	• Review of facilities • Facilities in 'control' of Infection Control team • Isolation policy and risk assessment tools in place • Staffing assessments undertaken	DIPC	Green
7 *Secure adequate access to laboratory support.* Overall Status: 'MEETS'		Providers should ensure that laboratories used to provide microbiology services have in place appropriate protocols and that they operate according to the required accreditation standards – CPA (UK) Ltd.	• Labs are CPA accredited	DIPC	Green

8 *Have and adhere to appropriate policies and protocols for the prevention and control of HCAI.* Overall Status: 'MEETS'		Providers have a list of core policies in place (List ref Act 2008 p15)	• All listed policies are in place • An audit programme exists to audit compliance • Policies are widely available • Policies are included in staff training	DIPC	Green
9 *Ensure as far as practicable that healthcare workers are free of and protected from exposure to infections during the course of their work and that all staff are suitably educated in the prevention and control of infection.* Overall Status: 'MEETS'	9a	All staff can access relevant occupational health services	• Manual of services • Service advertised widely • Referral system	Director of Workforce	Green
	9b	Policies are in place for prevention and management of communicable diseases including immunisations.	• Policy documents	Director of Workforce	Green
	9c	Prevention and control of infection is included in the induction programme for new staff and in training programmes for all staff.	• Training prospectus • Registers • Training packages • Report to Executive Infection Control Committee	Director of Workforce	Green
	9d	There is a programme of ongoing education for existing staff	As per 9c	Director of Workforce	Green
	9e	There is a record of relevant immunisations	• Records are in place • Report to Executive Infection Control Committee	Director of Workforce	Green
	9f	There is a record of training and updates for all staff.	As per 9e	Director of Workforce	Green
	9g	The responsibilities of each member of staff for the prevention and control of infection is reflected in their job descriptions and in PDRs.	• All job descriptions reflect this • Audit of Job descriptions • Audit of PDRs • Report to Executive Infection Control Committee	Director of Workforce	Green

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Cleanliness/PEAT report
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Steve Clarke, Deputy Director of Facilities
DATE OF MEETING:	27 August 2009

SUMMARY OF KEY POINTS:

The report is provided to inform the Board the results from the National Standards of Cleanliness and PEAT audits and give an update on the PEAT inspections for 2008.

The report provides an overview of the:

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

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To receive and note the quarterly report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to reduce hospital infection rates, and achievement of national and local targets
Annual priorities	
NHS LA standards	2.4.9 Infection Control
Core Standards	C21 - Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Not previously considered

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD

27TH AUGUST 2009

Subject:	Cleanliness/PEAT Report

The following report details:

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

PEAT

External Assessments

PEAT is an annual assessment of in-patient healthcare facilities in England with more than ten beds and is self-assessed, with validation visits to a small number of sites. PEAT teams inspect standards across a range of patient services including food, cleanliness, infection control and patient environment (bathroom areas, décor, lighting, floors and patient access).

In 2009, 1,265 sites from 321 trusts took part in the PEAT assessment. The overall national scores across privacy and dignity, environment and food are:

	Excellent	Good	Acceptable	Poor	Unacceptable
Environment	302 (24%)	761 (60%)	190 (15%)	9 (1%)	3 (Less than 1%)
Food	688 (58%)	437 (37%)	62 (5%)	2 (Less than 1%)	1 (Less than 1%)
Privacy & Dignity	551 (44%)	634 (50%)	77 (6%)	1 (Less than 1%)	2 (Less than 1%)

Confirmation of the Sandwell and West Birmingham Hospitals NHS Trust PEAT assessments have been received from the National Patient Safety Agency and compare favourably with the national statistics.

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

Internal Inspections

The responsibility for the PEAT inspections has now been devolved to the relative Matron/Ward Managers. The reports are sent to the PEAT Co-ordinator and assessed and the necessary actions prioritised then forwarded to the relative departments for action.

All PEAT expenditure on equipment and staff costs are funded from the PEAT environmental budget.

NATIONAL STANDARDS OF CLEANLINESS (NSOC) GUIDELINES

NSoC Revised Healthcare Cleaning Manual

The Revised Healthcare Cleaning Manual has been designed to help every NHS Trust meet its obligation to aid the delivery of high-quality, effective and safe healthcare in clean premises that support the control of healthcare associated infections and make a positive contribution to healthcare outcomes.

The Revised Healthcare Cleaning Manual is intended as a resource for the Trust Board member or senior manager with responsibility for cleanliness and for all managers and staff with responsibilities for cleaning. The manual is applicable to all healthcare settings including hospitals, ambulances and primary care.

The aim of the manual is to provide guidance on cleaning techniques and best practice advice on defining responsibilities, scheduling work, measuring outcomes, reporting and driving improvements.

The new guidelines are in the process of being reviewed and implemented where necessary, an update will be provided in the next cleanliness board report.

NSoC Audit Returns

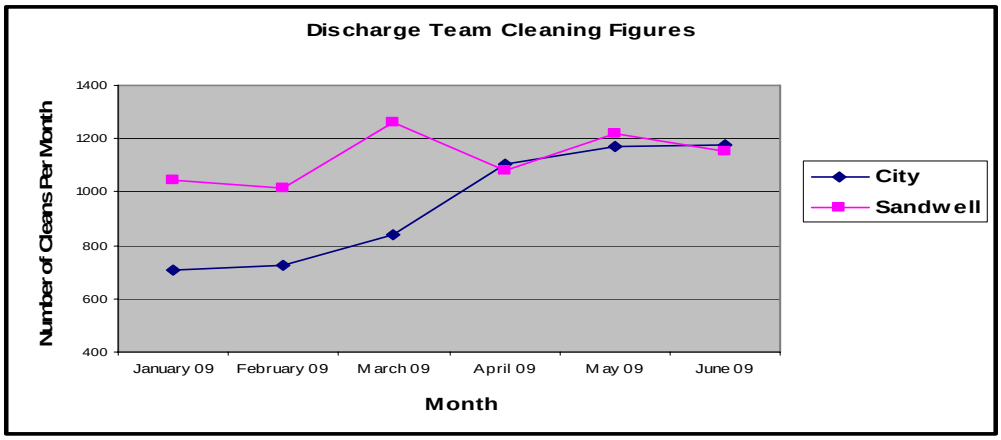
The NSoC audit returns are still producing very good results in all of the critical areas. The audit process has been reinforced, all audits are checked and 'signed off' by both the Hotel Services line management and the Ward/Departmental Manager/Representative.

	April 09		May 09		June 09	
	V High	High	V High	High	V High	High
	%		%		%	
City	95	95	93	96	94	95
Sandwell	98	97	98	97	97	97
Rowley	N/A	97	N/A	97	N/A	97
BTC	98	96	97	97	98	97
Target	**98**	**95**	**98**	**95**	**98**	**95**
Overall Average	**97**	**96**	**96**	**97**	**96**	**97**

Note: No areas classed as 'very high' at Rowley

Discharge Cleaning Teams – Performance 2008/09

Although the service will always be somewhat inconsistent the overall view is that the service is delivering in terms of cleanliness, in general the beds are available within a relatively short time from discharge and the presentation of the beds and patient furniture has improved dramatically.



ENVIRONMENTAL ISSUES

Sterinis (Decontamination Robots)

The new upgraded Sterinis decontamination machines have been delivered, training has been provided, and the machines were introduced into service on Monday, 20th July 2009.

One of the old machines has been retained and transferred to Church Lane, this will be dedicated for vehicle/ambulance decontamination.

Waste

The replacement bin programme is complete, however there is still some old stock surfacing that need changing, this will be achieved as part of the ongoing replacement programme.

Steam Cleaners

Following on from successful demonstrations and trials, 6 steam cleaners have been purchased for use in non-clinical areas. Although a number of Trusts are using steam cleaning in wards and departments, this option will be reviewed following extensive testing in conjunction with health and safety.

Privacy & Dignity Screens

The installation of the privacy and dignity screens and hand wash stations at Sandwell is on target for completion at the end of August 09.

All wards at Sandwell & City will be deep cleaned after the installations are complete.

The programme for City (Sheldon Block) is targeted for completion at the end of October 09, this is subject to the release of the wards.

Hand Hygiene

Following recommendations from the Healthcare Commission (CQC) audit in November 2008 the following work is being undertaken:

- Additional hand wash basins installed in all dirty utility/sluice rooms at City.
- Janitorial units fitted in all cleaning rooms.
- Hand wash stations fitted in all wards at Sandwell (programme on target for completion end of August).
- Hand wash stations to be fitted along the main spine (City) in strategic locations so they will not hinder the day to day traffic.

STEVE CLARKE
DEPUTY DIRECTOR - FACILITIES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Safeguarding Steering Group
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	27 August 2009

SUMMARY OF KEY POINTS:

The attached report from the Trust Safeguarding Steering Group is intended to update the Trust Board on the Trust's position with regard to Safeguarding of both adults and children.

The group and sub structures are now in place and functioning well.

The Trust declared non compliance with core standard C2 for 2008 – 09 mainly due to poor data for training. The report provides an update on the current position and also the Care Quality Commission's report on Children's Safeguarding and plans for future monitoring.

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 progress to date and areas that continue to be a challenge.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	Delivery of safeguarding agenda.
NHS LA standards	Safeguarding Adults
Core Standards	C2 – Safeguarding Vulnerable People
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical		
Workforce	**x**	Training requirement continues to be a challenge.
Environmental		
Legal & Policy		
Equality and Diversity	**x**	Safeguarding agenda is concerned with very vulnerable individuals.
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

This report would normally go to Governance Board first but due to the timing of the CQC report it has been brought forward by a month.

TRUST SAFEGUARDING STEERING GROUP
REPORT TO THE TRUST BOARD
July 2009

1. Introduction

The Trust Board have previously received separate reports on Adult Safeguarding and Safeguarding Children and reports have also been taken on a regular basis to the Trust Governance Board.

The Board have also received reports and action plans on specific areas of safeguarding, for example the 'Baby P' case and Deprivation of Liberties legislation.

It was, however, decided that due to the considerable overlap of issues and a rapidly growing agenda, there was significant benefit to be had from merging the two safeguarding strands together and creating a Trust Safeguarding Committee reporting to the Governance Board and the Trust Board on a quarterly basis.

There have to date been two meetings of the new committee and there has been good progress made.

2. Structure.

Safeguarding Committee – This is executively led by the Chief Nurse and includes the leads within management, nursing and medical staffing for each safeguarding stream, Learning and Development, Risk, Human Resources, the Medical Director and a Divisional General Manager representative.

The Child and Adult Safeguarding Operational Committees sit beneath the Trust Safeguarding Committee and both have similar membership to the Trust committee plus leads from each sub group:

2.1 Sub Groups

Adults – Falls and Older people
End of Life
Stroke
Learning disabilities
Mental capacity, Deprivation of Liberty and Vulnerable adult protection

Children – Serious case reviews
Policies and procedures
Domestic violence
Training
Recommendations from various reports/standard documents

2.2 Safeguarding Personnel

Adults

Management Lead – Debbie Talbot, Assistant Director of Nursing (Quality)
Nursing Lead – Diane Rhoden, Safeguarding Adults Nurse
Medical Lead – there is a lead in some of the sub groups but no overall medical lead for the whole adult safeguarding agenda. This is not currently a requirement within Adult Safeguarding guidance.

Children

Management Leads – Carole Potts, Children's Service Manager and David Low, Paediatrician
Nursing Lead – Ann Sharples, Child protection Nurse (named nurse)
Medical Lead – Michael Plunkett (named doctor)
Designated Doctor (advisory to Sandwell Local Safeguarding Board) – David Low
Designated Doctor (advisory to Birmingham Local Safeguarding Board) – Ann Aukett
Named Midwife – Kathy Senessie

3. Action Plans

Both strands now have a comprehensive RAG rated action plan in place. These will be presented to endorsement to the Governance Board. The key features and issues are summarised below.

3.1 Key issues that apply to both action plans

- Lack of comprehensive training data
  We know that considerable training is being given, but it continues to be difficult to get a clear picture of training numbers by staff group. This is being addressed as part of the Trust's drive on mandatory training.

- Variances of services across the Trust
  Both children and adult leads have identified different levels of services offered to vulnerable adults and children across the Trust from the PCTs. This is being addressed through the Safeguarding Boards.

- Safeguarding Link roles
  There is a need to develop a network of champions across the Trust for Safeguarding. This is in hand but has been slow to progress. Ann Sharples, Named Nurse for Child Protection, is undertaking a project for the Safeguarding Leadership course involving this work. This is due to be completed and presented in September this year.

- There is a need to ensure we are linking safeguarding children issues with adult services eg domestic violence, mental health issues alcohol and drug abuse. This is in hand and forms part of adult safeguarding, substance misuse and domestic violence training.

- Safeguarding needs to be incorporated into Personal Development Reviews and Knowledge Skills Framework development as a common standard for all staff. Learning and Development are looking into this.

- Interpreting service is not always able to respond to need
  A review of the interpreting service is planned but it is unlikely that a service will be affordable that can always respond to demand other than via the telephone system currently in place. We are also looking at alternative means of communication with vulnerable groups, eg picture prompts.

3.2 Issues specific to Child safeguarding within the action plan

- Executive attendance at Safeguarding Boards
  There are two adult and two Childrens' Local Safeguarding Boards that meet quarterly. The Chief Nurse is a member of both adult boards and the Sandwell Local Safeguarding Children Board. The Trust has requested to be executively represented on the Birmingham Local Safeguarding Children Board and is awaiting the result of a Board decision.
- Lack of GP registration of some adult patients makes it very difficult to ensure children at risk do not get lost to the authorities. This is a Safeguarding Board and PCT issue and is being actively discussed.
- Investigation of sexual abuse is very resource intensive and requires specially trained doctors to be available 24 hours a day, every day. This is a particular problem across the region as no trust is able to provide this with a "legal" medical rota. The SHA are looking at regional solutions *for the Sandwell area, as Birmingham has a regional rota.* In the mean time two SWBHT paediatricians operate an incomplete ad hoc rota. *Support is provided by the Paediatric Consultant on call.*
- Investigation for Serious Case Reviews is very resource intensive and the Trust Safeguarding staff are very stretched – resources need to be reviewed.
- It is very difficult and time consuming to implement recommendations from Serious Case Reviews in adult based services or services for children which are not managed by the W&C Directorate. A clear process needs to be developed. *It is envisaged that the Safeguarding Steering Group (SSG) will promote greater partnership working and co-ordination of corporate actions across the organisation.*

3.3 Issues specific to Adult Safeguarding within the action plan

- Delay in delivering a Self Harm policy and training
  This has been due to considerable differences of clinical opinion in the emergency departments on which risk assessment to adopt. A pilot

study has therefore been required. We expect a standard Trust approach by October 2009.

- Data monitoring
  Systems for monitoring referrals across agencies has yet to embed. There is also a need to agree thresholds for referrals and an infrastructure for collating and reporting incidents. This is an item for the Safeguarding Boards to resolve. In the meantime we are collecting our own data.
- Training for Trust volunteers needs to be sourced and delivered.
- The Trust needs to develop a web based library of information and detail support available for staff and the public.

3.4 Progress to date of note

There has been considerable progress in a number of areas, most notably:

- Creation of comprehensive action plans as attached.
- Clear structures identified.
- Better reporting and investigation of vulnerable adult incidents.
- Production of New Adult and Updated Children Safeguarding Leaflets to comply with Level 1 training
- Delivery of level 1 training leaflets via payslips and induction training.
- Increased delivery of level 2 Child Protection training in the Trust, – pending data to evidence this.
- Policies for safeguarding are now in place.
- The Trust are represented on the majority of boards/committees.
- A robust RAG rated action plan is now in place for Serious Case reviews in children.
- Referral data is collected and reported within adults.
- Considerable progress against the adult streams eg:
  - Falls reporting, action plans and equipment purchase.
  - Mental capacity, DOL and safeguarding training
  - Stroke work (reported separately to TB)
  - Learning disabilities – scoping exercise complete; linked to E+D agenda.
- Domestic violence training in place.

4. Declaration of Non Compliance Core Standard C2

The Trust Board will recall that we declared non compliance against core standard C2 for the year 2008/9 . This was primarily because our training databases were not sufficiently sophisticated to provide accurate training data to provide assurance to the board. This was further supported by results of the Health Care Commission (Care Quality Commission) Children's Service review which indicated that there were still issues around recording of training. (See section 5). The Trust has declared compliance for 2009/10 on the basis that adequate training is being undertaken – we need to ensure that this is properly evidenced.

5. Care Quality Commission Report July 2009

The CQC recently published its findings into Safeguarding in the NHS following the Baby P case. This was based on a return sent in from Trusts and PCTs in March. The Trust is yet to receive its individual report. The CQC report found that although most Trusts had the right people and structures in place to help protect children there were worrying shortfalls in the numbers of staff with up to date training. Other issues that the report raised included:

- Lack of clarity over roles of doctors and nurses with responsibility for Safeguarding.
- Lack of key policies.
- Poor Board reporting.
- High case loads of staff in the community.
- Content of training.
- Follow up of children who miss appointments.
- Collaboration between organisations is variable.
- Process for reviewing individual cases is not always robust.

The CQC intends to follow up on Trusts who declared non compliance in their annual declarations and carry out a 3 year programme of week long inspections. They are also urging the Department of Health to expand its annual Children's Services Review to include Safeguarding more prominently.

Finally the CQC intend to use its registration powers to include Safeguarding standards and Trusts will be required to declare compliance against safeguarding standards in order to register as a provider of health services.

5.1 Actions for us as a result of the report

- Review all roles involved with safeguarding and in particular ensure there is a distinction between the "named doctor" and "designated doctors" and ensure direct professional reporting lines to the Executive lead.
- Review medical sessional time allowed for safeguarding responsibilities within the Trust.
- Ensure a Safeguarding report comes to both the Governance Board and Trust Board quarterly.
- Ensure delivery of the Children's Service action plan before November this year when data collection is next due.
- Review content of training and continue to develop robust systems of reporting training numbers.
- Ensure a process is in place to identify children who fail to attend out patients appointments.

6. Children's Hospital Services Review

This review is undertaken every year by the Healthcare Commission and is intended to ensure that children cared for in an acute hospital setting are managed safely.

This is not strictly a safeguarding issue and has not therefore been part of discussions at the safeguarding committee. However, because it has links to safeguarding in specific specialities and because the CQC intend to try to use this as a vehicle in the future for reviewing trust safeguarding standards in more detail it is worth updating the Trust Board on progress within this report.

The last report, received early this year, relates to the Trust position as of November 2008. The next data collection exercise will relate to the Trust position as of end of November 2009.

Executive responsibility for this review was allocated to the Chief Nurse in March this year. Since then there have been a series of review meetings against the action plan developed in response to the review.

The review looks at specific services only :

- A+E/emergency care
- Daycase units
- Out patients
- Surgeons – general, orthopaedic and ENT
- Anaesthetists – elective and emergency
- Surgical teams

It asks about the following areas for each:

- Safeguarding training – level 1 and level 2+
- Basic paediatric life support training
- Advanced paediatric life support training
- Use of paediatric pain assessment tools
- Administration of analgesia by Patient Group Directive (PGD) - The Trust scored well on this and no action plan was required.
- RN C (Childrens Nurse) presence in all areas where children are treated
- Numbers of child cases carried a year by surgeons and anaesthetists.

Each division has a divisional management lead for this work.

6.1 The last review highlighted a number of areas of poor performance

There remain significant challenges around reducing the number of surgeons and anaesthetists operating on children. Every general acute trust scored poorly on this standard and are likely to continue to do so. This is because in order to reduce the number of consultants carrying out such surgery a

separate out of hours rota would have to be created which would be non compliant with European Working Time Directive.

In the absence of robust training data each division has been asked to complete a training template of staff who have received training, against head count. This will give us an accurate picture of where we are pending better training data.

Training packages have been developed around pain assessment.

A system has been set up to a rota to provide advice from a senior children's nurse to non-paediatric areas on a 24/7 basis.

We expect an improved report in most areas for this year. A detailed action plan is available for the Trust Board members if they wish to see it.

7. Adult Safeguarding referrals

Safeguarding as a formal system for identifying and caring for vulnerable adults is fairly new to the Trust and therefore very little data is currently available to us. However the common themes currently being seen from safeguarding referrals *about the Trust* are around:

- Pressure area care
- Nutrition
- Discharge planning
- Bruising
- General care

Referrals made *by the Trust* about other agencies/community tend to be of a very similar pattern and are usually around care given in nursing and residential home settings.

We will include more analysis of this data in the next report when there will be more data to work with.

Currently all referrals made about the Trust are investigated and the Safeguarding Nurse is working with Risk services to identify how best to get these incidents into the Trust risk systems in a similar way to incidents and referrals about children.

8. Children's Safeguarding Activity

Data regarding serious case reviews is collected and there exists a robust action plan for every case which is overseen by the Adverse Events Committee and Childrens Safeguarding Committee internally and the Safeguarding Boards externally.

A paper based system for collecting child safeguarding activity is in place and the first report will be available at the next Safeguarding Committee to include referrals, exchanges of multi-agency information, child abuse medical examinations undertaken, court reports and attendance at court of staff members, case conference and strategy meeting attendance is monitored. Data base for this information would improve the data collection

9. Conclusion

Although good progress has been made in a number of areas, there remains considerable work to do to ensure we consistently help to protect the most vulnerable of our patients. The systems and processes that have been in place for Children for some time and put in place over the past year for adults better place us for achieving the standards set in the various guidelines, reviews and core standards.

The Trust Board is recommended to **note** the content of this report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance and Performance Management Committee – v0.1

Venue Executive Meeting Room, City Hospital **Date** 23 July 2009; 1430h – 1630h

Members Present		In Attendance	Apologies
Mr R Trotman	[Chair]	Mr J Adler	Mr D O'Donoghue
Mrs S Davis		Mr R White	Miss R Overfield
Ms I Bartram		Mr R Kirby	
Mrs G Hunjan		Mr T Wharram	
Dr S Sahota		Mr M Harding	
Miss P Akhtar			
Prof D Alderson			

Secretariat		Guests			
Mr S Grainger-Payne	[Minutes]	Mrs K Olley	[Item 4 only]	Mr S Power	[Item 4 only]

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Mr Donal O'Donoghue and Miss Rachel Overfield.	
2 Minutes of the previous meeting – 18 June 2009	**SWBFC (6/09) 061**
The minutes of the previous meeting were agreed to be an accurate reflection of discussions held on 18 June 09.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBFC (6/09) 061 (a)**
The Committee noted the updated action log.	
4 Ophthalmology performance following KPMG review	**SWBFC (7/09) 070** **SWBFC (7/09) 070 (a)** **SWBFC (7/09) 070 (b)**
Mrs Kathy Olley joined the meeting to provide an overview of ophthalmology performance since the publication of the outcome of the consultancy work undertaken by KPMG LLP in 2006. In terms of the accident and emergency workstream, Mrs Olley advised that the area had overperformed against the target savings proposed, delivering £240k against a target saving of £100k. Additional consultants have been recently appointed and will be joining the Trust in 3-6 months. Performance against the inpatient target was noted to be mixed. A reduction in	

bed numbers was achieved, however coping with the requirements to deliver single sex accommodation has been difficult given the physical constraints of the estate. Additional space will be needed to conduct any day case activity over and above that already delivered. Good progress has been made on the theatre workstream, although it is acknowledged that there is still much work to do. To assist, a ward and theatre management group has been established, which will focus on cancellations and late starts. To date, there has been limited improvement in this area. A major focus of the outpatients workstream has been examining ways to reduce the DNA rate. As a consequence, a significant reduction in performance in this area has been seen. A reminder letter has been reintroduced and there is a process in place whereby a check can be made as to whether a patient can attend an appointment and if not, alternative arrangements can be made to fill the slot. A number of premium rate clinics have been moved to run more efficiently now and as such, referrals have risen by 25% and activity by 15%. Some recent appointments which would have previously been regarded as premium rate working are now included as outpatient sessions within standard job plans. Mrs Davis commented that it was important to ensure that contracts are flexible to encourage development such as this. Mrs Olley continued that follow up rates have improved considerably and consideration is being given to providing greater accessibility for viewing images in clinics. In terms of work in the community, South Birmingham clinics are under development. Progress with the administration processes workstream was discussed. Duplication of registration desks has been eliminated and letters and other communication with patients have been simplified. In relation to the workforce workstream, greater savings than planned have been achieved. £50k of workforce saving is included within the current year's CIP, although this covers areas other than ophthalmology. Savings in cataract surgery have been delivered as part of the procurement/non-savings workstream. The supplier for the standard lenses has been changed and other trusts around the region have followed suit to take advantage of the savings to be gained. Small savings have been delivered in the purchase of drugs. Specific income streams were suggested as part of the income workstream. A shortfall of £392k has been delivered against the target £1,266K proposed, although there is a proportion of the suggested income that on closer analysis is undeliverable. Mrs Olley discussed the division's overall performance, highlighting that it was required to deliver a CIP of £779k, and was on track to achieve this overall. Included within the CIP is £200k for premium rate working, which is likely to be gained from outpatient work than from any other area. As part of the CIP, oral surgery, ENT and audiology have all been targeted with efficiency savings. Mr Kirby summarised that the KPMG report had provided a stimulus for the Trust to look at a number of areas in ophthalmology, although further work was needed on outpatient processes and administration. The Electronic Patient Records (EPR) team is engaged with looking at the processes. Mrs Olley was thanked for her useful presentation and wished well for her forthcoming retirement.	
5 Trust Board performance management reports	

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5.1 2009/10 month 3 financial position and forecast	**SWBFC (7/09) 064** **SWBFC (7/09) 064 (a)** **SWBFC (7/09) 064 (b)**
Mr Wharram reported that an in-month deficit of £5k against a target surplus of £202k was achieved in-month. An adjustment has been made in respect of the Imaging tariff and expenditure associated with the Trust's response to the 'flu pandemic has also been factored in. A proportion of the contingency budget has been used to mitigate the position to some degree. The Strategic Health Authority has been made aware of the situation. In-month FTEs were noted to be 67 below plan, with the cash balance being £174k below plan at present. The Committee was asked to note the continuing rise in pay costs. Divisional performance remains similar to the previous month, with the majority of the clinical divisions, together with the Facilities division underperforming financially. Of these, Surgery A has a significant issue with income received from its activity at present. Divisions reporting a balanced position were noted to be overspent on pay, yet this is corrected by a better than planned performance on income. The Facilities situation was reported to be driven by the requirements of the current cleaning regime. Mrs Davis remarked that as many vacancies appeared to have been filled, there was an expectation that pay costs would have been within budget. She was advised that although vacancies had been filled, the use of bank and agency staff did not appear to have dropped commensurately. Mr White added that many of these agency members support the cleaning staff teams. A fundamental issue relates to the exhaustion of the external funding received for deep cleaning. There are plans to discuss the matter at the forthcoming divisional review with Facilities. It was reported that costs associated with bank and agency Healthcare Assistants was a significant issue. Miss Bartram suggested that the Trust needed to be aligned with the best times for the recruitment of nursing students. Capital expenditure was noted to be considerably below plan, which is reflective to some degree of the change to the estates element of the programme. The CIP was noted to be underachieved by £250k, which is contributing to the overall financial position. Mr Trotman asked whether the forecast outturn is rolled over and asked that if there is a plan to adjust the forecast, that the Committee be notified at the end of Month 4. Dr Sahota asked what the impact of Swine 'Flu would have had on the paybill. He was advised that the financial consequences of Swine 'Flu would be met by an allocation in the budget which had been set aside specifically for this purpose; the paybill position is mainly shaped by the agency staff costs. A supplementary paper regarding the Month 3 financial position was considered. Individual meetings with budget holders have been held and there appears to be a degree of volatility in the way income is currently reported, therefore plans are to be implemented to ensure that there is greater accuracy in the way income is charged to the correct divisions. The forecast included an assumption regarding the level of long stay patients that would be seen by the Trust. There has been some shortfall against this assumption	

however and more short stay patients have been seen than was predicted. Recovery plans to deliver a balanced performance by Month 6 have been requested of all divisions which will be considered at the next meeting of the Financial Management Board (FMB). An analysis of extra contractual pay is underway and stringent vacancy controls will be implemented, led by the Chief Operating Officer. A review of all current vacancies will be prepared and all administration and clerical areas will be assessed. Miss Bartram asked whether the number of beds in the Trust had reduced since April 2007. She was advised that there had been a significant reduction in beds during this period. Mr Adler stressed the need for recovery to be addressed rigorously and that measures should be taken to staunch the upward trend in manpower, as this is pivotal to the plans for a successful recovery. The detail behind the plans to address headcount is still to be worked through, however the Trust's managers are to be presented with an overview of the plans at the September 'Hot Topics' briefing. Mrs Davis suggested that appropriate behaviour is instilled in managers, particularly with respect to their reliance on agency and banks staff. Mr Trotman suggested that the timing of the plans should be brought forward and perhaps a discussion at the August Trust Board may be helpful. The Committee was advised that the Transitional Funding Framework included a provision for restructuring if required.	
ACTION: **Mr Grainger-Payne to schedule a discussion around addressing manpower at the August meeting of the Trust Board**	
5.2 Performance monitoring report	**SWBFC (7/09) 065** **SWBFC (7/09) 065 (a)**
Mr Harding presented the Trust's summary performance during June 2009. In terms of the cancelled two-week waits for cancer referrals, the Committee was advised that all were due to patient choice. Mrs Davis asked whether the Trust was performing in line with other similar Trusts. Mr Kirby advised that the Trust is performing better than the national average against the target. Dr Sahota proposed that consideration be given to the impact of language on the cancelled operations. Miss Akhtar asked what work was underway with GPs to ensure that patients are aware of the arrangements and what information was issued to the local population, including hard to reach groups. Professor Alderson advised that from his experience, there is a considerable amount of information available in different languages, covering areas such as bronchoscopy and endoscopy. Mr Harding advised the Committee that the Care Quality Commission was not assessing performance against cancer targets covering the last quarter. A third more referrals have been received, although there has not been a corresponding rise in cases of identified cancers. Of the cancelled operations, the Committee was advised that the majority related to ophthalmology and general surgery cases. There were four delayed transfers of care during the month, all at Sandwell Hospital. Performance against the stroke target was noted to be poor, however the situation is being addressed through the divisional review process. A significant improvement is due to be seen when the stroke pathway is amended to ensure that patients are routed directly to a stroke unit, rather than through the MAU.	

The Trust's performance against Accident and Emergency targets has remained good, despite an increased level of attendance. In relation to the CQUIN targets, the Committee was advised the caesarean section rate performance has improved and 167 patients had been seen following a smoking cessation referral. It was noted that as the target specifies the number of patients referred and not the number attending the appointment, that the performance against the target would be revised. A pleasing downward trend for sickness absence was noted and theatre utilisation had also improved. Dr Sahota noted that there appeared to be a high adjusted perinatal mortality rate. Mr Adler assured him that this was not reflective of any sustained trend and would be reviewed by the Maternity Taskforce. Professor Alderson returned to the position regarding theatre utilisation. He noted that late starts had improved by 19%, although early finishes had increased despite a lower throughput of patients. Mr Kirby highlighted that the improved early starts is an achievement, with any sessions starting late being due to ward-related delays. Utilisation is being addressed in a theatre by theatre systematic approach. Mrs Davis suggested that consideration should be given to inviting key surgeons to attend the meeting to discuss the issues. It was agreed that a more appropriate measure may be to organise a more in depth discussion around theatre utilisation for the September meeting of the Finance and Performance Management Committee.	
ACTION: **Mr Kirby to organise for the presentation of an in depth analysis of theatre utilisation issues at the September meeting of the Finance and Performance Management Committee, arranging for the attendance of key surgeons as appropriate**	
5.3 CQUIN targets and associated financial implications	**SWBFC (7/09) 069** **SWBFC (7/09) 069 (a)**
The Committee was asked to note the report outlining the derivation, nature and financial value associated with the various CQUIN schemes, agreed with commissioners as part of the 2009/10 contractual agreements.	
5.4 Foundation Trust compliance report	**SWBFC (7/09) 067** **SWBFC (7/09) 067 (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 remains green.	
5.4 NHS performance framework	**SWBFC (7/09) 066** **SWBFC (7/09) 066 (a)**
Mr Harding presented the Trust's performance against the indicators comprising the NHS performance framework. The Committee was pleased to note that the overall score for Quarter 1 was 2.92, classifying the Trust as a 'performing' organisation.	
6 Cost improvement programme (2009/10)	
6.1 CIP delivery report	**SWBFC (7/09) 068** **SWBFC (7/09) 068 (a) -** **SWBFC (7/09) 068 (d)**

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Mr Wharram presented the monthly 2009/10 CIP delivery report, which it was noted had been reviewed in detail at the Financial Management Board meeting. It was reported that the CIP was £250k adrift of plan, with the greatest variances being attributed to the same divisions as reported during the previous month. Performance of the CIP has contributed to the overall financial performance. A schedule detailing 'brought forward' non-recurrent schemes was reviewed, which are being monitored in the same manner as other CIP schemes. It was suggested that the programme of divisions reporting to the Committee may need to be prioritised according to performance. Mr White offered to consider the schedule. In relation to the schedule of 'brought forward' CIP schemes, Mrs Hunjan noted a disparity regarding the scheme attributed to Medicine A, which reported an annual planned saving of minus £135,000. Mr White reported that this was due to an inconsistency in the way in which the information was reported and would be corrected in the next version of the report.	
ACTION: **Mr White to reconsider the schedule of divisions presenting to the Finance and Performance Management Committee**	
7 Minutes for noting	
7.1 Minutes of the Strategic Investment Review Group	**SWBSI (7/09) 001**
The Committee noted the minutes of the SIRG meeting held on 9 June 09.	
7.2 Actions and decisions from the Strategic Investment Review Group	**SWBFC (7/09) 069**
The Committee noted the actions and decisions arising from the meeting of SIRG meeting held on 14 July 09.	
7.3 Minutes of the Financial Management Board	**SWBFM (6/09) 057**
The Committee noted the minutes of the FMB meeting held on 23 June 09.	
8 Any other business	**Verbal**
There was none.	
9 Details of next meeting	**Verbal**
The next meeting is to be held on 20 August 2009 at 1430h in the Executive Meeting Room at City Hospital.	

Signed .....

Print .....

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Date .....

MINUTES

Sandwell and West Birmingham Hospitals NHS Trust

Governance and Risk Management Committee – Version 0.3

Venue Executive Meeting Room, City Hospital **Date** 23 July 2009; 1030h – 1230h

Members Present

Miss I Bartram [Chair]
Mr R Trotman
Mr J Adler
Mr R White
Ms K Dhami
Prof D Alderson

Apologies

Mr D O'Donoghue
Miss R Overfield

In Attendance

Mr P Finch [Items 1 - 4 only]
Mrs R Gibson [Items 1 - 7 only]
Mr D Masaun [Items 9 – 10 only]

Secretariat

Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Mr Donal O'Donoghue and Miss Rachel Overfield. It was noted that at a previous meeting, an amendment to the Terms of Reference of the Committee proposed that in the absence of the Medical Director, a deputy Medical Director should attend. Mr Adler agreed to discuss the matter with Mr O'Donoghue to ensure that there was adequate representation in future.	
ACTION: Mr Adler to discuss adequate representation by the Medical Director at future meetings of the Governance and Risk Management Committee	
2 Minutes of the previous meeting	**SWBGR (5/09) 032**
The Governance and Risk Management Committee approved the minutes of the meeting held on 21 May 2009 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 (5/09) 032 (a)**
The updated actions list was noted by the Committee. There were no overdue actions. Miss Dhami updated the Committee on the outcome of the recent selection	

process for the Trust's legal services provider. She advised that Browne Jacobson had been selected as the firm to provide legal services, replacing Mills and Reeve LLP as the Trust's current provider. A number of complex cases will however remain with Mills and Reeve until they have been resolved. Mr Trotman advised that as chair of the selection panel, he was satisfied with the process that had been undertaken and that Browne Jacobson was clearly the best provider from the candidates interviewed. Mr Grainger-Payne added that in terms of cost effectiveness, the rates published under the Heathcare Purchasing Consortium framework agreement, were slightly lower for Browne Jacobson than those of the existing provider.	
4 Local Security Management Specialist workplan for 2009/10	**SWBGR (7/09) 034** **SWBGR (7/09) 034 (a)** **SWBGR (7/09) 034 (b)**
Mr Finch joined the meeting to present the annual workplan for local security management. Mr White noted that there were a number of capital projects within the workplan and asked that these be expedited if possible. He was advised that the projects are progressing well, however formal approval from SIRG for the investment needed is required. Mr Adler suggested that any slippage in other parts of the capital programme should be used to fund security capital initiatives if possible. Mr Trotman suggested that in terms of the dates assigned to the activities, completion dates should be removed. He also asked whether the plan incorporated risk assessment activities for security. Mr Finch advised that this was the case, which Mrs Gibson confirmed. Mr Trotman asked what the financial implication of the lone worker policy was. He was informed that there was not a significant financial impact. The plans to separate portering and security functions at Sandwell Hospital was noted. Mr Finch advised that the plans were progressing well and will take effect fully from 1 November 2009. Mr Finch was thanked for his informative report.	
5 NHS Litigation Authority risk management standards assessment update	**SWBGR (7/09) 038** **SWBGR (7/09) 038 (a)** **SWBGR (7/09) 038 (b)**
Mrs Gibson provided an overview of the progress with preparing for the forthcoming assessments by the NHS Litigation Authority against general risk management standards in December 2009 and maternity standards in March 2010. An interim visit is planned at the beginning of September and work is underway to collect evidence to support the assessments. As attendance at Mandatory Training has been identified as a particular 'hot spot' much work is being channelled into improving performance in this area. Staff attendance at 14 modules of training is a difficulty, therefore further work will be considered as to introducing alternative methods of delivering the training in the longer term. Surgeries have been organised to preview evidence available to support the	

assessments. Mr Trotman asked whether the red status against medical devices training was a particular concern. He was advised that it was an area of focus at present, although is not as serious as some other areas which span a number of standards. In terms of the embedding of the 'Being open' policy, much work is being undertaken to embed this further within the organisation. Spot checks are occurring to determine whether the conversations required when something goes wrong, are happening. Mr Adler noted the red status against the safeguarding adults standard and asked for the reason behind this rating. He was informed that this concerned the lack of evidence provided to date and did not necessarily suggest that the Trust's performance against this standard is weak. The Committee was advised that the areas not rated were those over which the Trust had no control as they were determined by factors such as the ALE assessment. Mr White reported that it was unlikely that there would be any change to the preliminary ALE scores awarded following moderation. Sickness absence was reported to be unrated as this was a pilot standard and would not be included as part of the forthcoming assessment.	
6 Integrated risk, complaints and claims report	**SWBGR (7/09) 036** **SWBGR (7/09) 036 (a)**
Mrs Gibson presented the integrated risk, complaints and claims report. Mr Grainger-Payne reminded the Committee that at the Trust Board meeting in June, there had been a concern over the level of slips, trips and falls within the Trust and over the organisations selected as a comparison for claims information. It was noted however that both queries had been resolved either by the further detail in the report or by discussion outside of the meeting. It was noted that incidents related to unsafe staffing levels had dropped sharply during the quarter, following a steady rise previously. Mrs Gibson was asked to review this information and provide an update as to the reason for this pattern at the next meeting. Mr Adler suggested that this may be connected with the recent ward establishment review which had revealed that only a small number of wards were operating with an unsafe level of staffing, with the rest needing more efficient rostering arrangements and sickness absence management. The 26% rise in 'baby tagging' incidents was noted, however Mrs Gibson advised that this rise was due to better reporting of lost baby tags, rather than being reflective of any serious underlying security breaches. Mr Trotman asked what the 'disclosure of records' stage in the legal process of managing claims entailed. He was advised that this indicated that personal records had been requested with a view to making a claim. A significant number of cases cease at this point with no further action being taken after the notes are reviewed. Mr White reported that as part of the Strategic Health Authority's review of the Trust's Statement on Internal Control (SIC), it has been mandated that any significant control issues, including Serious Untoward Incidents (SUIs) should be included within the conclusion of the SIC. The guidance as to which SUIs justified inclusion was unclear however. Mrs Gibson offered to determine the practice in other Trusts.	

ACTION: **Ruth Gibson to provide an analysis of the pattern of incidents relating to unsafe staffing levels at the next meeting** **ACTION:** **Ruth Gibson to determine the practice regarding inclusion of SUIs within the SIC, within other Trusts**	
7 Trust risk register	**SWBGR (7/09) 037** **SWBGR (7/09) 037 (a)**
Mrs Gibson presented the updated Trust risk register, which was due to include the risk around potential operational disruption due to Swine 'Flu. It was noted that this risk was to be scored as 16 (RED) and will be added to the version of the risk register due to be presented to the Trust Board. Professor Alderson was asked to comment on the scoring of this risk. He advised that he agreed with the assessment.	
8 Assurance Framework update 2009/10	**SWBGR (7/09) 043** **SWBGR (7/09) 043 (a)**
Mr Grainger-Payne presented the quarterly update on actions taken to address the gaps in control and assurance against the risks to the delivery of the Trust's corporate objectives. The Committee was asked to note that the pre and post mitigation assessment of the risks to the objectives, together with their respective controls and assurances was now included in the Assurance Framework, in line with feedback from various corporate meetings and as a specific recommendation from the Historical Due Diligence audit held in Autumn 2008. The pre mitigation scores were noted to be amber for the majority of the risks, although when treatment plans were applied, the status of the risks reduced to yellow for the majority. The risk status remained red for three objectives, after mitigation: achievement of national targets, which concerns the potential disruption due to Swine 'Flu; the delivery of the new hospital; and the achievement of Core Standards in the light of difficulty with the delivery of single sex accommodation requirements. A debate ensued concerning the relationship between the Assurance Framework, the Trust risk register and the corporate objectives progress report. It was suggested that there should be two sets of red risks relating to the corporate objectives included on the Trust risk register: those relating to a lack of assurance or controls over the delivery of the corporate objective and those relating to the potential obstacles to the delivery of the objective. It was proposed that the current system does not record those red risks concerning possible issues with the delivery of the Trust's objectives. It was agreed that the relationship between the internal control documents should be considered by the Executive Team outside of the meeting.	
ACTION: **Simon Grainger-Payne to schedule a discussion around the relationship between the Trust's control documents at a future meeting of the Executive Team**	
9 Heath and Safety update	**SWBGR (7/09) 040** **SWBGR (7/09) 040 (a)**

Mr Masaun joined the meeting to present the report on Heath and Safety covering Quarter 4 2008/09. Two policies had been approved during the period: the control and restraint policy and the security policy. The fire safety policy had been issued and was noted to be due for Trust Board approval on 30 July. Two risk assessment sessions were delivered during the period and the roll-out of the Health and Safety File to all wards and departments within the Estates, Facilities, Imaging, Medicine A and Workforce divisions/directorates is planned by the end of August. Much work is underway by Occupational Health to review the causes and controls in connection with needlestick injuries. The corporate health and safety induction training has been reviewed to ensure the information is more current and compliant with NHS LA risk management standards. During the quarter, health and safety incidents increased by 16%, the position being reflective of the ongoing drive to improve reporting of patient falls. Likewise, the majority of all incidents reported were noted to be green risk, indicative of the improved reporting of all health and safety incidents. Considerable activity is ongoing in respect of fire safety, where again reporting of near misses appears to have improved. False alarms have also reduced. Moving and handling performance continues to be positive, with c £250k having been invested on equipment and on moving and handling training. The number of sharps incidents was reported to be static, although there have been more near misses. There has been a big reduction in verbal and aggression incidents, thought to be attributable in part to the success of conflict resolution training. Mr Trotman asked whether these incidents were staff to staff. He was advised that most are staff to staff incidents, however escalation of these issues is very effective. It was noted that RIDDOR events are now included in the report. Professor Alderson asked what constituted a RIDDOR event. He was advised that this would be an incident which prevents a member of staff undertaking their usual role for three days or more. Mr Masaun advised that there had been a significant increase in RIDDOR events, due mainly to an internal safety alert around RIDDORS which encouraged reporting of these incidents. Levels of incidents in Medicine A and Medicine B divisions were noted to be higher than that of all other divisions/directorates, which was reported to be as a consequence of the high throughput of patients in these areas. Mr Adler advised that stress management is a national focus at present, however the Trust's position is good due the 'Listening into Action' philosophy being embedded in the organisation. It was suggested that the impact of Listening into Action on health and safety should be considered as a future article in Heartbeat.	
ACTION: **John Adler to arrange for the impact of Listening into Action on health and safety to be included as a future article in Heartbeat**	

10 Safety alerts update	**SWBGR (7/09) 039** **SWBGR (7/09) 039 (a)**
Mr Masaun presented a summary of alerts received from the Department of Health's Central Alert System (CAS) covering Quarter 4 2008/09. The Committee noted that 26 alerts were received, 17 of which required action. Mr Adler observed that there were a number of actions still in progress relating to alerts dating back several years and asked what measures were in place to ensure that these are resolved. He was advised that the Risk Management Group is currently focussing on ensuring that these actions are completed. It was agreed that the status of these actions should be reported to the Committee annually. A position statement against these actions was requested for the next meeting.	
ACTION: Dally Masuan to present a position statement against outstanding actions to address CAS alerts at the next meeting	
11 Clinical Audit Forward Plan - monitoring report 2009/10	**SWBGR (7/09) 035** **SWBGR (7/09) 035 (a)**
Miss Dhami presented the latest update on progress against the 2009/10 clinical audit forward plan. Progress with the majority of audits was noted to be on track. The Committee was informed that the report had been reviewed in detail by the Governance Board at its July meeting. Professor Alderson remarked that those staff undertaking the audits need to have sufficient support and resources.	
12 Minutes from the Governance Board	**SWBGB (5/09) 088** **SWBGB (6/09) 101** **SWBGB (6/09) 101 (a)**
The Governance and Risk Management Committee received and noted the minutes from the Governance Board meetings held on 8 May and 5 June 2009. The Committee also reviewed the actions log presented at the meeting held on 3 July 2009.	
13 Minutes from the Clinical Quality Review Group	**SWBGR (7/09) 041** **SWBGR (7/09) 042**
The Governance and Risk Management Committee received and noted the minutes from the Clinical Quality Review Group meetings held in May and June 2009. Miss Dhami reported that the workplan of the Group consists of a combination of a review of some of the Trust's quarterly reports, together with some themed meetings.	
14 Any other business	**Verbal**
Professor Alderson highlighted that there was potential for doctors to register a wish to opt out of the European Working Time Directive practices and recommended	

that the Trust should consider its response to such requests. It was agreed that this matter should be discussed at a future meeting of the Executive Team.	
ACTION: **Simon Grainger-Payne to schedule a discussion around the Trust's response to doctors wishing to opt out of the EWTD arrangements at a future meeting of the Executive Team**	
12 Details of the next meeting	**Verbal**
The date of the next meeting is 17 September 2009 at 1030h in the Executive Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

MINUTES

Sandwell and West Birmingham Hospitals NHS Trust

Trust Board (Private Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 30 July 2009

Present:	Mrs Sue Davis	Dr Sarindar Sahota	
	Mr Roger Trotman	Miss Rachel Overfield	
	Miss Isobel Bartram	Mr John Adler	
	Mrs Gianjeet Hunjan	Mr Robert White	
	Mr Donal O'Donoghue		
In Attendance:	Mr Colin Holden	Mrs Jessamy Kinghorn	Mr Matthew Dodd
Secretariat:	Mr Simon Grainger-Payne		

Minutes	**Paper Reference**
1 Minutes of the previous meeting	**SWBTB (6/09) 127 (PR)**
The minutes of the meeting held on 25 June 09 were approved.	
AGREEMENT: The minutes of the previous meeting on 25 June 09 were approved as a true and accurate reflection of discussions held	
2 Update on actions from previous meetings	**Verbal**
There were no outstanding actions.	
3 Minutes of the Acute Hospital Project Board	**SWBTB (7/09) 144 (PR)** **SWBTB (7/09) 144 (a) (PR)**
The Trust Board received and noted the minutes of the Acute Hospital Project Board held on 25 June 2009.	
4 Red incident report	**Hard copy paper**
Mr O'Donoghue reported that 14 red incidents had occurred in June 2009, one of which was classified as a Never Event. The Trust Board was advised that there is a growing concern around incidents reported at Sandwell Accident and Emergency department, notably a failure to learn from previous adverse events. A new management team is in place however and work is being undertaken to review the trends on adverse events in the area. Further corporate oversight is also planned in the form of an Action Team, similar to that used for Maternity. Mrs Hunjan noted that an incident had been reported involving the theft of a laptop and asked whether patients were to be contacted. She was advised that	

letters are due to be sent out to patients to advise that there is a minimal risk of issues arising from the theft. Dr Sahota asked whether there was a clause in the contract with the company from which the laptop was stolen, to mandate it to advise the Trust of such security incidents. He was advised that this is the case. Internal guidelines around the handling of such situations are also to be developed.	
5 Trust risk register	**SWBTB (7/09) 145** **SWBTB (7/09) 145 (a) (PR)**
Mr Grainger-Payne presented the latest version of the Trust risk register, advising that it had previously been considered in detail by the Governance and Risk Management Committee. The most notable addition concerned the risk around the potential for operational disruption due to the Swine 'Flu pandemic. The Chair asked what the position was concerning compliance with the European Working Time Directive (EWTD). Mr Adler advised that there was daily monitoring of EWTD compliance and full compliance has been achieved in all specialities. Vacancies in some areas exist at present and filling these gaps is dependent on securing locums to cover the positions. Mr Holden noted that EWTD compliance affects all staff and reported that a Trust wide review of the position is in progress. The Chair suggested that Mr Holden present an overarching view of EWTD compliance, including the position regarding medical staff, at the September Trust board meeting.	
ACTION: Mr Holden to present an overarching view of EWTD compliance at the September Trust board	
6 Consultant exclusion	**Verbal**
Mr O'Donoghue reported that a consultant had been dismissed, however an appeal had been lodged. There is the potential for this to be delayed however, due to the outcome of a recent Court of Appeal ruling. A resignation letter had been received from a second consultant and is to be effective from mid October 2009. A further consultant has been excluded based on alleged inappropriate conduct during a patient examination.	
7 Any other business	**Verbal**
Mr Trotman advised that the Trust's legal advisors are due to be changed shortly, following the outcome of a recent selection panel.	

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Signed ……

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Date ……