Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 26 November 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)	
Mrs L Barnett	(LB)	
Mrs J Kinghorn	(JK)	
Miss J Whalley	(JW)	
Mr J Cash	(JC)	

Secretariat

Mr S Grainger-Payne	(SGP)	[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 29 October 2009 as true and accurate records of discussions*	**SWBTB (10/09) 208**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (10/09) 208 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	MATTERS FOR APPROVAL		
7	**Business case for a replacement CT scanner at Sandwell Hospital**	**SWBTB (11/09) 223** **SWBTB (11/09) 223 (a)**	**RK**
8	**Business case for redevelopment of the Medical Assessment Unit at City Hospital**	**SWBTB (11/09) 227** **SWBTB (11/09) 227 (a)** **SWBTB (11/09) 227 (b)** **SWBTB (11/09) 227 (c)**	**RK**
9	**Single tender action: mobile MRI scanner**	**SWBTB (11/09) 215**	**RK**
10	**Order for Sterile Service Provision from BBraun**	**SWBTB (11/09) 209**	**GS**
11	**Application to use the Trust Seal: contract documents for capital works on the Midwifery Led Unit at City Hospital**	**SWBTB (11/09) 210**	**GS**

12	**Application to use the Trust Seal: contract documents for capital works on ward D16 at City Hospital**	**SWBTB (11/09) 211**	**GS**
13	**Declaration of compliance against Core Standards**	**SWBTB (11/09) 235** **SWBTB (11/09) 235 (a)** **SWBTB (11/09) 235 (b)**	**KD**
14	**Complaints policy**	**SWBTB (11/09) 229** **SWBTB (11/09) 229 (a)** **SWBTB (11/09) 229 (b)** **SWBTB (11/09) 229 (c)** **SWBTB (11/09) 229 (d)**	**KD**
15	**Do Not Attempt Cardiopulmonary Resuscitation policy**	**SWBTB (11/09) 231** **SWBTB (11/09) 231 (a)** **SWBTB (11/09) 231 (b)** **SWBTB (11/09) 231 (c)** **SWBTB (11/09) 231 (d)** **SWBTB (11/09) 231 (e)**	**KD**
16	**Disciplinary policy**	**SWBTB (11/09) 230** **SWBTB (11/09) 230 (a)** **SWBTB (11/09) 230 (b)** **SWBTB (11/09) 230 (c)**	**LB**
MATTERS FOR INFORMATION/NOTING			
16	**Quality and Governance**		
16.1	The 'Shared Narrative'	SWBTB (11/09) 212 SWBTB (11/09) 212 (a)	JA
16.2	Integrated risk, complaints and claims report – Quarter 2	SWBTB (11/09) 218 SWBTB (11/09) 218 (a)	KD
16.3	Heath and Safety annual report	SWBTB (11/09) 228 SWBTB (11/09) 228 (a)	LB
16.4	High impact actions for nursing and midwifery	SWBTB (11/09) 221 SWBTB (11/09) 221 (a)	RO
16.5	Cleanliness report	SWBTB (11/09) 220 SWBTB (11/09) 220 (a)	RO
16.6	Infection control assurance framework	SWBTB (11/09) 219 SWBTB (11/09) 219 (a)	RO
16.7	Infection control update	SWBTB (11/09) 216 SWBTB (11/09) 216 (a)	BAO
17	**Strategy and Development**		
17.1	'Right Care, Right Here' programme: progress report	SWBTB (11/09) 222 SWBTB (11/09) 222 (a) SWBTB (11/09) 222 (b)	RK
17.2	New acute hospital project: progress report	SWBTB (11/09) 214 SWBTB (11/09) 214 (a)	GS
18	**Performance Management**		
18.1	Monthly finance report	SWBTB (11/09) 217 SWBTB (11/09) 217 (a)	RW
18.2	Monthly performance monitoring report	SWBTB (11/09) 232 SWBTB (11/09) 232 (a)	RW

18.3	NHS Performance Framework monitoring report	SWBTB (11/09) 233 SWBTB (11/09) 233 (a)	RW
19	**Operational Management**		
19.1	Sustainability strategy	SWBTB (11/09) 213 SWBTB (11/09) 213 (a)	GS
20	**Update from the Board Committees**		
20.1	Finance and Performance Management Committee		
▶	Minutes from meeting held 17 September 2009	SWBFC (10/09) 206	RT
21	**Any other business**	**Verbal**	**All**
22	**Details of next meeting** *The next public Trust Board will be held on 17 December 2009 at 1430h in the Churchvale/Hollyoak Rooms, Sandwell Hospital*	**Verbal**	**Chair**
23	**Exclusion of the press and public** *To resolve that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).*	**Verbal**	**Chair**

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Board (Public Session) – Version 0.2

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 29 October 2009 at 1430 hrs

Present:	Mrs Sue Davis	Dr Sarindar Sahota	Miss Rachel Overfield
	Mr Roger Trotman	Mr John Adler	Mr Donal O'Donoghue
	Miss Isobel Bartram	Mr Robert White	
	Mrs Gianjeet Hunjan	Mr Richard Kirby	
In Attendance:	Mrs Gayna Deakin	Miss Kam Dhami	Mr Graham Seager
	Mrs Jessamy Kinghorn	Mr John Cash [Sandwell LINks]	

Guests: Dr John Middleton (Sandwell PCT) [Item 7 only]

Secretariat: Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Miss Parveen Akhtar.	
2 Declaration of interests	**Verbal**
No declarations of interest were made in connection with any agenda item.	
3 Chair's opening comments	**Verbal**
Mrs Davis advised that Miss Parveen Akhtar would be stepping down as Non Executive Director, following her recent appointment to a position within Heart of Birmingham tPCT. The November Board meeting would be Miss Akhtar's last Trust Board meeting.	
4 Minutes of the previous meeting	**SWBTB (9/09) 184**
Subject to minor amendment, the minutes of the meeting held on 24 September 09 were approved. Mr O'Donoghue reported that in connection with the discussion concerning mortality at the last meeting, that the Trust's Standardised Mortality Rate is due to be rebased, which could cause a significant change to the currently reported number of deaths. Mr O'Donoghue was asked to provide a brief explanatory note for this decision at a future meeting.	

ACTION: **Mr O'Donoghue to present an explanation for the decision to rebase SMR figures at a future meeting** **AGREEMENT:** **Subject to minor amendment, the minutes of the previous meeting on 24 September 09 were approved as true and accurate reflections of discussions held**	
5 Update on actions from previous meetings	**SWBTB (9/09) 184 (a)**
The updated action list was reviewed. There were noted to be no outstanding actions requiring escalation.	
6 Questions from members of the public	**Verbal**
There were no questions from members of the public in attendance at the meeting. Mr Cash reported however, that the recent Trust staff awards had been well received by public patient representatives.	
7 Public Health Matters: Sandwell PCT	**Presentation**
Dr John Middleton, Director of Public Health at Sandwell PCT, was welcomed to the meeting. He presented an overview of the key points from the PCT's last annual report. Dr Middleton reported that many members of the local health economy are incurring a 'health debt' due to poor lifestyles. Much work is being undertaken, therefore, to reinforce the requirement to adopt dietary needs to support a healthy life, as opposed to a desired lifestyle. Work includes growing food locally and encouraging members of the community to undertake more exercise. The PCT is also taking responsibility for equipping people with the required knowledge to support a healthy lifestyle. Crime and disorder were highlighted to be prevalent across the region. These were noted to be linked inextricably to alcohol and drug-related health disorders. In terms of improving health, some specific measures were outlined to include a focussed approach to reducing cardiovascular disease, smoking cessation, cancer prevention and a reduced alcohol intake. Other workstreams underway concern supporting independence by supporting carers and reducing length of stay. Work is also in train, aimed at ensuring a better start to life through the reduction in infant deaths, increased breastfeeding, reduction in childhood obesity, reduction in child poverty and increased physical activity. As part of this work, a reduction in teenage pregnancy has been seen on a scale ahead of the national position. The workstream to build stronger and safer communities concerns improving the quality of local environments and links to work to improve skills and provide jobs in the community. Health trainers are in place to assist people with improving their lives and health. The Chair asked what the Trust, as an acute provider, could do to support the work of the PCT. Dr Middleton suggested that the Trust's delivery of CQUIN targets, such as smoking cessation referrals would be a considerable benefit. The work around the 'Stop before the Op' initiative was highlighted as assisting the work of cardiologists and surgeons. Elimination of smoking on all NHS premises was also	

highlighted as a potential further measure that would assist. Work to reduce alcohol intake should be targeted next, supported by Aquarius. Physical activity and healthy eating should be reinforced to patients as a key priority. Mr O'Donoghue remarked that intervention regarding alcohol consumption was more difficult to target than smoking cessation. Mr Trotman noted that the ban on smoking on NHS premises seemed to be targeted at staff only and suggested that this should be extended to patients and visitors. Dr Middleton agreed. Mr Cash asked in connection with hospital discharges, whether it was the responsibility of the Patient Transport Service to ensure that a patient's quality of home facilities and amenities was adequate. Miss Overfield explained that this is the responsibility of the discharge teams. The Patient Transport staff are required only to ensure that access is appropriate. Dr Middleton was asked how the PCT was performing in relation to referrals on breast screening, cervical screening and prostate cancer. Dr Middleton reported that breast screening services had been reconfigured and the referral level for women between 50 and 65 was acceptable, however there was a shortfall against referrals for women between 65 and 70 years of age. There is also a shortfall against referrals for cervical screening, although this situation is currently being investigated. Mrs Kinghorn reported that work is underway with Trust members to promote health messages and good work is in progress with young members in terms of dissemination of messages concerning sexual health, smoking and drugs. Dr Middleton was thanked for his informative presentation and it was suggested that he should be invited to attend again early in the new year to provide an update against the PCTs new annual report.	
ACTION: **Simon Grainger-Payne to schedule a presentation by Dr Middleton for early in 2010**	
8 Compulsory Purchase Order for the new hospital project – emergency action	**SWBTB (10/09) 187** **SWBTB (10/09) 187 (a)**
Mr Seager reported that shortly after the approval of the Compulsory Purchase Order at the last meeting, there had been a need to slightly amend the Order in relation to crane oversailing rights and boundaries. To avoid any delay to the process, Chair's action had been taken to make the amendments. The Trust Board was asked to and did, ratify the amendments made.	
AGREEMENT: **The Trust Board ratified the amendments to the Compulsory Purchase Order for the new hospital plans**	
9 Estates strategy – annual review	**SWBTB (10/09) 178** **SWBTB (10/09) 178 (a)** **SWBTB (10/09) 178 (b)** **SWBTB (10/09) 178 (c)**
Mr Seager presented the routine update on the Trust's estates strategy, which it was noted projects to 2016.	

A key point of note was the estates efficiency and performance, particularly in terms of how much it would cost to transform the estate into an 'as new' condition. To upgrade the estate to this state would require significant investment and extensive work. Regarding the energy and environmental performance, Mr Seager reported that energy certificates are displayed at prominent places around the Trust. Overall, from an environmental perspective, the Trust's efficiency rating is average compared with other Trusts. Mr Kirby asked how the Trust performed on a site by site basis and was advised that the Sandwell site is in line with average energy efficiency levels, however the City site performed more poorly.

In terms of the work required to achieve compliance with the Core Standard C20b, allied with the delivery of single sex accommodation requirements, the Board was advised that good progress had been made.

With reference to the level of expenditure on maintenance of the estate, this was reported to be within the lower quartile of average spend in comparison with other Trusts. Amount spent on cleanliness is in line with other trusts. The Trust was noted to perform well against other trusts in terms of spend on food.

The Board noted that an update on capital schemes was included in the estates strategy and a progress report on the plans for the new hospital are also provided. Mr White highlighted that an explicit statement concerning the Trust Board's approval of the capital budget should be included to satisfy the requirements of the forthcoming ALE assessment.

The higher than desired level of Carbon Dioxide consumption was noted, which Mr Seager advised was currently being reviewed with a targeted approach to reduction being planned. Mr Trotman remarked that a Listening into Action event around sustainability has been held and asked for an update on the outcome. He was advised that this feedback would form the basis of a substantive report to the Trust Board at its November meeting. Mr Seager advised however that approximately 60 people had attended the event and shown a great willingness to tackle sustainability issues.

Mr Cash noted that it was planned to complete an energy efficiency scheme by March 2010 and asked where the forecast financial savings would benefit. He was advised that any savings resulting from this work would be retained by and would benefit the Trust.

Mr Seager was asked what additional measures were planned in terms of lower level measures to ensure the Trust is more environmentally friendly. He advised that good housekeeping campaigns were underway, facilitated by the Carbon Trust. Mr Cash advised that the LINks was engaged with work to reduce waste. Mr Seager reported that the Trust's waste output was reducing. Miss Overfield added that measures such as this are within the remit of the ward service officers.

Mrs Hunjan asked what level of investment in the Trust's estate would be required to achieve estates code 'Condition B', where the estate is classified as sound, operationally safe and exhibits only minor deterioration. Mr Seager advised that significant investment would be required as the Trust is currently at 'Condition C'. The Birmingham Treatment Centre was noted to be at 'Condition A' at present, although would move to 'Condition B' in the next few years.

The Chair suggested that when relocated into the new hospital, every effort should

be taken to retain 'Condition B' indefinitely. The Trust Board unanimously approved the refreshed estates strategy.	
AGREEMENT: The Trust Board approved the updated estates strategy	
10 Safeguarding declaration	**SWBTB (10/09) 188** **SWBTB (10/09) 188 (a)**
Miss Overfield reminded the Board that it had received a progress update on the work of the Safeguarding Steering Group at the August meeting, however a formal declaration around the Trust's commitment to safeguarding needed to be completed for the Strategic Health Authority. The Trust Board was asked for and gave its approval to the wording proposed for the safeguarding declaration.	
AGREEMENT: The Trust Board approved the Safeguarding Declaration	
11 Grievance and Disputes Policy	**SWBTB (10/09) 198** **SWBTB (10/09) 198 (a)** **SWBTB (10/09) 198 (b)** **SWBTB (10/09) 198 (c)**
Mrs Deakin presented the revised Grievance and Disputes policy for approval. Minimal changes had been made to the policy, mainly around including definitions as to where exceptions to this policy may occur and how they may be handled, such as in connection with national terms and conditions and issues that are already subject to staff consultation. The policy also clarifies which issues should be progressed via the Trust's Dignity at Work policy as opposed to Grievance and Disputes. The Trust Board was advised that the policy had undergone significant consultation with appropriate groups of staff and had been approved at the October meeting of the Trust Management Board. The Chair suggested that future policies to be presented for approval, should highlight specifically where changes have been made. Mrs Hunjan asked how informal grievances are monitored. Mrs Deakin advised that these instances are monitored where known but are largely handled on an informal basis between managers and members of staff. Mrs Hunjan asked how informal issues are handled if they are not resolved early. She was advised that handling the grievance informally is an initial stage of the overall process and formal records should be kept of any discussions held. It was suggested that it should be made clear that the Equality Impact Assessment relates to the formal process. Subject to these comments, the Trust Board approved the Grievance and Disputes policy.	
AGREEMENT: The Trust Board approved the Grievance and Disputes Policy	

12 Trust Board Committees Terms of Reference	**SWBTB (10/09) 197** **SWBTB (10/09) 197 (a) -** **SWBTB (10/09) 197 (e)**
Mr Grainger-Payne presented the terms of reference for the Trust Board Committees for ratification, advising that they had last been formally approved by the Trust Board in September 2006. Amendments since 2006 had been mainly confined to the terms of reference for the Audit Committee and Governance and Risk Management Committee. The Chair suggested that the vice chairs of the Committees should be added into the terms of reference and that the language used in the Audit Committee terms of reference be made consistent with that of other Committees' terms of reference. With reference to the terms of reference for the Finance and Performance Management Committee, Mr Kirby suggested that the duty to 'consider the financial aspects of business cases for significant revenue or capital expenditure prior to submission to the Board' should be removed as this is no longer within the remit of the Committee. Dr Sahota asked that a duty to consider charitable fundraising for the new hospital be added into the terms of reference for the Charitable Funds Committee. It was suggested that the responsibility of the Chair in connection with the Audit Committee should read that the Chair may recommend the Chair of the Audit Committee to the Board, which may approve this recommendation. Additionally, the Audit Committee terms of reference should reflect that the Chief Executive and other directors will be invited to attend as appropriate. Annual appointment of members was agreed to be a necessary addition to all terms of reference. Consistency with format and page numbers was recommended.	
ACTION: Simon Grainger-Payne to amend the Trust Board Committees' terms of reference in line with suggestions made at the Trust Board meeting **AGREEMENT: Subject to the amendments made at the meeting, the Trust board approved the Trust Board Committees' terms of reference**	
13 Quality and Governance	
13.1 CQC ratings 2008/09	**SWBTB (10/09) 200** **SWBTB (10/09) 200 (a)**
Mr Adler asked the Trust Board to formally receive and note the annual ratings for Quality of Service and Use of Resources, awarded by the Care Quality Commission for 2008/09. The Trust was awarded 'Good' for both, maintaining the ratings awarded for 2007/08, which was noted to be particularly pleasing given the slippage in ratings in some areas of the region. It is anticipated that the ratings can be improved next year, providing that the current plans for compliance with core standards are achieved.	

The Chair congratulated the team on achievement of the ratings, however she noted that there had been non-compliance on the core standard relating to safeguarding children. She was advised that concerns had centred on training requirements and appropriate systems to ensure compliance had been put in place from 1st April. In terms of the non-compliance with the core standard concerning discrimination, Miss Overfield advised that this was reflective of the lack of infrastructure around equality and diversity, however this had been rectified by the implementation of the Single Equality Scheme and Equality and Diversity Steering Group. Compliance against both standards has now been achieved.	
13.2 CQC registration	**SWBTB (10/09) 186** **SWBTB (10/09) 186 (a)**
Miss Dhami reported that a new regulatory framework was being introduced by the Care Quality Commission (CQC) and all health providers will be required to register with the CQC by April 2010. Registration is required for all health and adult social care providers delivering regulated activities. Such activities include personalised care; surgical procedures; diagnostic procedures; and treatment of disease, disorder or injury. This regulation will supersede the current Standards for Better Health framework. The core standards declaration will support the registration process and a statement of compliance for the first six months of 2008/09 will be presented to the Trust Board at its November meeting. The locations from which regulated activities are delivered need to be listed as part of the registration, therefore for Trusts comprising more than one site, compliance with the CQC registration terms will be assessed for each. The new regulations governing the CQC registration framework are due to be laid before Parliament in autumn 2009, however the final details will not be received until December. Following this, a statement of compliance with the framework standards will need to be submitted during January 2010. In February and March, the CQC will approach trusts where there is a concern with the details provided for registration. Annual assessment by and registration with the CQC are not expected, with continuous assessment anticipated instead. The view of external bodies, such as Local Involvement Networks (LINks) will feed into the registration process. The Chair asked Mr Cash whether LINks had been briefed in relation to the CQC registration process. He advised that the process is expected to work well.	
13.3 Assurance Framework – quarter 2 update	**SWBTB (10/09) 204** **SWBTB (10/09) 204 (a)**
Mr Grainger-Payne presented the updated Assurance Framework, showing progress with actions to address gaps in control and assurance against delivery of the Trust's corporate objectives. The Board noted that the majority of pre-mitigation scores assigned to the risks in the Assurance Framework were amber, yet changed to yellow or green following the application of the treatments plans to address the gaps. The post-mitigation score against the risk associated with the objective to continue to achieve national targets was noted to be at red status, due to the potential for	

organisational disruption due to the swine 'flu pandemic. Mr Trotman suggested that this status should be downgraded to amber, however Mr Kirby advised that as the impact of swine 'flu is not current clearly understood, this should remain as red.	
14 Strategy and Development	
14.1 Corporate objectives progress report – quarter 2 update	**SWBTB (10/09) 192** **SWBTB (10/09) 192 (a)**
Mr Kirby presented the updated progress on delivery of the Trust's corporate objectives. He asked for the Board's approval to change the objective around achievement of Foundation Trust status to 'continue to pursue NHS Foundation Trust status and explore complementary approaches to further increasing patient, public and staff engagement'. The Trust Board approved this change. Mr Kirby highlighted that a higher proportion of objectives were at amber status to date in comparison to the previous year, however work is underway to develop more objective criteria against which achievement of objectives is measured. The amber status against the objective concerning Service Line Reporting was noted. Mr White explained that this is reflective of the issues concerning the availability of routine information.	
AGREEMENT: The Trust Board approved the proposed change to the corporate objective concerning achievement of Foundation Trust status	
14.2 'Right Care Right Here' programme: progress report	**SWBTB (10/09) 194** **SWBTB (10/09) 194 (a)** **SWBTB (10/09) 194 (b)** **SWBTB (10/09) 194 (c)**
The Trust Board was asked to receive and note the latest version of the 'Right Care, Right Care' programme progress report. Mr Kirby highlighted that there had been some significant pieces of work arising from the recent revision of the programme. The development of services for the Greet Health Centre was also noted. This work is particularly important given that it represents an opportunity in an area of the region not traditionally within the Trust's catchment. The interim Director of Business Development and Planning is working on fostering GP ownership of these services. A more detailed briefing paper on this work is to be presented at a future Board meeting. Mr Cash asked for clarification on the issues regarding step-up beds at the Rowley site. Mr Kirby advised that the issue concerned the need to apply robust criteria to identify patients who were sufficiently in need of care to occupy a step-up bed.	
14.3 New acute hospital project: progress report	**SWBTB (10/09) 195** **SWBTB (10/09) 195 (a)**
Mr Seager presented the key areas of progress in the new hospital project. He advised that the end of the objection period against the Compulsory Purchase Order (CPO) was approaching. In terms of planning, the CPO is on the critical path, therefore the progress with this work is kept closely monitored. A due diligence exercise is planned and a selection process for the procurement provider for the new hospital is due shortly.	

It is proposed that a group be reconvened to oversee the delivery of the design vision, which will establish criteria against which designs are to be judged. Mr Cash noted that there had been a number of public consultation meetings at which comments on the new hospital had been submitted. He asked how these comments were being considered. Mr Seager advised that the appropriate comments will be reviewed by and incorporated into the work of the Design and Vision Group.	
14.4 PCT procurement strategies	**SWBTB (10/09) 203** **SWBTB (10/09) 203 (a)**
Mr White reported that the Trust's two principal PCT partners had published their procurement strategies, setting out a strategic view of how services are commissioned with some indication on how this shapes relationships with healthcare providers. The approaches have been adopted in the context of World Class Commissioning and the 'Right Care, Right Here' programme. Since the strategies were published the philosophy has changed slightly on the basis of the Health Secretary's message that competition should not be mandatory. This reinforces the requirement for the NHS to be regarded as the preferred provider while the 'Right Care, Right Here' programme is being pursued. Mr Kirby remarked that the work was welcomed and the position set out is helpful for the Trust. Mr Cash asked why there were no prescriptive requirements for tendering in connection with the contestability framework. Mr White advised that this was reflective of how a Trust was performing under World Class Commissioning.	
15 Performance Management	
15.1 Monthly finance report	**SWBTB (10/09) 199** **SWBTB (10/09) 199 (a)**
Mr White reported an in month surplus of £257k against a target of £229k. Year to date, the surplus is £1.3m although the position remains adverse at £156k below plan. An end of year surplus of £2.3m continues to be forecast. The Board was advised that the position regarding the medicine divisions had been discussed in detail at the Finance and Performance Management Committee, where it had been highlighted that the average income per admission had reduced due to a change in the case mix towards short stay admissions. There is an increased focus on pay budgets, especially as the Trust is now approaching a full establishment. Steps are being taken to address this situation through recovery plans and controls on recruitment into vacancies. There is a slight improvement on the delivery of the Cost Improvement Plan, although this will be closely monitored over the winter months.	
15.2 Monthly performance monitoring report	**SWBTB (10/09) 205** **SWBTB (10/09) 205 (a)**
Mr White presented a summary of the Trust's performance against a number of key	

targets and indicators for the period April - September 2009. The Board was advised that there had been an improvement in the rate of cancelled operations. An increase in delayed transfers of care was reported however. Mr Kirby reported that the rise in these instances is largely due to recategorisation of delays in transfers of patients from the Sheldon Block. This has been undertaken to provide a more realistic picture to Birmingham City Council of the delays experienced. In terms of performance against the stroke care target, there has been an improvement in the number of patients spending 90% or more of their stay on an acute stroke unit. Both *C difficile* and MRSA bacteraemia infections remain within trajectory. Regarding performance against the CQUIN targets, work is underway to finalise the joint interpretation as to what constitutes procedures counted within the brain imaging target. Smoking cessation referrals were reported to have increased, however there is to be a greater focus on ensuring that these relate to patients due to undergo elective surgery. Mr Cash asked when the patient survey would be undertaken. Miss Overfield advised that this was an ongoing process. Sickness absence levels have reduced and remain below the Trust's target. PDR returns were noted to have been good.	
15.3 NHS Performance Framework monitoring report	**SWBTB (10/09) 206** **SWBTB (10/09) 206 (a)**
Mr White presented the NHS Performance Framework monitoring report. The Board was pleased to note that the score for September was 2.94, classifying the Trust as a 'performing' organisation. It was noted that the performance against the 'stay on a stroke unit' target remained at amber status.	
15.4 Annual Audit Letter 2008/09	**SWBTB (10/09) 190** **SWBTB (10/09) 190 (a)**
Mr White presented the annual audit letter for 2008/09, prepared by KPMG LLP. The letter has been considered by the Audit Committee. The letter was noted to detail any issues that the auditors raised during the annual audit of accounts and also reports the position against the ALE assessment. Mrs Hunjan, as chair of the Audit Committee, confirmed that the recommendations raised by the auditors had been reviewed by the Audit Committee. Mr Grainger-Payne was asked to arrange publication of the annual audit letter on the Trust's internet site.	
ACTION: Simon Grainger-Payne to arrange publication of the annual audit letter on the Trust's internet site	
16 Operational Management	
16.1 Update on preparedness for Swine 'Flu pandemic	**SWBTB (10/09) 191** **SWBTB (10/09) 191 (a)**

	SWBTB (10/09) 191 (b)
Mr Kirby presented an update on the Trust's preparedness for the swine 'flu pandemic. The Board was advised that two areas remain at amber status: discharge processes and Primary Care capacity. The staff vaccination programme has commenced, with 22% of staff having now been vaccinated against seasonal 'flu. Swine 'flu vaccinations are now being offered to staff in priority areas, such as Critical Care and Maternity and to vulnerable patients. Mr Kirby advised that there had been a steady increase in the number of patients admitted with 'flu. Numbers at the City Hospital site are higher at present than at Sandwell Hospital. Mr Kirby was asked how long the staff vaccination programme would last. He advised that no end date had been set and the programme would continue for as long as necessary. Mr Cash remarked that patients' expectations would be that clinicians had been vaccinated.	
16.2 Patient experience action plan: progress report	**SWBTB (10/09) 189** **SWBTB (10/09) 189 (a)**
Miss Overfield reported the patient experience action plan incorporated key elements arising from patient complaints and feedback. Privacy and dignity work is currently high profile and much work is underway to deliver the requirements of single sex accommodation guidelines issued by the Department of Health. A launch of ten key actions to support privacy and dignity work is planned shortly. In terms of nutrition, it was reported that patients do not feel that they have sufficient choice of food. This may however, be due to staff offering the ethnic menu or the main menu, but not both. Some issues were reported around ensuring patients are fed, however this is being closely monitored. Hygiene has improved considerably, with c. 80% compliance reported in handwashing audits. Mr Cash remarked that it was good to see that the issue concerning nightwear is being addressed and positive that the need to address patients by name is being reinforced. He asked for an explanation of the term 'optimal wards'. He was advised that these were the wards on which the range of measures for improvement, identified during Listening into Action events, were being implemented. Dr Sahota asked whether there was any way of standardising appointment letters as feedback suggests that these are confusing. Mr Kirby advised that this feedback related to duplicate letters received. Issues to eliminate these mistakes are being worked through systematically. More user-friendly text is also being developed.	

17 Update from the Committees	
17.1 Finance and Performance Management	**SWBFC (9/09) 192**
The Board noted the minutes of the Finance and Performance Management Committee meeting held on 17 September 2009.	
17.2 Governance and Risk Management	**SWBGR (9/09) 054**
The Board noted the minutes of the Governance and Risk Management Committee meeting held on 17 September 2009.	
17.3 Audit	**SWBAC (9/09) 061**
The Board noted the minutes of the Audit Committee meeting held on 3 September 2009.	
17.4 Charitable Funds	**SWBCF (9/09) 016**
The Board noted the minutes of the Charitable Funds Committee meeting held on 3 September 2009.	
18 Any other business	**Verbal**
There was none.	
19 Details of the next meeting	**Verbal**
The next meeting is scheduled for Thursday 26 November 2009 at 14.30pm in the Anne Gibson Boardroom, City Hospital.	
20 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: 26 November 2009, Anne Gibson Boardrooms @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

29 October 2009 - Sandwell Hospital

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

In Attendance: Mrs G Deakin (GD), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Mr J Cash (JC)

Apologies: Miss P Akhtar (PA)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 20 November 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 December	In hand - review next meeting	17-Dec-09
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	RO	24-Sep-09	Update to be provided within next SES update	In hand - review next meeting	17-Dec-09
SWBTBACT. 110	Trust Board Committees Terms of Reference	SWBTB (10/09) 197 SWBTB (10/09) 197 (a) - SWBTB (10/09) 197 (e)	29-Oct-09	Amend the Trust Board Committee terms of reference in line with suggestions made at the Trust Board meeting	SGP	17-Dec-09		In hand - review next meeting	
SWBTBACT. 084	MRI business case	SWBTB (4/09) 093 SWBTB (4/09) 093 (a)	30-Apr-09	Present a post implementation review of the City Hospital MRI scanner	RK	29-Apr-10	**ACTION NOT YET DUE**	Future	
SWBTBACT. 106	Response to the HCC report into Mid Staffs NHS FT	SWBTB (8/09) 164 SWBTB (8/09) 164 (a) SWBTB (8/09) 164 (b)	27-Aug-09	Present an update on the Quality Management Framework at the January 2010 meeting of the Trust Board	DOD	01-Jan-10		Future	
SWBTBACT. 109	Public Health Matters	Presentation	29-Oct-09	Schedule a presentation by the Director of Public Health for Sandwell at a meeting early in the new year	SGP	25-Mar-10		Future	
SWBTBACT. 096	Sustainability	Presentation	25-Jun-09	Present the sustainability strategy at the November meeting of the Trust Board	GS	26-Nov-09	Included on agenda of November 2009 meeting	Completed Since Last Meeting	
SWBTBACT. 106	Annual report	SWBTB (9/09) 176 SWBTB (9/09) 176 (a)	24-Sep-09	Determine the reason behind the rise in security incidents	KD	26-Nov-09	Will be included as part of integrated risk, complaints and claims update	Completed Since Last Meeting	
SWBTBACT. 107	Quarterly integrated risk, complaints and claims report	SWBTB (9/09) 181 SWBTB (9/09) 181 (a)	24-Sep-09	Prepare an analysis of the rise in complaints against national trend data	KD	26-Nov-09	Will be included as part of integrated risk, complaints and claims update	Completed Since Last Meeting	
SWBTBACT. 108	Minutes of the previous meeting	SWBTB (9/09) 184	29-Oct-09	Present an explanation for the decision to rebase SMR figures at a future meeting	DOD	26-Nov-09	Included on the agenda of the private session	Completed Since Last Meeting	

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 111	Annual Audit Letter - 2008/09	SWBTB (10/09) 190 SWBTB (10/09) 190 (a)	29-Oct-09	Arrange publication of the annual audit letter on the Trust's internet site	SGP	26-Nov-09	Published as requested	Completed Since Last Meeting	

Next Meeting: 26 November 2009, Anne Gibson Boardrooms @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

29 October 2009 - Sandwell Hospital

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

In Attendance: Mrs G Deakin (GD), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Mr J Cash (JC)

Apologies: Miss P Akhtar (PA)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 20 November 2009

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.119	Minutes of the previous meeting	SWBTB (9/09) 184	29/10/2009	Subject to minor amendment, the minutes of the previous meeting were accepted
SWBTBAGR.120	CPO - emergency action	SWBTB (10/09) 187 SWBTB (10/09) 187 (a)	29/10/2009	The Trust Board ratified the amendments to the CPO for the new hospital plans
SWBTBAGR.121	Estates strategy	SWBTB (10/09) 178 SWBTB (10/09) 178 (a) - SWBTB (10/09) 178 (c)	29/10/2009	The Trust Board approved the updated estates strategy
SWBTBAGR.122	Safeguarding declaration	SWBTB (10/09) 188 SWBTB (10/09) 188 (a)	29/10/2009	The Trust Board approved the safeguarding declaration
SWBTBAGR.123	Grievance and disputes policy	SWBTB (10/09) 198 SWBTB (10/09) 198 (a) - SWBTB (10/09) 198 (c)	29/10/2009	The Trust Board approved the grievance and disputes policy
SWBTBAGR.124	Trust Board Committees terms of reference	SWBTB (10/09) 197 SWBTB (10/09) 197 (a) - SWBTB (10/09) 197 (e)	29/10/2009	Subject to amendments suggested at the meeting, the Trust board approved the Trust Board Committees' terms of reference
SWBTBAGR.125	Corporate objectives progress report - quarter 2	SWBTB (10/09) 192 SWBTB (10/09) 192 (a)	29/10/2009	The Trust Board approved the proposed change to the corporate objective concerning achievement of Foundation Trust

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Replacement of CT Scanner – Sandwell Site
SPONSORING DIRECTOR:	Richard Kirby
AUTHORS:	Dr J F Leahy – Divisional Director, Imaging Dr A Lovick – Consultant, Medical Physics Jackie Morton – Divisional General Manager, Imaging Tony Faulkner – Deputy Divisional General Manager, Imaging With input from Capital Projects, Holbrow Brookes and CT Project Leads
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

It is the purpose of this paper to provide an outline of the proposal to replace the CT scanner at Sandwell Hospital. The CT facility at Sandwell is one of the most heavily used items of imaging equipment across the Trust and is the subject of considerable demand from other divisions and Primary Care prompting the need for replacement/upgrading of the current facilities.

CT is a key diagnostic modality and in constant demand. CT supports performance targets including the stroke CQUIN target (24 hour head scans) and activity has grown considerably

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. APPROVE the replacement of the CT Scanner at Sandwell Hospital with a Dual Source CT Scanner along with accompanying capital improvements to the Department at a total capital cost of £1,930,000, recurrent revenue cost of £326,000 and non-recurrent revenue cost of £109,000.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	• ***Good use of resources-*** Imaging will monitor asset utilisation and quantify performance improvements associated with CT • ***Accessible and responsive care*** - The development will support local performance targets and improve patient turnaround in key areas
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**	£1,930 capital £326,000 recurrent revenue £109,000 non-recurrent revenue
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		The scanner was commissioned in 2001 and is approaching the end of its useful economic life. The age of the scanner presents technological limitations and potential service interruptions due to reliability.

PREVIOUS CONSIDERATION:

Approval in principle given for a Dual Source Scanner at SIRG on 10th November 2009.

1. Replacement CT Scanner – Sandwell Site

2. Strategic Context

2.1 The Imaging Capital Equipment replacement programme is aligned to the Trust's 10 year programme as part of the Right Care Right Here programme.

2.2 The long-term location of the scanner has been discussed, as part of this process. Since a diagnostic service will continue to be provided at Sandwell Hospital support has been given to locate the scanner in its current location.

2.3 The provision of a cost effective, high quality/efficient CT service is essential in maintaining reduced diagnostic waiting times (working towards a no delay Diagnostic Service), delivery of National targets (18 week RTT /31/62 day cancer targets, A/E 4 hour target) and guidelines (e.g. Stroke/CT Head Injury/Cancer Reform Strategy). The CT service underpins/supports Divisional CIP plans (reduced beds) service reconfiguration (e.g. Surgical Reconfiguration / Revisions in Provision of Emergency Care). All of which require improved access and timely reporting. Sandwell PCT have highlighted that one of their CQUIN priorities is improving time to CT scan for stroke patients, i.e. compliance with National Stroke Strategy

2.4 The availability of the CT service within and outside of conventional hours is crucial in terms of providing early diagnosis, reducing ALOS, supporting early discharge and is crucial in many patient care pathways, ensuring treatment commences promptly as well as delivering the above.

2.5 There have been significant advances in technology (including dual energy scanning) since the CT scanner was installed. This gives an opportunity to install state of the art, higher specification equipment, to meet clinical/service demand, as well as supporting higher throughput/improved productivity including extended hours working to improve capacity/access.

2.6 Sandwell General Hospital at present has a Siemens Volume Zoom CT Scanner, which will no longer meet the clinical needs of the Hospital. The demand for CT is increasing and the scanner is in use for around 70 hours per week (a few years ago this was 35 hours). Interim re-configuration of services has resulted in Sandwell becoming the main acute surgical site. The new scanner must be capable of coping with this emergency surgical patient workload, and the continuing and increasing demand for oncology scanning. We also anticipate that the scanner must offer cardiac CT scanning, perfusion and flow imaging for acute neurological admissions, and potential dual source imaging.

2.7 The new scanner should provide good quality clinical images for all modalities including neurological imaging.

2.7.1 The scanner must be able rapid acquisition of thoracic and abdominal image series in a single breathhold.

2.7.2 As interventional CT will form a significant part of the anticipated workload the system must be capable of offering this facility, with particular emphasis on dose reduction features.

2.7.3 CT scanning is a major source of radiation to the population. However, while the number of applications is growing and the clinical value of the modality is well accepted, in a properly regulated environment all scans will be clinically justified so it is not reasonable to expect a reduction in scan numbers.

2.8 The scanner should be operated using a simple but comprehensive user interface based around modern industry standard computer hardware and operating system.

CT scanning is a significant component of population radiation exposure and as a consequence the choice of scanner will be influenced by radiation dose dosimetry. Features which reduce the radiation dose or improve dose efficiency will be regarded favourably in the Tender evaluation. The

responder should highlight any such features. The strategies to reduce population radiation dose from CT scanning must revolve around the selection of equipment that is as dose efficient as possible.

This can be achieved via a number of methods including, the choice of the detector material used and the detector geometry design, while on the data acquisition side of the system efficient collection of data from all exposed areas, and the reprocessing of the same data sets for different imaging settings. With scanning involving the cardiac cycle, gated beam switching also contributes to dose reduction, so that cardiac CT scanning may offer potentially lower doses than existing techniques. Similarly, dual source scanning can provide a dose efficient method of gaining more accurate tissue characterisation information. It can also reduce dose to patients with repeat follow up exams e.g. oncology and reduce dose for the operator e.g. interventional techniques.

The Trust has a legal obligation to purchase equipment with the lowest radiation doses, but unfortunately these advanced features which reduce dose are only found in the higher specification CT scanners.

a) Objectives

The Imaging Division has reviewed workload and use of capital assets. These were outlined in the Division's Equipment Replacement Plan presented to SIRG and Trust Management Board. The proposal will achieve the objectives presented below:

The key objectives for the CT service at Sandwell Hospital have been identified as being:

- To maximise the reliability of the CT scanner and minimise unplanned down-time;
- To provide improved quality of images;
- To provide the widest range of examinations and the ability to support the Trust's and local health economy's planned service developments;
- To increase productivity and efficiency;
- To maximise the volume of CT services which can be provided at Sandwell Hospital and avoid the need for referrals to other providers;
- To maintain the volume of CT services in the short-term and long-term;
- To improve staff retention and recruitment

b) Reasons for Proposed Change

- The current CT scanner at Sandwell is 8 years old, and at the end of its economic life. Problems with reliability are anticipated, with more frequent breakdowns resulting in patients having to be transferred to City Hospital. This will result in increased maintenance costs, increased downtime, complaints from clinical colleagues and pressure on corporate and Divisional targets.

- The CT scanner is the only scanner on the Sandwell Hospital site, supporting the local population / Clinical Divisions at Sandwell, and should the scanner fail, the scanners at City Hospital would have insufficient capacity to maintain service provision. This represents a significant business continuity risk.

- The Division provide an extended hours service in order to meet the increase in demand for this service (44% increase 2005 – 2008).

- There are continuing and ongoing pressures to improve access to this service, including Surgical reconfiguration, and national guidelines such as NICE Guidelines/CT Head Injury Management/Stroke Guidelines.

- CT is used in the early diagnosis of a wide range of cancers, cardiovascular/infectious disease,

trauma, musculo-skeletal disorders and neurological disorders.

- There are clear benefits associated with a new CT scanner as follows:
  a. Earlier diagnosis
  b. Adding Clinical Value
  c. Making scans safer for patients
  d. Better management of workflow and increased productivity and efficiency.

- The Division proposes to work in collaboration with Cardiology to assess the benefits of implementing a Cardiac CT/MRI service.

- Demand has been increasing in recent years with and activity needs to grow to close the gap:

April 08 - March 09

	Site		
Patient Type Des	SDGH	RXK02	**Grand Total**
A & E Attender	580	1085	1665
GP Direct Access Patient	434	143	577
In Patient	2863	4359	7222
Other Patient		30	30
Out Patient	4171	6284	10455
Grand Total	8048	11901	19949

April 09 - July 09

	Site		
Patient Type Des	Sandwell	City	**Grand Total**
A & E Attender	312	385	697
GP Direct Access Patient	150	91	241
In Patient	1200	1454	2654
Other Patient		4	4
Out Patient	1482	2039	3521
Grand Total	3144	3973	7117
Est. FY 09/10 (Apr-Julx3)	9432	11919	21351
Est. % workload increase	17.2	0.2	7.0

An estimate of activity using up to date data indicates that there is a growth of 17% at the Sandwell site in year. This increase is to increase in the use of CT scans as a diagnostic tool by a range of specialties and as well as the impact of surgical reconfiguration concentrating emergency surgery and trauma at Sandwell.

3. Anticipated Outcomes and Benefits

Benefits	Achieved by when	How will it be measured	Review Date and Forum	Lead Manager
Reduce risks of major failure	Project completion	Reduced fault reporting/breakdowns	Governance	CH
Improved quality of images – diagnosis/outcomes	↓	Improved diagnosis/clinical outcomes (audit)	Governance	CH
Increased range of examinations	↓	Scope of examinations	DMT	FL
Improved productivity	↓	Activity increase	DMT	JM
Improved recruitment and retention		Staff turnover	DMT/HR	JM

4. Options

4.1 Consideration was given to a number of options available for the future provision of CT services at SDGH Hospital. A long list of options was initially assessed before the final list was produced to be taken forward.

4.2 Options Scanner Specification

Option	Description
1	Do nothing
2	Replace with a high specification dual source scanner
3	Replace scanner with a high specification machine

Option 1 – Do Nothing

4.21 The option to do nothing has been considered. The consequences are outlined below.

4.22 The possibility of re-configuring to provide CT at City Hospital only has been considered and has serious implications. There would be no CT service at Sandwell and no support for A&E, Surgery, Stroke services etc..

This option, of making no new capital investment, will involve the Trust acknowledging that the service will continue in its current format. The consequences of this are:

a) That equipment failure will increase incrementally over time with a significant risk of major failure

b) Increased intermittent maintenance costs

c) Increased non availability of the facility

d) Consequent failure to improve on targets e) progressively going “backwards” against targets

f) Consequential impact on other services, notably ED

g) Maintaining the service by either/or:

i) Introduction of mobile facilities ii) Transferring patients to Sandwell iii) Transferring patients to

other providers

4.23 Ultimately in the short to medium term the existing scanner will fail and be beyond economic repair. To reach a point of overall failure would significantly impact on business continuity to the point of withdrawing the CT service from Sandwell Hospital while reinstatement was considered/ implemented. This could effectively mean that there would be no CT service on site for a prolonged period.

4.24 The net effect of taking no action is that the revenue impact of maintaining the existing scanner will progressively increase to the point that it becomes prohibitive and consequently makes the facility uneconomic.

4.25 The detrimental effect on patient care would be significant.

4.26 The effect on staff morale and retention may also put the service at risk.

Option 2 – Replace with Dual Source High Specification CT

4.27 Dual source CT uses two x-ray sources and two detectors at the same time resulting in double temporal resolution, double speed and twice the power while lowering the radiation dose to a level the same as or lower than that produced by other high specification non dual source scanners and significantly lower than what we are currently achieving. Dual source CT potentially has the following advantages:

- It halves the imaging time and radiation exposure compared to conventional CT.
- It also allows imaging of the heart in diastole, without use of beta-blockers to reduce the heart rate, which is particularly important for the success of cardiac imaging.
- Dual source CT means that two Xray tubes work in parallel, revolving simultaneously around the patient's body at different energy levels; differentiating tissues, such as bone and blood vessels. This would normally require two scans. Adjunctive uses for this technique include, differentiating focal fat on liver CT, renal masses, in the use of CTPA, lung perfusion, CT colonography, imaging in gout, the solitary pulmonary nodule, bone mineral assessment, differentiation of renal stones and monitoring tumour response to treatment.
- Dual source CT can also be used for cerebral perfusion studies which can inform requirement for thrombolysis therapy. In many of these cases, a reduction in radiation dose is seen. This technology is relatively new but significant benefits have been described in published reviews. This technology would allow greater scope for developing techniques and potentially enhance the Divisional and Trust profile.
- Scanning obese patients with single source CT usually results in a trade-off between speed and image quality. Dual Source CT overcomes this limitation because it utilises a second Xray source. In other words I accumulates the power of the two independent sources resulting in an unprecedented 160 kW providing sufficient X-ray power reserves for high quality imaging of patients whether tall or small, thin or large – at maximum volume coverage speed and fastest rotation time. Because the scan speeds can be increased the higher power is used to improve quality, while dose remains the same as in single source CT.
- Dual Source CT also lets you examine uncooperative patients, patients short of breath or with high heart rates, quickly and without restriction.
- Dual Source CT enables you to quickly rule out the major causes of chest pain such as myocardial infarction, pulmonary embolism and aortic dissection in a stop stop diagnosis without the compromise of beta blockers. Chest pain patients can be accurately triaged within 10 minutes after presenting to A&E.
- Economically the dual source scanner reduces diagnostic time and therefore length of stay.

Option 3 – Replace with Conventional High Specification CT

4.28 Replacement of the scanner with a like for like machine also has been considered and the current range of available scanners would present opportunities to increase the scope of examinations. A high specification scanner would present many advantages. The scanner would provide good quality clinical images for all modalities including neurological imaging. The scanner could rapidly acquire thoracic and abdominal image series in a single breath-hold reducing the dose of radiation. As interventional CT will form a significant part of the anticipated workload the system must be capable of offering this facility, with particular emphasis on dose reduction features. Image quality is significantly improved with this technology with potential to detect lesions sooner and improve clinical outcomes.

5. Non Financial Option Appraisal

The table below sets out the outcome of the non-financial option appraisal of the three options.

Benefit Description	**Option 1 (Do Nothing)**	**Option 2 (Dual Source)**	**Option 3 (High Specification)**
Improved reliability	1	4	4
Improved quality of images – diagnosis/outcomes	1	4	3
Increased range of examinations	1	5	4
Improved productivity	1	4	4
Improved recruitment and retention	1	4	3
Total Score	**5**	**21**	**18**

Notes

Replacing the scanner in the existing unit provides the best solution in terms of functional relationships with other departments, proximity to clinical areas and productivity. There are additional building works required which improve patient safety and flow through the department and constitute a significant element of the overall capital investment. The items recommended by Infection Control include:

- Area for laying up trolleys
- Designated area for preparing contrast
- Macerator

Also additional bed spaces have been incorporated into the proposed design with the intention of providing faster and more responsive service to A&E and wards.

The proposed design will provide more bed spaces and improve inpatient turnaround, reduce the movements of the operator, provide a dedicated reporting area (free from interruptions) and provide a trolley lay up and clean utility/prep area. Design options are shown in Appendix I.

6. Estimated Capital Cost and Funding

Completed for considered options – The two options presented below reflect conventional and dual source scanner options. Option costs may be reduce at the detailed design stage.

6.1 Capital Costs

The costs shown in the table below are for updated high specification and dual source replacement options. Non-recurrent costs of the temporary facility that will be required while the new scanner is installed are included at the end of this table as a note.

	Option 2 Traditional Procurement (Siemans SOMATOM Definition Flash)	Option 3 revised Traditional Procurement (Siemans SOMATOM Definition AS)
Building and Engineering		
Building Works	£65,000	£65,000
Mechanical and Electrical Works	£259,300	£247,400
Main Contractors Discount 1/39	incl	incl
Design Risk 7.5%	£25,000	£25,000
Preliminary costs	£45,000	£45,000
Main Contractors Profit and Overheads	incl	incl
Additional works to provide new bed wait and reporting room	incl above	incl above
Total of Building & Engineering	**£394,300**	**£382,400**
MRI Equipment	**£1,100,000**	**£850,000**
Fees (Includes some actual fee elements)	**£77,170**	**£77,170**
VAT		
On Building and Engineering @ 17.5 %	**£69,003**	**£66,920**
On Fees @ 0.00%	**-**	**-**
On Equipment @ 17.5 %	**£192,500**	**£148,750**
CLIENT CONTINGENCY @10%/5%	**£95,149**	**£73,887**
TOTALS	**£1,928,122**	**£1,599,127**
Rounded Totals – Capital	***£1,930,000***	***£1,600,000***
Note: Non-recurrent revenue cost of temporary facility during installation of new scanner	***£109,000***	***£109,000***

6.2 Income & Expenditure analysis

	2009/10	Option 2 - DUAL SOURCE	Option 3 - HIGH SPEC
ACTIVITY	9432	9432	9432
	£000	£000	£000
Income - Av CT tariff £103	971	971	971
Direct Expenditure	(519)	(845)	(759)
Surplus	453	127	213
as a %	47%	13%	22%

As a guide, income has been derived using the average 2009/10 price of a CT attendance and has been calculated to show whether derived income for undertaking CT scans on the Sandwell site would cover the total recurrent expenditure for running the service with either a replacement high specification machine or a dual energy machine. This approach is consistent with the current unbundled tariff for diagnostics.

Both options would be funded by current income received for the service. The reduction in the surplus generated

There has been recent suggestion that tariff prices may decrease in 2010/11. If tariff prices fall below 12% of current levels the Dual source scanner will start to generate a deficit. However the tariff price would need to fall by 22% before the High Specification scanner starts to turn into a deficit. This analysis is based on delivering 09/10 forecast outturn.

The reduction in tariff could well be mitigated by an increase in activity levels as seen in recent years. A forecast projection for 09/10 is to deliver 17% more than 08/09 outturn activity. The Right Care Right Here programmed activity profile over the next 5 years also predicts an increase in the number of CT cases performed. There would be some costs associated with delivering this increased activity but these should only be marginal. The one area that may need some stepped investment in the near future is reporting sessions.

The expenditure analysis is shown in detail at Appendix III

6.3 Difference in base costs between options 2 and 3

	2009/10	Option 2 - DUAL SOURCE	Option 3 - HIGH SPEC
	£000	£000	£000
TOTAL RECURRENT EXPENDITURE	(519)	(845)	(759)
Increase in expenditure		(326)	(240)
Due to:			
Capital charges		(249)	(198)
Maintenance		(72)	(37)
Media costs		(5)	(5)
Total recurrent		**(326)**	**(240)**
Increase between options 2 & 3		**(86)**	
Due to:			
Capital charges		(51)	
Maintenance		(35)	
TOTAL INCREASE between 2 & 3		**(86)**	

The main increase in expenditure recurrently is due to the increased capital charges. This is because the current scanner in use has been fully depreciated and therefore has attracted no capital charges in the base year (09/10).

6.4 Sources of Funding

The Trust proposes to meet the recurrent costs of Options 2 and 3 as set out in the table below.

	2009/10	Option 2 - DUAL SOURCE	Option 3 - HIGH SPEC
	£000	£000	£000
TOTAL RECURRENT EXPENDITURE	(519)	(845)	(759)
Expenditure met by			
Baseline budget	519	519	519
Trust provision for capital charges as part of financial planning		249	198
Additional savings from Imaging Division		77	42
Total	519	845	759

The non-recurrent revenue costs of implementing the options (£109,000) will be met from non-recurrent provision in the Trust's 2010/11 Financial Plan.

6.5 Cost Benefit Scores

The table below summarises the combined cost benefit scores for each of the options.

	Option 1 - Do Nothing	Option 2 - DUAL SOURCE	Option 3 - HIGH SPEC
TOTAL RECURRENT COST	**(519)**	**(845)**	**(759)**
Benefit Score	**5**	**21**	**18**
Cost benefit score	**(104)**	**(40)**	**(42)**
RANK	**3**	**1**	**2**

Option 2 the Dual Energy Scanner is the higher cost option However when the benefit scores are applied the Dual Energy scanner has a slightly lower cost per benefit score than the high specification machine.

7. Risk Assessment and Management of Replacement Options

The table below sets out the main risks to delivery of each of the options along with a summary approach to mitigation. Option 1 is the highest risk option, with Options 2 and 3 carrying a similar level of risk.

Risk	Options			
	Option 1	**Option 2**	**Option 3**	**Mitigation**
Equipment supplier	0	1	1	Planned equipment procurement
Equipment costs	0	3	3	Obtain robust costs from suppliers
Impact on patient throughput	4	2	2	Minimised by use of contingency arrangements (City transfers) – rapid completion desirable. Improved productivity with high spec CT
Impact on performance	4	2	2	Minimised by use of contingency arrangements (portable/City transfers) – rapid completion desirable
Financial impact	2	3	3	Robust costing of options
Project management	0	1	1	Extensive experience – of project management within Capital Projects/Imaging
Market share/income/activity growth	3	1	1	Project is essential to maintain and grow direct access and other activity
Clinical quality	3	1	1	A high spec CT will improve diagnosis and clinical outcomes
Interim reconfiguration	3	1	1	Supports interim recon/surg recon – timeline and achievement of performance targets
Totals	19	15	15	

8. Proposed Timetable

A timetable for delivery of the project is set out in appendix II.

During the project all Sandwell Hospital activity will be undertaken using a mobile facility. Capacity will be monitored daily/weekly to ensure that performance targets are maintained and the CT scanners at City will provide additional capacity in the event of a shortfall. An alternative contingency arrangement is to be explored. This involves moving the existing 4 slice scanner (or an alternative) to a vacant x-ray room in the Imaging Department. This would reduce the requirement for a mobile to approximately two weeks (during the equipment transfer). However, this option requires more work to confirm feasibility and an exit strategy to decommission the scanner on completion of the project. Therefore, for the purpose of the business case, the mobile scanner option has been included as the contingency arrangement.

9. Preferred Option

There are two potential options to replace the scanner within the existing facility, the first with a High Specification scanner, the second with a Dual Source scanner

It is proposed on the basis of the option appraisal set out in this paper, that the favoured option is to

replace with a Dual Source scanner (Option 2). A review of the benefits of high specification/ dual source CT has been explored by the team undertaking site visit evaluations and it is considered to be the best option based on clinical evaluations.

10. Recommendation

The Division are seeking Trust Board approval to proceed with the procurement of a high specification dual source CT scanner, including redesign of the department where the scanner is located. Approval in principle was given at SIRG on 10th November. This will have immediate major clinical benefits for patients, whilst also providing opportunities for further development of the CT service in collaboration with other Clinical Divisions.

Clinical Benefits

- Provides high quality clinical images for all modalities including neurological imaging facilitating improved clinical management of patients
- Reduces the radiation dose given to patients
- Has the advantage of rapidly acquiring thoracic and abdominal image series in a single breath hold reducing the does of radiation
- Reduces the need for repeat/follow up CT examinations
- The high specification dual energy CT scanner will also support core clinical service, whilst also having the major advantage of supporting future service developments such as cardiac imaging (needs a separate joint Imaging/Cardiology business case)
- Has the potential to detect lesions sooner and improve clinical outcomes
- Ability to scan obese patients
- Enables you to quickly rule out the major causes of chest pain such as myocardial infarction, pulmonary embolism and aortic dissection without the compromise of beta blockers

Other Benefits

- Has the potential to reduce referrals for PET CT examinations
- Significantly raises the profile of SWBH NHS Trust, with marketing opportunities
- Supports recruitment and Retention of high calibre Consultant Radiologists and Radiographers
- Economically, reduces diagnostic time, resulting in greater throughput of patients which reduces length of stay

The Project has also provided an opportunity to provide a much improved design of the CT area, in collaboration with the Infection Control department, ensuring dedicated facilities are provided for preparing trolleys, contrast and reporting.

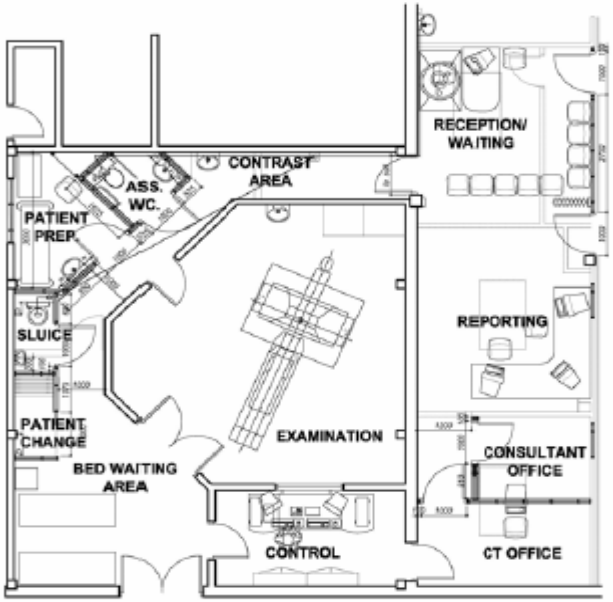
The provision of additional bed spaces supports the provision of a faster and more responsive service to A/E and wards. The clinical team will review scheduling arrangements and take other actions to support privacy and dignity of patients requiring a CT scan.

Trust Board is therefore recommended to:

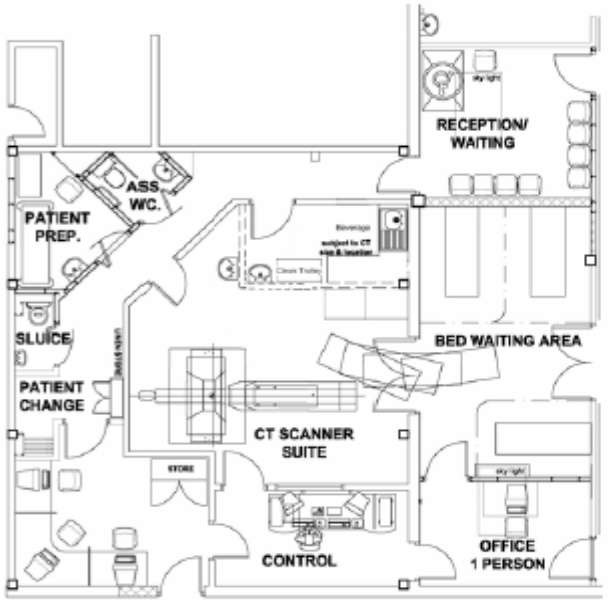
1. APPROVE the replacement of the CT Scanner at Sandwell Hospital with a Dual Source CT Scanner along with accompanying capital improvements to the Department at a total capital cost of £1,930,000, recurrent revenue cost of £326,000 and non-recurrent revenue cost of £109,000.

Appendix I – CT design options

A1



EXISTING PLAN



PROPOSED PLAN

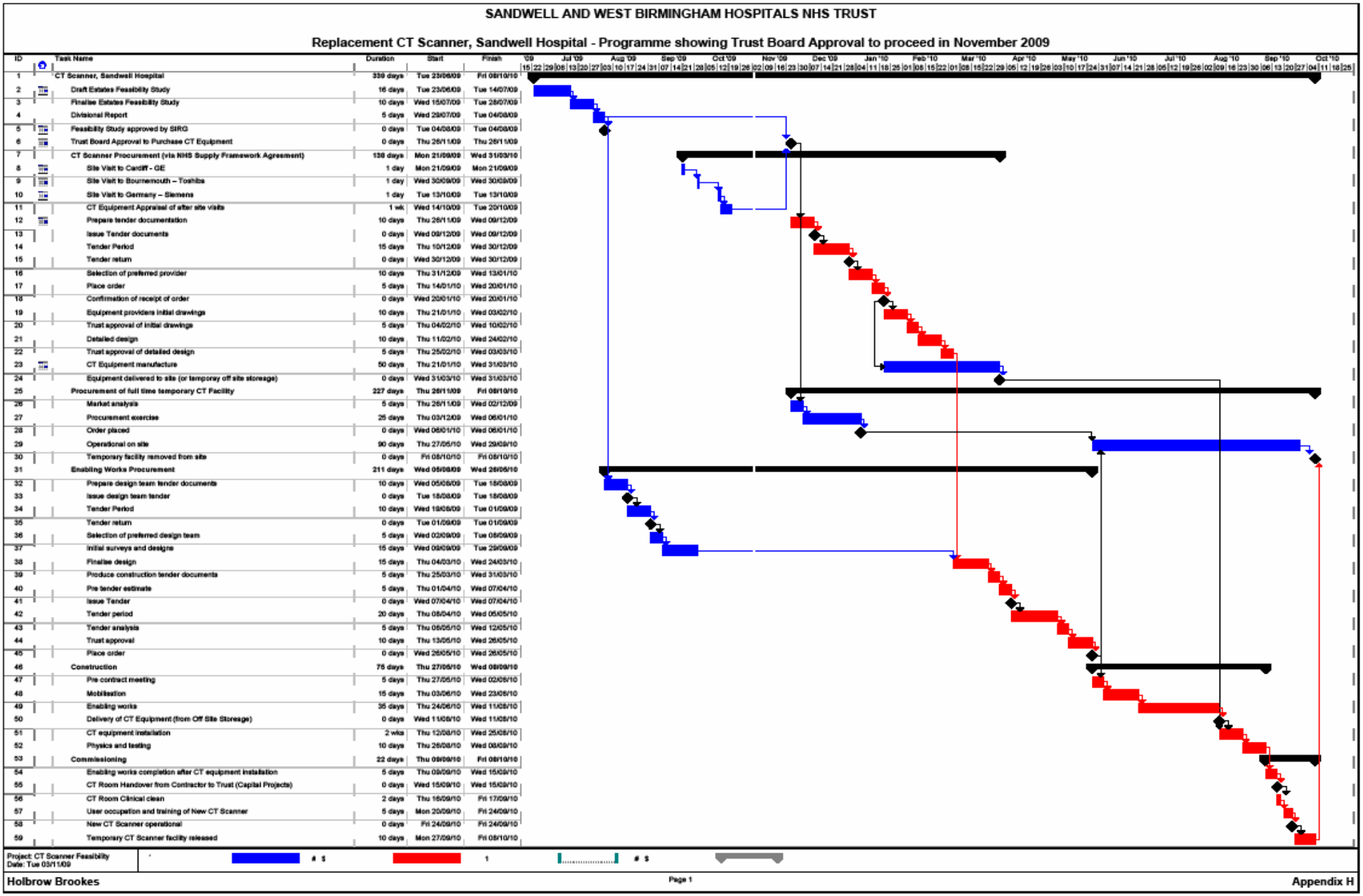
NOTE
Can X-ray reception be shared with CT
enquiries. Reception users to confirm

Project option
Replace doors to Ass WC, Patient Prep
and sluice with Bi-fold door leaf.

RPS ARCHITECTURE Birmingham
Planning & Development

Client: Sandwell and West Birmingham Hospital NHS Trust
Project: CT Scanner Replacement
Title: Existing and Proposed Plan
Status: APPROVAL
Job No: ABA5020 Dwg No: 001 Rev: F

Appendix II – Project timeline



Appendix III – Revenue expenditure

	2009/10		Option 2 - DUAL SOURCE SIEMANS		Option 3 - HIGH SPEC REVISED SIEMANS	
	WTE	£000	WTE	£000	WTE	£000
Pay						
Consultant Radiologist	12 PAs	(144)	12 PAs	(144)	12 PAs	(144)
OOH - Consultant	9 PAs	(118)	9 PAs	(118)	9 PAs	(118)
Radiographer - band 8	0.79	(49)	0.79	(49)	0.79	(49)
Radiographer - band 7	0.60	(28)	0.60	(28)	0.60	(28)
Radiographer - band 6	1.00	(39)	1.00	(39)	1.00	(39)
IDA - band 2	1.35	(24)	1.35	(24)	1.35	(24)
Support services		(58)		(58)		(58)
TOTAL PAY	5.84	(460)	5.84	(460)	5.84	(460)
Non Pay						
Direct Expenditure CT		(20)		(25)		(25)
Maintenance - CT		(38)		(110)		(75)
TOTAL NON PAY	-	(58)	-	(135)	-	(100)
Non-recurrent costs - based on 8 week hire						
Hire of temporary facility				(56)		(56)
Hire of temporary staffing				(42)		(42)
Contingency at 10%				(10)		(10)
IT - 1GB switch				(2)		(2)
TOTAL NON-RECURRENT	-	0	-	(109)	-	(109)
Depreciation						
CT equipment - new		0		(209)		(164)
Electrical & building works		0		(6)		(6)
Interest						
CT equipment – new		0		(26)		(20)
Electrical & building works		0		(8)		(8)
TOTAL CAPITAL CHARGES		0		(249)		(198)
Total expenditure	5.84	(519)	5.84	(954)	5.84	(868)
Difference in base expenditure				**(436)**		**(350)**
Due to:						
Non-recurrent costs				(109)		(109)
TOTAL NON-RECURRENT				**(109)**		**(109)**
Increase in media costs - apx 25%				(5)		(5)
Maintenance – scanner				(72)		(37)
capital charges – scanner				(235)		(184)
capital charges - buildings				(15)		(14)
TOTAL RECURRENT				**(326)**		**(240)**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Proposal for the re-modelling of the Medical Assessment Unit
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Andrew Brown, DGM Medicine A & B Divisions
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The purpose of this paper is to seek approval to proceed with the re-modelling of the Medical Assessment Unit in order to :

- Improve infection control
- Improve privacy and dignity for patients
- Improve compliance with the Delivering Same Sex Accommodation guidance
- Improve the general quality of the patient environment

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

Approval	Receipt and Noting	Discussion
x		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. APPROVE the re-modelling of the MAU at City Hospital as proposed in Option 3 including investment of £2,000,000 capital and £142,000 revenue.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	The proposal contributes to the achievement of 5 of the Trusts 6 Strategic objectives (except Care closer to home)
Annual priorities	• Contributes to the achievement of the 4 hour max. wait target • Improves infection control • Contributes to the efficiency of bed management procedures • Improves the quality of the current estate • Responds to LiA issues.
NHS LA standards	• Provision of a secure environment; Infection Control; Responding to complaints
Core Standards	• CO1a, CO4a, C13a, C20a, C20b, C21
Auditors' Local Evaluation	

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

Financial	**x**	Capital Costs approx. £2m Revenue £142,000
Business and market share		
Clinical	**x**	Improved Side Room provision Creation of monitored side rooms
Workforce		
Environmental	**x**	▪ To provide 4 additional siderooms (2 with monitoring facilities). ▪ To improve the sluice facilities on MAU. ▪ To increase the number of wash-hand basins. ▪ To refurbish the MAU kitchen. ▪ To address statutory standards compliance issues within MAU. ▪ Relocation of the assessment unit. ▪ Improved bathroom facilities. ▪ Improved privacy and dignity for patients in Bay 3. ▪ Greater flexibility in maintaining same sex accommodation. ▪ Improved storage. ▪ Improved reception and waiting area. ▪ Improved ventilation/airflow. ▪ Improved clean utility. ▪ The creation of a relatives' room. ▪ Improved staff accommodation.
Legal & Policy		

Equality and Diversity		
Patient Experience	**x**	See summary of key points above
Communications & Media		
Risks		If the scheme proceeds there is the risk of operational disruption during the building works but this can be mitigated through careful phasing of the work. If the scheme does not proceed the risks include : • Hospital Acquired infections • Complaints about the standard of accommodation • Breaches of the Hygiene Code • DSSA breaches • Poor publicity and negative impact on the Trust's reputation • Poor staff morale leading to retention and recruitment problems.

PREVIOUS CONSIDERATION:

Previous papers on the reconfiguration of MAU have been submitted to SIRG in November 2008 and April 2009.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

DIVISION OF MEDICINE AND EMERGENCY CARE 'A'

A report on the proposed re-modelling of the Medical Assessment Unit at City Hospital

Trust Board

November 2009

1. Introduction

The purpose of this report is to secure approval from the Trust Board to proceed with the re-modelling of the Medical Assessment Unit (MAU) at City Hospital.

2. The Configuration of the current MAU

The existing MAU at City Hospital is located on the ground floor behind the Accident and Emergency Department.

There is access to the MAU from the main corridor next to the Finance Office and via an inter-connecting corridor from the A&E Department.

The MAU is divided into 5 bays:-

Bay 1: is divided between an assessment area comprising 4 trolleys and 12 chairs alongside a bedded area with 5 beds.

Bay 2: 8 beds.

Bay 3: 6 beds including 2 side rooms.

Bay 4: 4 monitored beds.

Bay 5: 5 beds.

In total there are 28 beds, 4 trolleys and 12 chairs.

A detailed layout is attached as Appendix 1.

3. The function of MAU and the Patient Pathway

Acute medical emergencies form a major part of the core business of the Trust and the priority with which they are managed throughout their hospital stay, together with the effectiveness of the medical and nursing management, is of great importance not only for the quality of care for the individual patient but also impacts widely on other services provided by the Trust.

The ethos of the MAU is early and appropriate assessment. This should lead to early diagnosis or at least a differential diagnosis. An appropriate management plan should emerge which includes essential and immediate investigations together with initial treatment and a decision on whether the patient should return to the community, if necessary with support, or be admitted to an appropriate bed within the hospital. Essential investigations should occur at the earliest opportunity.

- The MAU operates 24 hours per day, 7 days per week.

- Patients arrive on the MAU usually via the A&E Department but can occasionally be referred from out-patient clinics or very occasionally from other sources eg. Transfers from other hospitals.

- Patients either arrive on foot, in wheelchairs, on trolleys or on beds.

- Most patients are first seen in the assessment area. The exceptions to this rule are:
  - ⇒ Patients needing monitoring (go to Bay 4)
  - ⇒ Infectious patients (go to siderooms)
  - ⇒ Patients who have been clerked by the medical team in the A&E Department (go to a bed in one of the bays)

- In the assessment area patients might wait on chairs prior to being assessed, whilst waiting for investigation results or whilst waiting for a decision to admit or discharge. The trolleys are used to examine patients. It is important to use the capacity provided by the chairs and trolleys flexibly to maximise the throughput of patients through the assessment area.

- Patients will remain in the assessment area until a decision is made to admit or discharge.

- If the patient is discharged arrangements will be made for the patient to leave the unit as quickly as possible, if necessary using the Discharge Lounge.

- If the patient is admitted they will be transferred to a bed on the MAU until a bed on a base ward becomes available.

- On average patients spend 12-24 hours on the MAU but this may vary from just a few hours to several days depending on circumstances.

- Bays 3 and 5 are used for same sex patients. Wherever possible the beds in Bays 1 and 2 are kept same sex but this cannot always be achieved. Bay 4 is mixed-sex. At all times maximum effect is made to maintain patients' privacy and dignity.

- The assessment area is mixed-sex.

- Whilst on the MAU patients remain under the care of the MAU medical and nursing team. Further investigations may be necessary to aid diagnosis and the development of a management plan. Where appropriate, patients may be discharged from the MAU.

4. Strategic Context

The evolutionary way in which the MAU has developed means that it is not well suited to its function described above. This has been accentuated in recent years by the increase in emergency medical admissions:

2007/08 = 15,160
2008/09 = 16,090 (+6.1%)
2009/10 YTD = 9,120 (+6.5%)

The Division has attempted to respond to the challenges that this presents by relatively modest changes to the layout and operational policy of the unit. The most recent changes took place in Autumn 2006 with the addition of Bay 5, however, the following fundamental problems remain:

(a) Infection Control

⇒ There is only one sluice for the entire unit. This issue is made worse because of the compartmentalised nature of the unit requiring nursing staff to carry bed pans with commodes etc through patient and public areas.

⇒ There are just 2 toilets and bathrooms for the Unit which is inadequate for the number of patients being cared for.

⇒ There are only 2 siderooms which require complete refurbishment. Also, it is often the case that there are infectious patients in the A&E Department that cannot be transferred to MAU because a sideroom is not available.

⇒ There is no facility for isolating infectious patients who are acutely unwell and require monitoring.

⇒ The kitchen is not large enough to accommodate the patients meals trolley. It therefore has to be sited in the corridor whilst meals are distributed.

⇒ There are an inadequate number of wash hand basins to maintain good hand hygiene.

(b) Privacy and Dignity

⇒ To access and exit the assessment area patients (and accompanying visitors) and staff have to work through a bedded area.

⇒ As referred to in (a) above there are just 2 toilets and bathrooms for the unit. Patients have to pass through public areas to use these facilities.

⇒ Bay 3 is used to access Bay 5. It can therefore feel more like a corridor than a bedded area.

⇒ Accommodation throughout the MAU is overcrowded. The ability to have personal conversations is very limited and there is nowhere to take patients and relatives to give them more privacy.

(c) Delivering Same Sex Accommodation (DSSA)

⇒ The constraints of the accommodation together with the variability of patient numbers and their clinical conditions means that it is extremely difficult to ensure that patients of the opposite sex do not share sleeping areas.

⇒ Since the beginning of October, Bays 3 and 5 have been same sex bays. However, it is not possible to keep Bays 1 and 2 as same sex bays. DSSA breaches are monitored weekly and every attempt is made to maintain same sex sleeping areas.

(d) General Accommodation

⇒ There is inadequate storage on the MAU, particularly for large items. Consequently MAU can often appear cluttered and untidy despite the best endeavours of staff.

⇒ There is no air conditioning in MAU and air-flow throughout the unit is poor due to the lack of windows and doors. Consequently temperatures on the unit, particularly during summer, often exceed what is acceptable for patients and staff.

⇒ There is a general lack of space on the MAU for clinical staff to write notes, make telephone calls or use the computer. This is particularly acute on MAU because of the number of clinical staff who are either based on or visit the MAU.

Healthcare Commission

In November 2008 the Healthcare Commission conducted an unannounced visit to the Trust. This included an inspection of MAU. The purpose of the visit was to assess the Trust's compliance with the NHS Hygiene Code. The Healthcare Commission concluded that the Trust had failed in 2 of its duties:

- To ensure that all parts of the premises in which it provides healthcare are suitable for the purpose, kept clean and maintained in good physical repair and condition.

- To ensure that there is adequate provision of hand-washing facilities.

DSSA Targeted Support Review

In August 2009 a review team from the Department of Health visited the Trust. The purpose of the review was to:

- Monitor current practice around same sex accommodation.
- Capture and highlight practice examples.
- Create additional focus within the organisation and health economy on the Trust's 'hotspot' areas.
- Support the Trust in delivering same sex accommodation.

The MAU was highlighted by the review team as a key challenge for the Trust. The review team recognised the plans the Trust had produced to refurbish the MAU but asked the Trust to review the plans to ensure that they will, as far as possible, ensure compliance with the DSSA guidance.

5. Options

Following the Hygiene Code inspection visit in November 2008 two options for the re-modelling of MAU were developed.

Option 1

- To provide 4 additional siderooms (2 with monitoring facilities).
- To improve the sluice facilities on MAU.
- To increase the number of wash-hand basins.
- To refurbish the MAU kitchen.
- To address statutory standards compliance issues within MAU.

Option 2

As per Option 1 plus:-
- Relocation of the assessment area.
- Provision of direct ambulance access.
- Expanded MAU clinic accommodation.

In the lead up to the DSSA visit and subsequent to it a further option has been developed.

Option 3

As per Option 1 plus:-
- Relocation of the assessment unit.
- Improved bathroom facilities.
- Improved privacy and dignity for patients in Bay 3.
- Greater flexibility in maintaining same sex accommodation.
- Improved storage.
- Improved reception and waiting area.

- Improved ventilation/airflow.
- Improved clean utility.
- The creation of a relatives room.
- Improved staff accommodation.

Option 4

To completely remodel MAU including partial demolition of existing accommodation and the building of an extension linked to the existing unit.

Option 5

Do nothing option.

6. Non-Financial Appraisal

Benefits	Option 1	Option 2	Option 3	Option 4	Option 5
1. To improve sideroom provision	5	5	5	5	0
2. To improve additional infection control measures	4	4	5	5	0
3. To improve privacy and dignity to patients	2	3	4	5	0
4. To comply with same sex accommodation guidance	1	1	4	5	0
5. To improve the quality of patient accommodation more generally	2	3	4	5	0
Total	**14**	**16**	**22**	**25**	**0**

7. Estimated Capital Cost and Funding

Expenditure/Funding Item	Option 1 £000s	Option 2 £000s	Option 3 £000s	Option 4 £000s	Option 5 £000s
Expenditure:					
Land					
Buildings	971	3,200	1,324	5,000	0
Furniture & Equipment			76		
IT					
Design Fees			185		
VAT			257		
Other (contingency)			158		
Total Expenditure	971	3,200	2,000	5,000	0
Funding:					
External Grants					
Other Externally Generated Funds					
Specific Capital Allocation (specify)					
Trust Capital Programme	971		2,000		
Charitable Funds					
Other (specify)					
Total Funding	971		2,000		0

Based on the feasibility study for Option 1, £1,000,000 was allocated from the 2009/10 Capital Programme. (£325,000 from Statutory Standards Funding and £675,000 from the Non-Specific Capital allocation). In light of the revisions made

to Option 1 to generate Option 3 the provisional sum allocated from the Capital Programme has been increased to £2,000,000 (£355,000 in 2009/10 and £1,645,000 in 2010/11).

The estimated costs of Option 2 and Option 4 based on a feasibility study ruled out these options as they did not offer value for money and they have not been considered any further. Based on the non-financial appraisal a judgement was made that Option 1 failed to address the problems that have been identified in section 4 of this paper. Therefore it was decided option 1 also should not be considered any further.

For the remainder of this paper only option 3 has been developed in more detail.

8. Estimated Revenue Costs

MAU CAPITAL SCHEME		2009/10	2010/11	Total
Total Buildings Additions		**355,000**	**1,569,000**	**1,924,000**
Depreciation		10,143	46,147	56,290
Rate of Return		12,425	54,915	67,340
Total Cap Charges (Building Works) per annum		**22,568**	**101,062**	**123,630**
Total Equipment Additions	(Life of 10 Years)		76,000	**76,000**
Depreciation			7,600	7,600
Rate of Return			2,660	2,660
Equipment Maintenance Costs	(10% of £76k in Yr 2)		7,600	7,600
Total Equipment Capital Charges & Maintenance Costs per annum			**17,860**	**17,860**
TOTAL CAPITAL CHARGES		22,568	111,322	**133,890**
TOTAL MAINTENANCE COSTS		0	7,600	**7,600**
TOTAL COSTS:				**141,490**
Total Cap Expenditure				**2,000,000**

With the exception of the capital charge implications and the maintenance costs there are no other revenue consequences. Maintenance costs will be accommodated within the Division's baseline budget. With regard to capital charges, each year the Trust makes an allowance for the increase in capital charges associated with new capital schemes and equipment purchases. This is off-set by the reduction in capital charges borne by the Trust as existing assets depreciate in value. Therefore, the capital charges associated with this scheme has been taken in to account in the Trust's future financial plans.

9. Risk Assessment and Management

Risk	Option 3	Option 4	Mitigation
1. Significant cases of hospital acquired infection	1	3	Good operational infection control practices
2. Complaints about the standard of accommodation	1	3	Focus on the development of the new hospital in 2016
3. Breaches of the Hygiene Code	1	4	No mitigation available
4. Poor publicity and negative impact on Trust reputation	1	3	As per (2) above
5. DSSA breaches with potential financial consequences	1	4	No mitigation available
6. Poor staff morale resulting in recruitment and retention problems	1	2	Maintain good management and HR practices
7. Operational Disruption during building works	3	0	Careful phasing of building work to minimise disruption

10.Business Continuity Plan

In order to minimise the disruption to MAU and the loss of bed capacity during the course of the scheme, it will be necessary to undertake the work in phases as outlined below:

MAU - Phasing Plan - 4/11/09

Phase	Description	Duration (weeks)	Facilities Lost
0	ENABLING WORKS IN OLD MEDICAL RECORDS AREA - TO BE COMPLETED IN 2009/10	6	NIL
1	ALL WORKS TO BAY 3 EXCEPT FIRST TWO ON-SUITE ROOMS ADJACENT TO ENTRANCE	9	NIL
2	ISOLATION ROOMS 1 & 2, RAMP AND STORES AND FIRST TWO ROOMS IN BAY 3	8	5 BEDS+STORES
3	BAY 4 + CONSULTANTS OFFICE NEW LOCKER ROOM	3	4 MONITORED BEDS ISOLATION ROOM 1
4	CENTRAL CORE AREA	9	NIL
5	NEW RECEPTION/WAITING ROOM + SISTERS OFFICE	8	EXIST. SISTERS OFFICE RECEPTION + STORE
6	NEW ASSESSMENT AREA	6	LARGE OFFICE
7	BAY 1 + NEW OFFICE + UPGRADE AIR CON.	4	5 BEDS
8	BAY 2 + WET ROOM + STAFF REFRESHMENT DISABLED WC + UPGRADE AIR CON.	3	8 BEDS

It is anticipated that it may be necessary to increase bed capacity elsewhere within the Division to compensate for the loss of beds for part of the scheme. Should this be the case then vacant ward accommodation will be utilised as required.

A capital scheme project team, involving medical and nursing staff, will oversee the implementation of the scheme and will be responsible for ensuring that an acceptable quality nof patient care is maintained throughout.

11.Preferred Option

The preferred option is Option 3 and a detailed layout of the preferred option is attached as Appendix 2.

12. Proposed Timetable

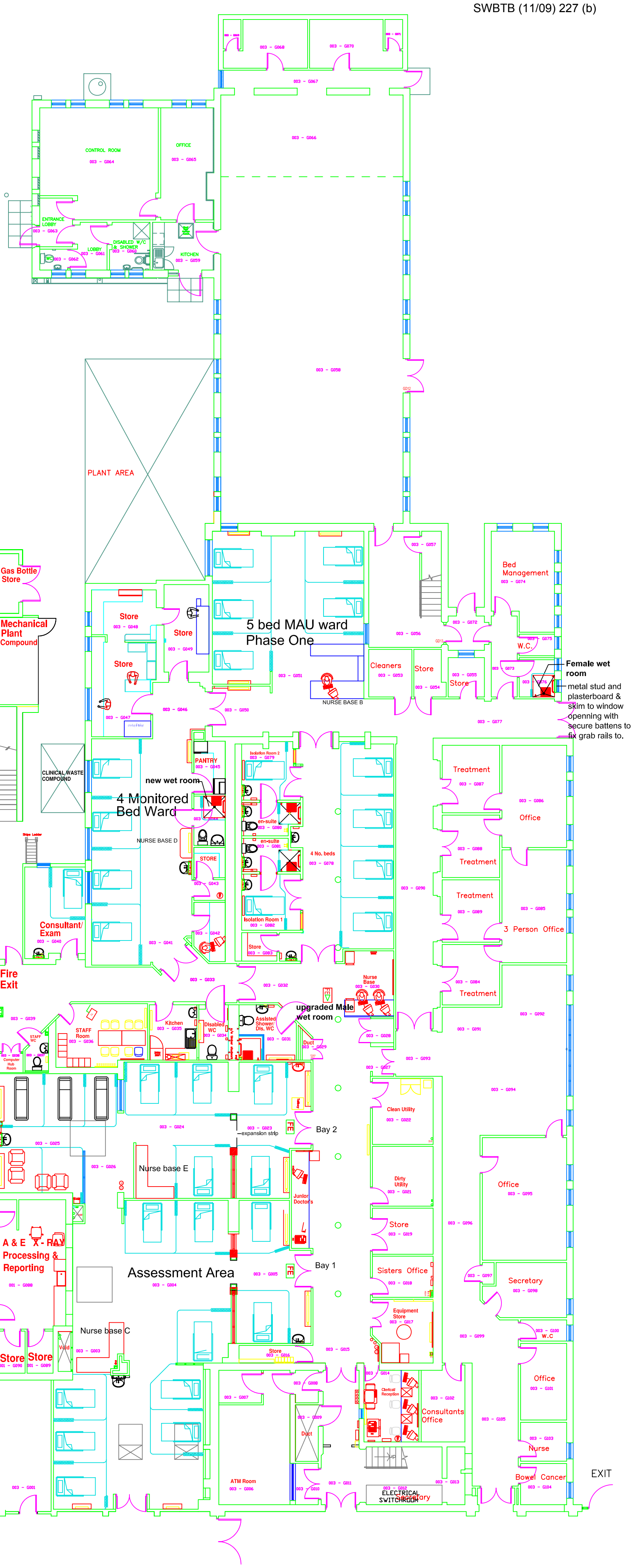
Subject to Trust Board approval it is anticipated that work will start on site during December 2009 and that the scheme will be completed by the end of March 2010.

13. Conclusion and Recommendation

The existing MAU is ill-designed for its purpose and despite attempts to improve the accommodation, it continues to present significant problems as outlined in section 4 of this report. It is inevitable that these problems will increase unless action is taken to address them.

Of the options considered only Option 3 delivers both the objectives of the scheme and justifiable value for money. The Trust Board is therefore recommended to:

1. APPROVE the re-modelling of the MAU at City Hospital as proposed in Option 3 including investment of £2,000,000 capital and £142,000 revenue.


003 - G068
003 - G070
003 - G067
003 - G066
CONTROL ROOM
003 - G064
OFFICE
003 - G065
ENTRANCE LOBBY
003 - G063
LOBBY
003 - G061
DISABLED W/C & SHOWER
003 - G060
WC
003 - G062
KITCHEN
003 - G059
003 - G058
GD12
PLANT AREA
Gas Bottle Store
Mechanical Plant Compound
5 bed MAU ward Phase One
Store
003 - G048
Store
003 - G049
Store
003 - G047
003 - G046
003 - G050
003 - G051
NURSE BASE B
003 - G057
003 - G072
003 - G056
GD13
Cleaners
003 - G053
Store
003 - G054
Store
003 - G055
Bed Management
003 - G074
W.C.
003 - G075
003 - G073
003 - G076
Female wet room
metal stud and plasterboard & skim to window openning with secure battens to fix grab rails to.
003 - G077
CLINICAL WASTE COMPOUND
PANTRY
003 - G045
new wet room
4 Monitored Bed Ward
Isolation Room 2
003 - G079
en-suite
003 - G080
en-suite
003 - G081
4 No. beds
003 - G078
NURSE BASE D
STORE
003 - G043
Isolation Room 1
003 - G082
Store
003 - G083
003 - G042
003 - G041
Consultant/ Exam
003 - G040
Fire Exit
003 - G090
003 - G088
Treatment
003 - G087
Office
003 - G086
Treatment
003 - G089
3 Person Office
003 - G085
Treatment
003 - G084
Secretary
003 - G098
003 - G100
W.C
003 - G099
Office
003 - G101
003 - G103
Nurse
Bowel Cancer
003 - G104
EXIT
Nurse Base
003 - G030
upgraded Male wet room
003 - G033
003 - G032
003 - G039
STAFF Room
003 - G036
Kitchen
003 - G035
Disabled WC
003 - G034
Assisted Shower/ Dis. WC
003 - G031
Duct
003 - G029
STAFF WC
003 - G038
003 - G037
Computer Hub Room
003 - G028
003 - G093
003 - G027
003 - G094
Clean Utility
003 - G022
003 - G024
003 - G023
expansion strip
Bay 2
003 - G025
003 - G026
Nurse base E
Dirty Utility
003 - G021
Junior Doctor's
Store
003 - G019
003 - G096
Office
003 - G095
A & E X-RAY Processing & Reporting
001 - G088
Sisters Office
003 - G018
003 - G097
Secretary
003 - G098
Assessment Area
003 - G005
003 - G004
Bay 1
Equipment Store
003 - G017
Nurse base C
Void
003 - G003
Store
001 - G090
Store
001 - G089
Store
003 - G016
003 - G015
003 - G014
003 - G008
003 - G007
003 - G009
Duct
Clerical/ Reception
003 - G102
Consultants Office
003 - G105
ATM Room
003 - G006
003 - G011
003 - G010
003 - G012
ELECTRICAL SWITCHROOM
003 - G013
Secretary
003 - G001

DO NOT SCALE:
ALL DIMENSIONS TO BE CHECKED ON SITE AND ARCHITECT NOTIFIED OF ANY DISCREPANCIES PRIOR TO COMMENCEMENT

NOTES:-

general design principles:

nurse stations are visible from ward entrances to provide clear points of reference for visitors & staff

columns within the circulation space are retained as free standing to help legibility as existsing corridor offsets through MAU

new circulation spaces link through directly with existing corridors

additional storage added within wards and secure storage added along circulation spaces wherever possible to allow circulation spaces to remain clear of obsticles

Key:

pink	propsed layout alterations
grey	circulation
green	remaining zones
yellow	additional work zones

Note A - Bay 4:
New Partitions in bay 4 to be floor to ceiling with 3 quaters solid surface wall and 1 quaters glazed. Design TBC

staff ancillary facilities:

existing staffroom facilities retained

possible staff refreshment area to replace existing kitchen - re-use exsisting drainage & services cost effectively

3 person office retained

consultants officest of circulation route adjacent existing treatment rooms with independent access

isolation rooms, bay 4 & ancillary facilities:

isolation rooms meet HBN4 Supl't 1 spaces standards

separation screen added to provide single sex bay areas, additional wet room added

secure storage along corridor allows discreet (out of site) zone for large scalew storage items beneath stair

public dis wc located to ensure travel distances between dis wc's meets standards

central zone facilities:

additional 'larger' clean utility rooms along with relocated dirty utility, and a new 'larger' kitchen servicing increased MAU

seminar room for 15 persons provides training/staffroom facilities at the heart of the MAU

bereavement room central to all wards for ease of access for families - possibly too central, may be required to reloacte to a quieter area within the MAU

reception/entrance zone

visual link between sisters' office and reception

reception desk visible on entrance to MAU, and has direct open relationship with the (12 person) waiting area where disabled waiting can be provided within the zone

dirty utility relocated and replaced by access wc/sh whilst the clean utility increases in size prior to refurbishment

screen & door added to circulation space to separate male & female bays

9 bed ward

ward divided to provide all en-suites and open bedded area at either end - layout prevents patients, staff & visitors passing en-suites ('silver' isolation rooms) to get to open bedded area

escape route prevents consultants corridor becoming a cluttered space (as it will be kept clear at all times)

security access retained via existing doorway to the rear of the nurses station

nurses staion central to ward & visible from both ends & entrance

natural light from existing window openings available to all bed spaces

ward entrance lines through with exsiting corridors to provide good visual linkage with existing MAU

Rev D - Amended to suit client comments - 140909 - BGF
Rev C - Amended to suit client comments - 080909 - PA
Rev B - Amended to suit client comments regarding single sex wards and wash spaces - 270809 - JJH
Rev A - Amended to suit client comments - 270709 - JJH

REVISIONS

PRELIMINARY

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SKETCH LAYOUTS

27 SPON STREET, COVENTRY, CV1 3BA TEL:- (024) 76527 600 FAX:- (024) 76520 424 E-mail:- info@idpartnership-midlands.com Web:- www.idpartnership.com
MIDLANDS - Coventry NORTHERN - Newcastle SCOTLAND - Glasgow IRELAND - Dublin LONDON - Tower Bridge

SCALE @ A1	1:100
DATE	July 2009
DRAWN	JJH
CHECKED	GB

CLIENT	City Hospital
JOB TITLE	New MAU, City Hospital, Birmingham
DRAWING TITLE	SKETCH LAYOUTS
DRAWING NO.	C-(H)141 / SK001D

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Single Tender Arrangement: MRI Mobile Scanner
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Tony Faulkner, Deputy Divisional General Manager for Imaging
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The Board is asked to approve a Single Tender Action for payment of c. £255,000 (excluding VAT) in respect of hiring and staffing a mobile MRI scanner service (6 days per week) for a period of 17 weeks. This is being commissioned as contingency during the transitional period when the new substantive MRI facility is being established at City Hospital. This will ensure that all national waiting time and local MRI waiting time targets (< 6 weeks), are maintained.

The Trust explored the possibility of providing mobile facilities with the two main suppliers and identified only one with the resources to meet our requirements. The single tender action is therefore requested on the grounds that there is only one company able to provide the service we require in the time available.

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 Single Tender Arrangement.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to improve current facilities through the delivery of the capital programme including replacement of the MRI scanner at City Hospital
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		
Clinical	**X**	
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		None identified

PREVIOUS CONSIDERATION:

Considered within the overall capital plan approved by the Trust Board at the beginning of the financial year

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Order for Sterile Service Provision from BBraun
SPONSORING DIRECTOR:	Graham Seager, Director of Estates/New Hospital Project
AUTHOR:	Graham Seager, Director of Estates/New Hospital Project
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

As part of the Pan Birmingham project the trust has transferred the decontamination of its reusable medical instruments off site to BBraun Sterilog.

The contract with BBraun Sterilog is now in its third year. An order needs to be raised for services in the 2009/10 financial year; an order of this value requires trust board approval.

The forecast contract value for this year is based upon the predicted volumes and values in the board approved business case, up lifted for RPI (in accordance with the contract) and further uplifted to reflect the greater volumes as a consequence of increased trust activity.

The estimated annual cost is estimated at £2,030,000.

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 raising of the order for supply of services from BBraun Sterilog

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
Annual priorities	
NHS LA standards	2.3.7 - Maintenance of medical devices and equipment
Core Standards	
Auditors' Local Evaluation	Value for Money dimension

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

Financial	**X**	Annual cost of £2,030,000
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Previously considered in 2007/08 and 2008/09 as this is the third year of the contract.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Application for the application of the Trust Seal: Midwifery Led Unit execution of contract as a deed
SPONSORING DIRECTOR:	Graham Seager, Director of Estates/New Hospital Project
AUTHOR:	Richard Kinnersley, Head of Capital Projects
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The Trust Board is requested to approve the request for the application of the Trust Seal to construction stage documents and to sign all required pages of two sets within the contract, in addition to the associated schedule for the Midwifery Led Unit at City Hospital.

The plans for the Midwifery Led Unit were presented to and agreed by the Trust Board at its meeting held on 28 May 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 recommended to approve the request for the Trust Seal to be applied to the construction documents.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Deliver significant improvements in the Trust's maternity services
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**	Capital cost of £800,000
Business and market share		
Clinical	**X**	
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		No risks have been identified with this proposal

PREVIOUS CONSIDERATION:

The plans for the Midwifery Led Unit were presented to and agreed by the Trust Board at its meeting held on 28 May 2009.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Application for the application of the Trust Seal: refurbishment of Ward D16 execution of contract as a deed
SPONSORING DIRECTOR:	Graham Seager, Director of Estates/New Hospital Project
AUTHOR:	Richard Kinnersley, Head of Capital Projects
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The Trust Board is requested to approve the request for the application of the Trust Seal to construction stage documents and to sign all required pages of two sets within the contract, in addition to the associated schedule for the refurbishment of Ward D16 at City Hospital.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to approve the request for the Trust Seal to be applied to the construction documents.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to improve current facilities through the delivery of the capital programme including upgrade of accommodation at City Hospital (including D16)
Annual priorities	
NHS LA standards	None specifically
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
Auditors' Local Evaluation	

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

Financial	**X**	Capital cost of £497,000
Business and market share		
Clinical	**X**	
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		No risks have been identified with this proposal

PREVIOUS CONSIDERATION:

Not previously considered

Sandwell and West Birmingham Hospitals NHS
NHS Trust

GOVERNANCE AND RISK MANAGEMENT COMMITTEE

DOCUMENT TITLE:	2009/10 Core Standards
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	19 November 2009

SUMMARY OF KEY POINTS:

2009/10 is a transitional year between regulatory systems and approaches. In 2010 all English NHS trusts, NHS foundation trusts and primary care trust (PCT) providers will be required to register against new regulations. These are essential standards of quality and safety that will replace the core standards set out in *Standards for Better Health*

Boards of NHS trusts will need to make a public declaration on the extent to which they are assured that their organisation is compliant with the core standards for the first seven months of the declaration year of 1st April 2009 to 31st October 2009.

The purpose of this report is to set out the Care Quality Commission's requirements for the declaration process this year, and provide a position statement on the Trust's compliance against the core standards.

In summary, two out of 24 core standards (C 11b and C20b) will be declared as 'not met' in the 2009/10 declaration to the Care Quality Commission.

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 proposed core standards declaration to the Care Quality Commission

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	An Effective NHS FT
Annual priorities	6.2 - Continue to achieve Annual Health Check Core Standards
NHS LA standards	
Core Standards	All
Auditors' Local Evaluation	Linkage to the 2009/10 ALE assessment as this also forms part of the overall HCC standards for better heath assessment

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

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

PREVIOUS CONSIDERATION:

The proposed Core Standards declaration was discussed at the Governance and Risk Management Committee on 19 November 2009

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Annual Health Check – Core Standards Assessment 2009/10

1. Introduction

1.1 2009/10 is a transitional year between regulatory systems and approaches. In 2010 all English NHS trusts, NHS foundation trusts and primary care trust (PCT) providers will be required to register against new regulations. These are essential standards of quality and safety that will replace the core standards set out in *Standards for Better Health*.

1.2 As reported to the Board last month, the introduction of the Health and Social Care Act 2008 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 will, by law, require all regulated health and adult social care providers to register with the Care Quality Commission (CQC). To do so they must show that they are meeting essential standards of quality and safety. The CQC will issue final guidance at the beginning of December with trusts invited to register under the new Act and make a declaration of their compliance with the regulations between the 4th and 29th of January 2010. In addition, a consultation has also been launched on proposed NHS registration fees.

1.3 Information received as part of this year's core standards declarations will be used by the CQC as part of their cross-checking to inform the decision on trusts' registration status in April 2010, where relevant.

1.4 The purpose of this report is to set out the CQC's requirements for the declaration process this year, and provide a position statement on the Trust's compliance against the core standards.

2. A summary of key changes to the declaration process

2.1 The key changes to the declaration process are as follows:

a) 2009/10 will be the last time that English NHS trusts, NHS foundation trusts and NHS primary care trust providers are assessed against the applicable parts of the 24 *Standards for Better Health*.

b) To avoid confusion with providers' applications for registration, the core standards assessment will be primarily based on a mid-year declaration and will not be directly linked to a programme of inspections.

c) Boards of NHS trusts will need to make a public declaration on the extent to which they are assured that their organisation is compliant with the core standards for the first seven months of the declaration year of 1st April 2009 to 31st October 2009.

d) The assessment year is still the full 12-month period, so there is a gap between the end of the declaration period (31st October 2009) and the end of the assessment year (31st March 2010). For that reason the CQC is asking trusts to inform them of any significant lapse in, or insufficient assurance of, compliance against a core standard after 31st October 2009. The process to allow such notification will be publicised later this year.

e) Commentaries from 'third parties' (representatives of people who use services and the public) will not be required as part of the core standards declaration. The CQC will include the views of people as part of their assessment of applications for registration.

f) Declarations will not include standards related to healthcare-acquired infections. From 1st April 2009, all NHS organisations to which the Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Healthcare Associated Infections applies were registered with the CQC. The following standards are, therefore, covered by CQC registration:

- C4a (Infection control)
- C4c (Decontamination)
- C21 (Clean, well designed environments) - element 2 only

g) The changes to this year's core standards assessment will be reflected in the methodology for the scoring rules. The CQC will publicise that methodology later, but it is expected to follow a similar format to earlier years.

h) In August, the CQC published the criteria for assessing the core standards for 2009/10. Only minor amendments were made to the standards for this year.

3. Core standards declaration requirements

3.1 The declaration is intended to confirm that the Board has received reasonable assurance that the Trust has complied with the core standards without any significant lapses. In considering significant lapses it is expected that the Board will consider the extent of risk presented to patients, staff and the public and the duration and impact of any lapse. The assessment is not intended as a medium for reporting isolated, trivial or purely technical lapses.

3.2 Where there are exceptions, there is a requirement to report these as (a) standards that are not met or (b) standards that lack assurance. For both a plan is required that sets out the action to be taken to rectify a reported lapse.

3.3 The declaration must be approved by the Board to acknowledge their accountability for the standards of care provided.

3.4 The core standards declaration must be submitted on-line by the deadline date. Declarations must be made available to the local community e.g. at a public Board meeting. It is also expected that declarations will be publicly available on trusts' websites by the same date.

3.5 The CQC will use information held by them to cross-check declarations. There will not be a programme of inspections to check that declarations are supported by evidence. The CQC will, however, use evidence from their assessment of applications for registration to cross-check declarations. Where registration evidence is relevant, and supports such an action, incorrect declarations will be qualified.

3.6 A summary of the key dates for the declaration process is shown below.

29th November 2009	Submission by trusts of completed declarations from this date
7th December 2009	Deadline for submitting declarations
29th January 2010	Deadline for publishing declarations to the local community
30th April 2010	Deadline for notifying the CQC of any changes to compliance during the assessment year
October 2010	The CQC to publish the results of the assessment of core standards

It is intended to present the draft declaration to the Trust Board on 27th November 2009 for approval.

4. The local self-assessment process

4.1 Executive Directors have overseen a self-assessment on the extent to which the Trust has met the core standards for the period 1st April 2009 to 31st October 2009.

4.2 Given the 2008/09 declaration made earlier this year, this work has focussed on whether compliance has been maintained and/or improved. The position statement presented to the Board in March 2009, and the supporting evidence held electronically, has been revisited to confirm the position for the first 7 months of this year.

5. Proposed SWBH declaration

5.1 The proposed compliance status for the core standards for the period 1st April 2009 to 31st October 2009 is summarised in Appendix 1.

5.2 Issues in achieving the requirements for same sex accommodation required in light of new tougher standards from the Department of Health resulted in the Trust declaring standard C20b as 'not met' in 2008/09. The date stated in the declaration for implementing the plan to address the issues identified was the end of December 2009.

The Trust's approach to delivering same-sex accommodation in the light of the above was approved by the Trust Board earlier in the year and regular progress reports provided. A further update is due to be reported to the Board in December.

Informed by the work to prepare for the forthcoming assessment against risk management standards by the NHS Litigation Authority, difficulties in meeting the requirements for mandatory training have come to light. Plans are in place to address areas for improvement identified, which primarily relate to data capture and staff attendance. As a consequence, it has become necessary to declare core standard C11b as 'Not Met', given that there is insufficient assurance of compliance.

5.3 In summary, two out of 24 core standards (C 11b and C20b) will be declared as 'not met' in the 2009/10 declaration to the Care Quality Commission.

6. General Statement of Compliance

It is proposed that the following statement is included in the relevant section of the declaration form:

> "Other than the exception noted on the domain form, the Trust Board has reasonable assurance that there have been no significant lapses in meeting the core standards during the period 1st April 2009 to 31st October 2009. The Trust Board is confident that sufficient action is being taken to correct the recorded exception".

7. Recommendation

The Trust Board is asked to APPROVE the proposed core standards declaration to the Care Quality Commission.

Kam Dhami
Director of Governance November 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

STANDARDS FOR BETTER HEALTH

Core Standards – Self-Assessment

	Standard	Lead	Compliance as at 31 October 2009	Comments
C1	Health care organisations protect patients through systems that:			
a)	identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents; and	Director of Governance	COMPLIANT	
b)	ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.	Director of Governance	COMPLIANT	
C2	Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.	Chief Nurse	COMPLIANT	
C3	Health care organisations protect patients by following NICE Interventional Procedures guidance.	Director of Governance	COMPLIANT	
C4	Health care organisations keep patients, staff and visitors safe by having systems to ensure that:			
a)	the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA;	Chief Nurse	Now assessed as part of the Hygiene Code	
b)	all risks associated with the acquisition and use of medical devices are minimised;	Director of Governance	COMPLIANT	
c)	all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed;	Director of Estates/New Hospital Project	Now assessed as part of the Hygiene Code	
d)	medicines are handled safely and securely; and	Chief Operating Officer	COMPLIANT	
e)	the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and safety of the environment.	Chief Nurse	COMPLIANT	
C5	Health care organisations ensure that:			
a)	they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care;	Director of Governance	COMPLIANT	
b)	clinical care and treatment are carried out under supervision and leadership;	Chief Nurse & Medical Director	COMPLIANT	
c)	clinicians continuously update skills and techniques	Chief Nurse &	COMPLIANT	

	Standard	Lead	Compliance as at 31 October 2009	Comments
	relevant to their clinical work; and	Medical Director		
d)	clinicians participate in regular clinical audit and reviews of clinical services.	Director of Governance	COMPLIANT	
C6	Health care organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.	Chief Operating Officer	COMPLIANT	
C7	Health care organisations:			
a)	apply the principles of sound clinical and corporate governance;	Director of Governance	COMPLIANT	
b)	actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources;	Director of Workforce	COMPLIANT	
c)	undertake systematic risk assessment and risk management;	Director of Governance	COMPLIANT	
d)	ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources;	Director of Finance and Performance Mgt	Measured through ALE process	
e)	challenge discrimination, promote equality and respect human rights; and	Chief Nurse & Medical Director	COMPLIANT	
f)	meet the existing performance requirements	Director of Finance and Performance Mgt	Measured through existing national targets assessment	
C8	Health care organisations support their staff through:			
a)	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; and	Director of Workforce	COMPLIANT	
b)	organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.	Director of Workforce	COMPLIANT	
C9	Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.	Chief Operating Officer	COMPLIANT	
C10	Health care organisations:			
a)	undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and	Director of Workforce	COMPLIANT	
b)	require that all employed professionals abide by relevant published codes of professional practice.	Director of Workforce	COMPLIANT	

	Standard	Lead	Compliance as at 31 October 2009	Comments
C11	Health care organisations ensure that staff concerned with all aspects of the provision of health care:			
a)	are appropriately recruited, trained and qualified for the work they undertake;	Director of Workforce	COMPLIANT	
b)	participate in mandatory training programmes; and	Director of Workforce	NOT MET	Plans have been developed to ensure compliance by 31 March 2010
c)	participate in further professional and occupational development commensurate with their work throughout their working lives.	Director of Workforce	COMPLIANT	
C12	Health care organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.	Medical Director	COMPLIANT	
C13	Health care organisations have systems in place to ensure that:			
a)	staff treat patients, their relatives and carers with dignity and respect;	Chief Nurse	COMPLIANT	
b)	appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information; and	Medical Director	COMPLIANT	
c)	staff treat patient information confidentially, except where authorised by legislation to the contrary.	Chief Operating Officer	COMPLIANT	
C14	Health care organisations have systems in place to ensure that patients, their relatives and carers:			
a)	have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services;	Director of Governance	COMPLIANT	
b)	are not discriminated against when complaints are made; and	Director of Governance	COMPLIANT	
c)	are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.	Director of Governance	COMPLIANT	
C15	Where food is provided, health care organisations have systems in place to ensure that:			
a)	patients are provided with a choice and that it is prepared safely and provides a balanced diet; and	Chief Nurse	COMPLIANT	
b)	patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.	Chief Nurse	COMPLIANT	
C16	Health care organisations make information available to patients and the public on their services, provide	Head of Communications	COMPLIANT	

	Standard	Lead	Compliance as at 31 October 2009	Comments
	patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.			
C17	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.	Head of Communications	COMPLIANT	
C18	Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.	Chief Nurse	COMPLIANT	
C19	Health care organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.	Chief Operating Officer	Measured through existing national targets assessment	
C20	Health care services are provided in environments which promote effective care and optimise health outcomes by being:			
a)	a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and	Director of Estates/New Hospital Project	COMPLIANT	
b)	supportive of patient privacy and confidentiality.	Director of Estates/New Hospital Project	NOT MET	Compliance anticipated by 31 December 2009
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.	Chief Nurse & Director of Estates/New Hospital Project	COMPLIANT	Assessment against element two concerning cleanliness levels is now assessed as part of the Hygiene Code
C22	Health care organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:			
a)	co-operating with each other and with local authorities and other organisations:	Chief Operating Officer	COMPLIANT	
b)	ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and	Chief Operating Officer	COMPLIANT	
c)	making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.	Chief Operating Officer	COMPLIANT	
C23	Health care organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.	Medical Director	COMPLIANT	
C24	Health care organisations protect the public by having a planned, prepared and, where possible,	Chief Operating	COMPLIANT	

	Standard	Lead	Compliance as at 31 October 2009	Comments
	practised response to incidents and emergency situations which could affect the provision of normal services.	Officer		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Policy on the Handling of Complaints
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Debbie Dunn, Head of Complaints and Litigation
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The Board was advised of the key changes to the Complaints Regulations at its meeting in April 2009 (see attached). These changes have now been built into the revised policy on the handling of complaints which is presented for approval. The policy is one of the policies requiring Trust Board approval according to the 'Policy for the Development, Approval and Management of Policies'.

Key changes include in overview:

- A complaint can be made to the PCT that purchased the service
- Complainants can now take legal action and pursue a complaint at the same time (Section 8)
- The Trust has a duty to co-operate with other health or social care providers to investigate a complaint and respond. One organisation will take the lead and deal with the complainant on behalf of all the agencies involved in the complaint (Section 10)
- The time limit for making a complaint has been extended from 6 months to 12 months (Section 13)
- Complaints must be acknowledged within 3 working days and this must include an offer to discuss the way in which the complaint will be handled and the timescale for responding. There is no fixed timescale for responding - this will be determined by the plan agreed with the complainant. This replaces the previous statutory timescale to reply within 25 days (Section 5.6c)
- In most cases the response will be in the form of a report and covering letter from the Chief Executive rather than a letter. The report must include details of any remedial action that is needed (Section 5.7h)
- The second stage of the complaints procedure where the complainant could refer their concerns to the Healthcare Commission to request an independent review has been removed and the complainant can now go straight to the Health Service Ombudsman if they remained dissatisfied after local resolution (Section 17)

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is recommended to APPROVE the draft policy.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality of care
Annual priorities	
NHS LA standards	Standard 5 Learning from Experience
Core Standards	Core Standard C14 a - c
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Previously reviewed at the Governance and Risk Management Committee on 19 November 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

DRAFT

POLICY ON THE HANDLING OF COMPLAINTS

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	To ensure that the Trust complies with the requirements of the NHS Complaints Procedure
Principal target audience	All staff groups
Application	Both adult and child patients
Accountable Executive Director	Director of Governance
Author(s)	Head of Complaints and Litigation
Impact Assessment	
Resource implications	None specifically
Training implications	This will be organised by the Learning and Development Department in conjunction with the Complaints and Litigation Department
Communications implications	All staff will be made aware of the revised policy via staff communications
Date of initial equality impact assessment	October 2009
Date of full equality impact assessment (if appropriate)	Not required
NHSLA risk management standards/ CQC core standards	NHSLA risk management standards Level 2 -Standard 2.5 CQC core standards 14a, 14b and 14c
Consultation and referencing	
Key stakeholders consulted/involved in the development of the policy	Trust wide - policy issued to all mailboxes for comment
Complementary Trust documents for cross reference	Incident Reporting Policy; Grievance Policy; Policy for supporting staff involved in an incident, complaint or claim; Being open policy; Policy for the Investigation, Analysis and Learning of Lessons from Adverse Events
Approvals and monitoring	
Approving body	Trust Board
Date of implementation	December 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	12-2007	12-2007	12-2010	Revision to the NHS Complaints Procedure
4	??	12-2009	12-2012	Revision to the NHS Complaints Procedure

Policy on the Handling of Complaints

CONTENTS

1.0 Introduction

1.1 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 require NHS and Local Authority bodies to make arrangements for the handling and consideration of complaints. The arrangements must ensure that:-

- Complaints are dealt with efficiently and are properly investigated
- Complainants are treated with courtesy and respect
- Complainants receive, as far as is reasonably possible, assistance to enable them to understand the complaints procedure or advice on where they may obtain assistance
- Complainants receive a timely and appropriate response
- Complainants are told the outcome of the investigation and action is taken if necessary

1.2 The policy sets out the Trust's approach to responding to complaints. Individual roles and responsibilities are set out, together with the timescales to be followed when implementing the policy. Some aspects are mandatory requirements and are indicated by the use of the word 'must.'

2.0 Objectives

2.1 To ensure that the Trust complies with the requirements of the NHS Complaints Procedure and that no difficulties are placed in the way of patients, carers or relatives wishing to complain about the services provided by the Trust

2.2 To provide an easily understood, accessible system for complainants

2.3 To ensure that information on the complaints procedure and complaints letters is made available to complainants in a way that meets their individual needs e.g. a translator attending complaints meetings, sending written information on CD/tape for dyslexic patients etc

2.4 To ensure minor complaints are handled by front line staff, responding sensitively, courteously and promptly to the complainant's needs

2.5 To ensure all complaints are treated seriously and sympathetically and actioned within agreed timescales

2.6 To reassure patients that their treatment will not be affected and that they will not be discriminated against in any way as a result of having made a complaint

2.7 To ensure all complaints are fairly investigated in an open, non-defensive way and an honest response sent to the complainant. If the Trust has been at fault it will say so and offer an apology

2.8 To give the complainant a full and clear explanation of the outcome of the investigation, with clinical terms and jargon explained as necessary, including

actions taken as a result of the complaint

2.9 To meet negotiated targets for responding to complaints. Where the Trust is unable to respond within the agreed timescale, it will inform the complainant of the reasons and renegotiate the timescale

2.10 To ensure trends and outcomes are monitored as part of the governance process, to ensure that lessons are learned from the complaints received, so improving service quality

2.11 To ensure that complaints are linked to other governance components of incident reporting and claims investigation

2.12 To ensure that where the Trust makes arrangements for the provision of services with an independent provider, that provider has procedures in place for the handling and consideration of complaints

2.13 To ensure that the Trust works with other agencies when investigating and responding to complaints

3.0 Scope

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

4.0 Definitions

4.1 Complaint

An expression of dissatisfaction requiring a response. A complaint can be made orally, in writing or electronically

4.2 Complaints Policy

The organisational statement of intent for the handling of complaints

4.3 Informal Complaint

A minor, oral complaint that can be resolved on the spot or not later than the next working day

4.4 Local Resolution

First stage of the complaints process, with emphasis on complaints being dealt with quickly and where possible, by those on the spot

4.5 Healthcare Service Ombudsman

A complainant who remains dissatisfied after the investigation may refer their complaint to the Ombudsman

4.6 Complaints Manager

The Head of Complaints and Litigation is the designated Complaints Manager and will deal with all formal complaints on behalf of the Chief Executive and provide help/support to staff in responding to complaints

4.7 PALS

The Patient Advice and Liaison Service provides assistance to patients and their relatives/carers in dealing with their concerns, which may become formal complaints.

4.8 ICAS

The Independent Complaints Advocacy Service provides help and support to people who want to complain

4.9 Independent Provider

Person or body (including a voluntary organisation but excluding a Foundation Trust) providing services to the Trust

5.0 Roles and Responsibilities

5.1 Trust Board

a) To receive assurance regarding implementation of the complaints policy
b) To receive and consider quarterly and annual reports on the handling of complaints

5.2 Chief Executive

a) To be accountable overall for the complaints process
b) To sign all responses to written complaints

5.3 Director of Governance

a) To ensure compliance with the arrangements made for handling complaints
b) To ensure that action is taken in the light of the outcome of any investigation

5.4 Complaints Manager (Head of Complaints and Litigation)

a) To deal with formal complaints on behalf of the Chief Executive
b) To develop a complaints procedure, setting out detailed steps to be taken to implement the complaints policy
c) To provide advice and support to staff on the handling of complaints
d) To liaise with PALS in the handling of concerns, in accordance with Trust

policies

e) To consider escalating complaints to the Chief Executive if there have been unnecessary and unreasonable delays in a member of staff providing information as part of a complaint investigation.
f) To review the draft responses received from investigating officers, ensuring quality and consistency, prior to sending the response to the Chief Executive for signature.
g) To provide information to the Health Service Ombudsman's office for complaints referred to them
h) To advise the Divisions on issues/actions arising from complaints
i) To monitor compliance with the Complaints Policy
j) To ensure that the outcome of individual complaints is fed back to the relevant staff
k) To monitor the completion of action plans following complaint investigations
l) To ensure that the learning needs of staff across the Trust in relation to complaints handling are identified and that appropriate training is provided
m) To accompany Executive Directors at meetings with complainants, as required
n) To consider the use of conciliation to resolve a complaint. This would involve an independent specially trained third party listening to all parties in the complaint to assist them in reaching a resolution
o) To maintain a complaints database
p) To monitor the demographic background of complainants, the feedback from complainants who have completed the complaints questionnaire and the number of complaints where the complainant remains dissatisfied after the first response and an additional investigation is required
q) To prepare quarterly and annual reports to monitor numbers, trends, response times, outcomes etc… for submission to the Trust Board and Governance Committees
r) To ensure that complaints are integrated with reports on incidents, PALS and claims
s) To ensure that staff, either within the Complaints Department or elsewhere in the Trust, are not treating patients, relatives and their carers differently as a result of a complaint.
t) In the event that any unfavourable treatment is discovered to ensure that this is escalated and managed appropriately in conjunction with the relevant Line Manager.

5.5 Senior Clinical Adviser

a) To provide support, advice and practical input to the complaints process on the resolution of complex clinical complaints

5.6 Complaints Department

a) To assist patients, relatives and their friends in expressing their views about the healthcare they have received.
b) To liaise with PALS in advising patients or their relatives how to pursue their concerns. This may involve referring a potential complainant to PALS for advice and assistance, or taking a query from PALS if it becomes clear that the patient wishes to make a formal complaint.

c) To ensure that all complaints are acknowledged within three working days, either orally or in writing, and forwarded to the investigating officer. The acknowledgement must include an offer to discuss with the complainant, at a time to be agreed with them, the way in which the complaint will be handled; the period within which the investigation is likely to be completed; and when the response is likely to be sent to the complainant.

d) To advise the complainant how complaints involving another NHS body, Local Authority, primary care provider or independent provider will be handled.

e) To send a 'Permission to Act on My Behalf' form for signature by the patient or next of kin if the complaint is made by a third party.

f) To grade complaints according to their severity and potential future risks to patients and/or organisation, using the complaint severity matrix (Complaint Severity Matrix, Appendix 1)

g) To track the progress of complaints and ensure that deadlines are met.

h) To keep complainants informed of the status of their complaint, by sending letters if the response is delayed, informing them of the reason for the delay and the likely revised timescale.

i) To send a copy of the completed response to the relevant Divisional General Manager/Executive Director and Clinical Director, for them to copy to those significantly involved in the complaint. The Complaints Department will confirm who should receive a copy of the response.

j) To maintain a database of formal complaints and record the number of informal complaints and thank you letters/cards received by the Divisions/Directorates.

k) To maintain a centralised complaint file for each complaint. Records will be kept for a minimum of 10 years after the complaint has been closed.

l) To provide advice and support to the Divisions/Directorates on how to handle complaints.

m) To ensure that information and advice about how to make a complaint is readily accessible to patients and their relatives. Ensure that leaflets and posters are distributed throughout the Trust and that information is available on the intranet

n) To ensure that patients, relatives and their carers are not treated differently and that they will not be discriminated against in any way as a result of having made a complaint

o) In the event that any unfavourable treatment is discovered, to ensure that this is escalated and managed appropriately in conjunction with the relevant Line Manager.

5.7 Investigating Officer

a) To receive a complaint when it has been acknowledged and start the investigatory process. If the complaint crosses several Divisions and Directorates, the investigating officer with the most involvement will take the lead in co-ordinating the investigation and response, as determined by the Complaints Manager.

b) To discuss with the complainant, at a time agreed with them, the way in which the complaint will be handled; the period within which the investigation is likely to be completed; and when the response is likely to be sent to them. If the

complainant does not accept the offer of a discussion to determine the response period and notify the complainant in writing.

c) To obtain the relevant medical records and liaise with staff concerning the complaint, keeping a written record of findings including statements and meetings

d) To ensure that for the more severe complaints (i.e. amber or red), a root cause analysis is undertaken (Root Cause Analysis, Appendix 2) following the investigative process set out in the Incident Reporting Policy

e) To ascertain whether a clinical and/or non-clinical investigation has been or is being undertaken and liaise with the investigating officer(s) to avoid duplication. Action identified as part of the clinical incident investigation will be included in the response, to reassure the complainant that steps have been taken to stop the same thing from happening again.

f) To investigate the complaint in a manner appropriate to resolve it speedily and efficiently, and keep the complainant informed during the investigation as far as is reasonably practicable about the progress of the investigation.

g) To highlight unnecessary and unreasonable delays in a member of staff providing information as part of a complaint investigation and escalate to the Chief Executive

h) To review the findings of the investigation and draft a response for signature by the Chief Executive which includes:-

- A report giving an explanation of how the complaint has been considered and the conclusions reached in relation to the complaint, including any remedial action that is needed
- Confirmation that the Trust is satisfied that any action needed in consequence of the complaint has been taken or is proposed
- Details of the complainant's right to take their complaint to the Ombudsman

If a response is not sent within 6 months of when the complaint was received a letter must be sent to the complainant explaining why and a response must be sent as soon as possible.

i) To ensure that the views of the relevant clinician(s) are ascertained where matters of clinical judgement are included in the draft complaint response. Any divergence of view between the investigating officer and the clinician(s) is to be highlighted when the draft response is submitted.

j) To ensure, as far as is possible, that the response is agreed by the Divisional General Manager or the Director for non-clinical Directorates. For complaints covering more than one Division/Directorate, the response should be agreed by all the Divisional General Managers/Directors involved in the complaint.

k) To make every effort to determine whether there have been any significant changes in the patient's condition relevant to the concerns raised before the response is sent to the complainant.

l) To identify at the earliest opportunity if a delay is likely, so that the complainant can be informed and a revised date agreed.

m) To undertake a further investigation if the complainant remains dissatisfied after the first response letter and arrange a meeting with the complainant and the relevant staff if appropriate.

n) To attend meetings with complainants and take notes, which will form the basis of the second response from the Chief Executive (Guidelines for Meeting with Complainants, Appendix 3)

o) To consider whether the severity of the complaint should be regraded following

the investigation.

p) To ensure that staff, either within the Complaints Department or elsewhere in the Trust, are not treating patients, relatives and their carers differently as a result of a complaint.

q) In the event that any unfavourable treatment is discovered to ensure that this is escalated and managed appropriately in conjunction with the relevant Line Manager.

5.8 Staff

a) To be aware of the requirements of the complaints policy and the role that all members of staff have in dealing with complaints.

b) To deal with informal complaints on the spot or not later than the next working day, by giving the complainant reassurance and responding sympathetically. A speedy response could prevent a minor problem from becoming a major complaint

c) To keep a written record at Ward/Departmental level of the informal complaint and the action taken.

d) To involve their Line Manager/Ward Manager/Head of Department in trying to resolve the complaint if it escalates and they feel unable to deal with the situation. Contact should be made with the Senior Manager On Call if a patient/carer/relative wishes to make a complaint outside normal office hours. The Senior Manager On Call will then determine whether to undertake direct handling of the complaint or provide support/guidance.

e) To advise the complainant of their right to make a formal complaint if they remain dissatisfied and that they should contact either the Chief Executive or the Complaints Manager by telephone or in writing.

f) To forward all written complaints directly to the Complaints Department by fax, so that they can start the complaint investigation.

g) To respond with the set deadline when asked to provide comments or a statement as part of a complaint investigation. The comments/statement should concentrate on fact rather than opinion and should be open and honest in addressing the issues raised by the complainant (Guidelines on Writing Statements, Appendix 4)

h) To attend training as determined by their Line Manager to increase their awareness of the importance of responding well to complaints and to develop the necessary communication skills to respond to a complainant's needs

i) To ensure that patients' treatment will not be affected and that they will not be discriminated against in any way as a result of having made a complaint

5.9 Divisional General Manager/Executive Director/Clinical Directors

a) To monitor arrangements for local complaints handling e.g. compliance with performance targets, the recording of informal complaints and thank you letters. To consider trends in complaints and the links between reported incidents, staffing levels etc…

b) To ensure that staff are trained to deal with complaints and are aware of the importance of responding within set deadlines

c) To circulate complaint responses to the relevant staff within their

Division/Directorate

d) To consider lessons to be learned from complaints and develop action plans
e) To report the action plans to the Divisional/Directorate Governance Group
f) To monitor the action plans and ensure that action arising from a complaint is implemented. Report progress to the Divisional/Directorate Governance Group
g) To include the action arising from complaints in the Divisional/Directorate reports to the Governance Board.
h) To ensure that staff, either within the Complaints Department or elsewhere in the Trust, are not treating patients, relatives and their carers differently as a result of a complaint.
i) In the event that any unfavourable treatment is discovered to ensure that this is escalated and managed appropriately in conjunction with the relevant Line Manager.

6.0 Out of Hours Arrangements

6.1 Staff in the Complaints Department are available from 8.30am to 5.00pm, Monday to Friday to respond to enquiries from complainants. Outside of these hours, or if staff are temporarily unavailable during the working day, an answer phone service is available and a member of staff from the Complaints Department will respond to the call within 1 working day.

7.0 Liaison With PALS

7.1 The Complaints Manager will liaise with PALS staff to ensure that comments, queries, concerns and complaints from patients and their relatives are handled in the most appropriate manner and in accordance with Trust policies.

7.2 Statistical information on the categories of concern raised via PALS and via the complaints process will be shared to highlight trends and areas for further investigation.

8.0 Exclusions

The following complaints are excluded from the complaints process:

8.1 A complaint made by a local authority, an NHS body (i.e. Strategic Health Authority, PCT, hospital Trust, Foundation Trust), primary care provider (i.e. GP, dentist, optician, pharmacist) or independent provider (i.e. a person providing healthcare but who is not an NHS body or a primary care provider)

8.2 A complaint made by an employee about their employment

8.3 An oral complaint which is resolved to the complainant's satisfaction not later than the next working day after the complaint was made

8.4 A complaint which has previously been made and resolved as above

8.5 A complaint previously investigated under the 2009 Regulations, the 2004 Regulations, or a relevant complaints procedure

8.6 A complaint being investigated by the Ombudsman

8.7 A complaint arising out of the alleged failure to comply with a request for information under the Freedom of Information Act

8.8 A complaint relating to superannuation

Where a complaint will not be considered the complainant must be notified of the decision in writing and the reason for it (except where an oral complaint was resolved the next day).

A complainant can pursue a complaint and take legal action at the same time, so the complaints process will continue if a claim is received.

9.0 Complaints and Disciplinary Procedures

9.1 The Complaints Policy is concerned only with resolving complaints, not with investigating disciplinary matters. Some complaints however may indicate a need for disciplinary investigation. In such instances the Complaints Manager will pass the relevant information to a suitable person to consider/initiate action.

10.0 Duty to co-operate

10.1 Where a complaint about the Trust's services also contains material about another local authority, NHS body, primary care provider or independent provider, the Trust must co-operate with them to co-ordinate the handling of the complaint and ensure that the complainant receives a co-ordinated response. The duty to co-operate includes:-

- The two (or more) organisations should seek to agree which should take the lead in co-ordinating the handling of the complaint and communicating with the complainant.
- Providing to the other organisation information relevant to the consideration of the complaint which is reasonably requested by the other organisation
- Attending or being represented at any meeting required in consideration of the complaint

11.0 Publicity

11.1 The right to complain, advice on how to complain and the help available to assist the complainant must be well publicised. Publicity (in the form of leaflets, posters, the internet, etc) should cover:

- Arrangements for handling complaints
- How to refer a complaint to the Complaints Manager or Chief Executive
- That help and advice can be obtained via PALS and/or ICAS

12.0 Who May Complain

12.1 A complaint may be made by:-

- A person who receives or has received services from the Trust or a person who is affected/likely to be affected by the action, omission or decision of the Trust
- A representative of a person above who has died; or is a child (under 18 years old); or is unable to complain themselves due to physical incapacity or lack of capacity; or has asked the representative to act on their behalf

12.2 Where a representative makes a complaint on behalf of a child the complaint must not be considered unless the Complaints Manager is satisfied that there are reasonable grounds for the complaint being made by a representative instead of the child and if he/she is not satisfied they must notify the representative in writing, giving the reason for the decision.

12.3 Where a representative makes a complaint on behalf of a child or a person who lacks capacity and the Complaints Manager is satisfied that the representative is not conducting the complaint in the best interests of the person, the complaint must not be considered and the representative must be notified in writing, giving the reason for the decision.

13.0 Time Limit

13.1 A complaint must be made not later than 12 months after the date the subject matter of the complaint occurred or the date the subject matter of the complaint came to the notice of the complainant.

13.2 The time limit will not apply if the Complaints Manager is satisfied that the complainant had good reason for not making the complaint within the time limit and, notwithstanding the delay, it is still possible to investigate the complaint effectively and fairly.

14.0 Dealing with Habitual or Vexatious Comments

14.1 While dealing with complaints, staff may come into contact with a small number of complainants who take up a disproportionate amount of NHS resources. The difficulty in handling such complainants places a strain on time and causes undue stress for staff who may need support in difficult situations.

14.2 Staff will deal with patience and empathy to the needs of all complaints but there are times when there is nothing further which can reasonably be done to assist

them or to rectify a real or perceived problem.

14.3 Guidelines for dealing with habitual or vexatious complainants are set out in Appendix 5.

15.0 Support for Staff

15.1 Dealing with a complaint can be stressful for staff, particularly if it involves the death of a patient

15.2 If staff feel anxious they should discuss their concerns with their line manager. Additional support is also available from the Divisional management team, the Complaints Department and the Occupational Health Department (for stress related issues)

15.3 For some complaints a debrief led by either the Head of Complaints and Litigation or a senior Divisional representative, may be helpful after the resolution of the complaint to respond to issues arising from the complaint and to facilitate the learning of any lessons. This will be considered on a case by case basis

15.4 Further advice may be accessed through professional organisations e.g. RCN, UNISON etc

15.5 Further guidance, is available in the Trust's Policy for Supporting Staff Involved in An Incident, Complaint or Claim

16.0 Local Resolution

16.1 Most complaints will be initiated with front-line staff and can be dealt with on the spot by giving the complainant reassurance and an immediate sympathetic response. Even where the complainant has declared themselves satisfied, a record of the incident will be kept at ward or departmental level. Informal, oral complaints of this nature should be resolved on the spot or not later than the next working day. A written response should not normally be sent following an informal complaint. If the complainant specifically requests a letter, this should be discussed with the Complaints Manager, to agree the wording of the letter and who within the Trust should sign the letter. Each Division/Directorate should record informal complaints and send details to the Complaints Department on a monthly basis.

16.2 Informal complaints may become formal complaints where:

- The complainant is dissatisfied with the initial response and wishes to take the matter further
- The complainant wishes to complain to someone not involved in their care
- Front line staff feel they are unable to deal with the complaint due to the serious or complex nature of the complaint.

16.3 All formal complaints (whether oral or in writing) should be referred to the

Complaints Manager. An initial acknowledgement will be sent within 3 working days, either orally or in writing, and forwarded to the investigating officer. The acknowledgement must include an offer to discuss with the complainant, at a time to be agreed with them, the way in which the complaint will be handled; the period within which the investigation is likely to be completed; and when the response is likely to be sent to the complainant. Where the complaint has been made orally the acknowledgement will be accompanied by a written record of the complaint.

16.4 The complaint will be entered on a centralised database and the Complaints Manager will refer the complaint to the appropriate investigating officer.

16.5 Where the complaint relates to more than one Division/Directorate, the investigating officer with the greatest involvement will take the lead, as determined by the Complaints Manager

16.6 The investigating officer will discuss with the complainant, at a time agreed with them, the way in which the complaint will be handled; the period within which the investigation is likely to be completed; and when the response is likely to be sent to them. If the complainant does not accept the offer of a discussion to determine the response period and notify the complainant in writing.

16.7 The investigating officer will review the findings of the investigation and draft a response for review by the Complaints Manager which includes:-

- A report giving an explanation of how the complaint has been considered and the conclusions reached in relation to the complaint, including any remedial action that is needed
- Confirmation that we are satisfied that any action needed in consequence of the complaint has been taken or is proposed
- Details of the complainant's right to take their complaint to the Ombudsman

16.8 All responses will be signed by the Chief Executive or, in his absence, by the person designated to act on his behalf. Complicated clinical terms/jargon will be avoided. An appropriately worded apology will be given where the Trust has been at fault and the letter will include action to be undertaken to prevent recurrence.

16.9 A questionnaire will be sent with the response (except where the patient is deceased) seeking the complainant's view on how the complaint was handled.

16.10 Meeting a complainant (see Appendix 3) to resolve a complaint or to discuss the findings of an investigation should be considered and will be determined by the Complaints Manager, in consultation with the relevant staff. Meetings will be offered for the more serious/complex complaints, particularly where there has been a bereavement. The investigating officer (or the lead for the cross Division/Directorate complaints) will attend the meeting together with the relevant Consultant(s), Ward Manager (s), Head(s) of Department or the Senior Clinical Adviser. For some complaints it may be appropriate for the Complaints Manager to attend, together with the appropriate Executive Director(s). The complainant will be notified in writing of the purpose of the meeting and the people who will be attending. A record will be kept of the issues discussed at the meeting and a letter

will be sent to the complainant, enclosing the record of the meeting and confirming any agreed action.

16.11 An action plan will be completed showing the action to be taken as a result of the complaint. Monitoring of the returned action plans will be undertaken by the Complaints Department using the complaints database and progress will be reported via the Governance framework. For further guidance, see 5.9. (See also, Policy for the Investigation, Analysis and Learning of Lessons from Adverse Events).

17.0 Health Service Ombudsman

17.1 In any case where the complainant is not satisfied following the investigation of their concerns the complainant may request the Health Service Ombudsman to consider the complaint

17.2 On receipt of a complaint the Ombudsman's Office will assess the nature and substance of the complaint and decide how it will be handled. A copy of the complaint file will be sent to the Ombudsman, together with a copy of the relevant medical records

17.3 Following consideration of the complainant's concerns by the Ombudsman, further action will undertaken as required by the Ombudsman

17.4 Details of actions taken as a result of consideration of a complaint by the Ombudsman will be included in the annual report on complaints

18.0 File Maintenance

18.1 The Complaints Department is responsible for maintaining the master complaint file and the computerised database during the course of the investigation

18.2 The master file in conjunction with the computerised database will be a comprehensive record containing all details of the investigation, including any internal or external letters, e-mails and file notes.

18.3 These files must be kept for a minimum of 10 years and will be required for Health Service Ombudsman investigations and action planning. In the event of legal action, all papers must be considered disclosable to the claimant's solicitor.

18.4 Copies of complaint correspondence should not be kept in the patient's medical records

19.0 Summary of Performance Targets

19.1 Oral complaints should be resolved on the spot or by the next working day

19.2 Where this is not possible and for formal written complaints, an initial acknowledgement should be sent within 3 working days.

19.3 Complaints will be investigated and responded to within the negotiated timescale

19.4 Where these targets cannot be met, the complainant should be informed of the delay and the revised timescale for the response.

20.0 Reporting Procedures

20.1 The Trust Board will receive quarterly reports on complaints. The reports will (as a minimum):

- Specify the numbers of complaints received
- Identify the subject matter of those complaints
- Summarise how they were handled, including the outcome of the investigation

20.2 In addition, demographic information, feedback on completed complaints questionnaires and the number of complaints where the complainant remains dissatisfied after the first response will be included

20.3 Regular reports will be sent to the Trust's Governance Committees

20.4 Information will also be collected on thank you letters to present a more balanced view.

20.5 An annual report on complaint handling must be sent to the PCTs which arranged for the provision of the services by the Trust

20.6 The annual report must:-

- Specify the number of complaints received
- Specify the number of complaints that were well-founded
- Specify the number of complaints referred to the Ombudsman
- Summarise the subject matter of the complaints; any matters of general importance arising out of the complaints or the way in which they were handled; any matters where action has been or is to be taken to improve services

20.7 Monitoring of the procedure and action arising from complaints and the preparation of reports will be undertaken by the Complaints Manager

21.0 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.

22.0 Policy Review

This policy will be reviewed in 3 years time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

23.0 Training and Awareness

23.1 All staff should know how to react and what to do if someone makes a complaint

23.2 The initial response to someone who feels aggrieved can be crucial in establishing the confidence of the complainant that their concerns will be treated appropriately

23.3 Ongoing training will be required for all staff to

- Increase their awareness of the importance of responding well to complaints
- Develop the necessary communication skills so that staff are adequately equipped to respond to the complainant's needs and can prevent a minor problem from becoming a major complaint

23.4 Staff will receive training in managing and where appropriate in investigating complaints in the Training Needs Analysis in the Trust Induction and Mandatory Training Policy and as identified through personal development reviews. Such training will be organised/followed up by the Learning and Development Department in conjunction with the Complaints and Litigation Department.

24.0 Monitoring

24.1 Monitoring of compliance and effectiveness of this policy will be the responsibility of the Head of Complaints and Litigation. This will include:-

- Reviewing response times and all outstanding complaints on a weekly basis and escalating concerns to the Chief Executive as appropriate
- Preparing quarterly and annual reports for the Trust Board
- Preparing quarterly and annual reports for the Divisional Governance Groups
- Preparing bi-monthly reports for the Adverse Events Committee on red complaint action plans and complaints referred to the Health Service Ombudsman
- Reviewing feedback from the Health Service Ombudsman on complaint handling
- Reviewing feedback from complainants via the complaints questionnaire

25.0 References

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- Trust Incident Reporting Policy

26.0 Appendices

Appendix 1 Complaint Severity Matrix
Appendix 2 Root Cause Analysis
Appendix 3 Guidelines for Meeting with Complainants
Appendix 4 Guidelines on Writing Statements
Appendix 5 Guidelines for Dealing with Habitual or Vexatious Complainants

27.0 Further Enquiries

Further information relating to this policy can be obtained from the Head of Complaints and Litigation.

Appendix 1

COMPLAINT SEVERITY MATRIX

Assessing the seriousness of the complaint

The following has been adapted from the Department of Health (2009) guidance: Listening, responding, improving: a guide to better customer care.

The full document is accessible on-line via www.dh.gov.uk.

By correctly assessing the seriousness of a complaint about a service, the right course of action can be taken. It is useful to categorise a complaint when you first receive it, and then review that category based on the results of any investigation. It is also important to remember that a complaint can have a very different effect on an organisation compared with an individual. This is especially important if someone is vulnerable for any reason, such as poor health, communication difficulties or recent bereavement.

The following process can help you assess the seriousness of an issue and take the relevant action.

Step 1: Decide how serious the issue is

Seriousness	Description
Low	Unsatisfactory service or experience not directly related to care. No impact or risk to provision of care. **OR** Unsatisfactory service or experience related to care, usually a single resolvable issue. Minimal impact and relative minimal risk to the provision of care or the service. No real risk of litigation.
Medium	Service or experience below reasonable expectations in several ways, but not causing lasting problems. Has potential to impact on service provision. Some potential for litigation.
High	Significant issues regarding standards, quality of care and safeguarding of or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation, and so require investigation. Possibility of litigation and adverse local publicity. **OR** Serious issues that may cause long-term damage, such as grossly substandard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues. A high probability of litigation and strong possibility of adverse national publicity.

Step 2: Decide how likely the issue is to recur

Likelihood	Description
Rare	Isolated or “one off” – slight vague connection to service provision
Unlikely	Rare – unusual but may have happened before
Possible	Happens from time to time – not frequently or regularly
Likely	Will probably occur several times a year
Almost certain	Recurrent and frequent, predictable

Step 3: Categorise the risk

Seriousness	Likelihood of recurrence				
	Rare	Unlikely	Possible	Likely	Almost Certain
Low	Low				
		Moderate			
Medium					
			High		
High				Extreme	

EXAMPLES OF DIFFERENT TYPES OF INCIDENTS

Low	(simple, non-complex issues)	▸ Delayed or cancelled appointments. ▸ Event resulting in minor harm (e.g. cut, strain) ▸ Loss of property. ▸ Lack of cleanliness. ▸ Transport problems. ▸ Single failure to meet care needs (e.g. missed call-back bell). ▸ Medical records missing
Moderate	(several issues relating to a short period of care)	▸ Event resulting in moderate harm (e.g. fracture). ▸ Delayed discharge. ▸ Failure to meet care needs. ▸ Miscommunication or misinformation. ▸ Medical errors. ▸ Incorrect treatment. ▸ Staff attitude or communication

High	(multiple issues relating to a longer period of care, often involving more than one organisation or individual)	▸ See moderate list. ▸ Event resulting in serious harm (e.g. damage to internal organs)
Extreme	(multiple issues relating to serious failures, causing serious harm)	▸ Events resulting in serious harm or death. ▸ Gross professional misconduct. ▸ Abuse or neglect. ▸ Criminal offence (e.g. assault)

Appendix 2

ROOT CAUSE ANALYSIS
(FOR AMBER/RED COMPLAINTS)

NAME (Patient or person involved)			
Complaint number		Incident date	
Summary of complaint (fact not opinion)			
1.Organisational/ management	**Action**		
2. Work environment	**Action**		
3. Team	**Action**		
4. Task/procedure	**Action**		
5. Individual	**Action**		
Print name ……	**Post title** ……		
Signature ……	**Contact number** ……		
Date ……			

Appendix 3

GUIDELINES FOR MEETING WITH COMPLAINANTS AND DEALING WITH COMPLAINANTS OVER THE TELEPHONE

1.0 Introduction

Risk assessments on violence to staff identified that there was no clear guidance for staff in relation to meeting with complainants, what is and is not an appropriate environment and safe systems of working. Also, how to deal with complainants over the telephone, particularly those who are verbally abusive and aggressive.

These guidelines are not all encompassing and are intended primarily to raise staff awareness on the possible risks when meeting with complainants. It is recognised that at ward/department level staff very often meet with complainants on an unplanned basis. However, local arrangements can still be in place for dealing with such situations, such as agreeing a designated room for meeting with complainants and, particularly, safe systems of working.

2.0 Aims

2.1 To ensure the safety of staff at all times whilst meeting complainants.

2.2 To ensure staff are aware of what actions they can take when dealing with complainants over the telephone who are verbally abusive and aggressive

3.0 Objectives

3.1 To ensure the environment in which complainants are met is as conducive as possible.

3.2 To ensure staff recognise the importance of safe systems of working.

3.3 To ensure staff are comfortable in dealing with complainants over the telephone.

4.0 Meeting with Complainants — What to Consider

4.1 Environment

The environment in which complainants are met will depend very much on the history of the complaint and previous meetings with the complainants. Ideally meetings will be scheduled and there will therefore be time to arrange the environment in which you meet complainants, although it is acknowledged that in ward/department areas meetings are very often unplanned. However, whatever the background, the following should be borne in mind:

4.1.1 Location

Should this be in your immediate work area or elsewhere?

Is there any risk of the complainant returning unannounced? If you feel this might be a possibility, you should consider arranging the meeting away from your area of work.
Is the room of sufficient size? Consider the size of the group you are meeting, bearing in mind that often more relatives come that you expect.
Where is the room located? Ensure it is not too isolated.

4.1.2 Room Layout

Should this be informal, ie. no physical barriers between yourself and the complainant, or should it be more formal with tables and chairs?
Remember, whatever the layout, it is always advisable to place yourself nearest the door in case it is necessary for you to leave the room quickly.

4.1.3 Refreshments

Should refreshments be made available at the beginning or during a meeting?
Would it be useful to have refreshments on standby, offering an excuse to leave the room and an opportunity to defuse a given situation?

4.2 Safe Systems of Working

It is important to remember, whoever the complainant, your own safety and security at all times. Whether meetings are scheduled or unscheduled, always consider the following points:

4.2.1 As far as possible DO NOT meet complainants on your own, even if you are meeting only one person. It is, however, understood that this may be unavoidable.

4.2.2 Always ensure someone knows where you are and who you are with.

4.2.3 Arrange for someone to check on you after an agreed period of time — this is especially important if you are meeting someone on your own.

4.2.4 If you feel a situation could get out of hand, make an excuse to leave the room for a short period of time to allow both parties time to calm down.

4.2.5 Offer refreshments if you feel they will help.

4.3 Meeting with Complainants in their own homes

When meeting complainants in their own homes, it is difficult to control the environment. However, you may still be able to control the environment to some degree, such as where you sit in a room and therefore what barriers are between you and the complainant.

You can also ensure safe systems of working by following 4.2.1 to 4.2.3 above.

5.0 Dealing with Complainants over the Telephone

Whilst the majority of complainants who contact you by telephone will be civil and polite, a small minority will not and can be verbally abusive and/or aggressive. This can be extremely upsetting for the member of staff taking the call and it is therefore important that

staff are aware of what they can do in such a situation. This guidance can also be followed when receiving calls from anyone who becomes abusive and/or aggressive, not just complainants.

5.1 If a complainant starts to become either verbally abusive or aggressive, inform them in a calm, civil voice that verbal abuse/aggressive behaviour is not acceptable and that if they continue in such a manner you will put the receiver down.

5.2 If the complainant continues in the same manner, tell them you are going to put the receiver down and then do it.

5.3 Immediately following the call you should inform your line manager, giving the complainant's name, any details you have taken regarding the complaint they were making and details of their behaviour and the action you took before putting the receiver down. Also discuss the action you should take if the complainant phones again. In some cases it may be appropriate to notify your Departmental Manager or Head of Service.

5.4 If the call has been particularly upsetting, if you can take time away from your desk, have a drink or talk it over with your with colleagues (without giving details of the caller in question).

5.5 Complete a non-clinical incident form and make a file note of the conversation.

6.0 Training

6.1 All staff should be conversant with the Trust's policy on "Violence and Aggression"

6.2 Requirements for further training should be identified during the annual violence and aggression risk assessments undertaken by senior managers.

7.0 Monitoring and Audit

Monitoring will take place as part of the annual health and safety report for each area and the violence and aggression risk assessments for staff.

8.0 Financial Implications

There may be financial implications arising from training requirements identified outside those already identified within the Violence and Aggression Policy.

Appendix 4

GUIDELINES ON WRITING STATEMENTS FOR INCIDENT REVIEW AND COMPLAINT INVESTIGATION

1.0 Introduction

Sandwell & West Birmingham Hospitals Trust actively encourages incident reporting within the Trust. The Trust will therefore not seek to apportion blame but ensure that any incidents which are reported are openly investigated, concentrating on the causes of incidents, so that lessons are learned. This enables the Trust to reduce risks and improve the care it delivers. You will be asked in writing for a statement if you are involved in an incident review or complaint investigation.

The statement from a member of staff following an incident or a complaint is a written record of events that occurred. When all the information is put together, the outcome should be that the events leading to the incident have been clearly defined and any latent system failures can be identified.

Information for incident reviews will be used at the Trust's tabletop reviews and is an internal review of what happened. Reports for a specific complaint will contribute towards the final response to the complainant from the Chief Executive. The report will be confidential but may be sent to the Coroner (if appropriate) or used by the Health Service Ombudsman should the complainant remain dissatisfied. Any subsequent Ombudsman Inquiry may question the member of staff against what is written in the report.

2.0 Aim

To provide written guidance for staff on how they should write up statements and summaries of discussion

3.0 Objectives

The key task required of every factual witness is to assist the enquiry with evidence that is:

Factual, i.e. no opinion or guesses about provision of care;
Accurate, e.g. refer to relevant contemporaneous records
Relevant, avoid blaming or judging others or including areas in your statement you have not been involved in

At some stage during the course of dealing with an incident or complaint it is likely that written responses are needed from staff within the Trust. The following advice is intended to assist you in composing your report:

Identify the concerns that have been raised. It is often helpful to set out an account of what took place, even if this is background information, but do not lose sight of the issues.

The purpose of the response is to establish the facts and add to the whole picture

Avoid Jargon — use plain English

The response should be typed, so that it is clearly legible

4.0 Content of the Statement

4.1 Confidentiality

Confidentiality is important and care should be taken to ensure only those who will be involved and implementing actions for the Trust read the statement. It is important to learn lessons and the essential information from the cases involved will be anonymised for lessons to be learned. Statements should, therefore, be headed 'Confidential' and addressed to the requesting individual. A heading is helpful, something like 'Report concerning……By…….

4.2 Biography of writer

The first few lines may be a potted biography of the writer's role to put into context for the reader. Where appropriate, a summary of the patient's condition and principal symptoms being treated is a useful start. A defined period of time must be known for the report, it may be from admission or it may be for a few hours if that is all you have been involved in. It is important that the statement only refers to the writer's input in this respect.

4.3 Team Members involved in the provision of Care

The provision of care is never delivered by one person alone, so it is important to establish the team members involved in provision of care eg Medical Staff, Consultant(s) speciality, Nursing Team, Skill mix on duty for episodes of care, Therapy involvement. The statement should state who was working and what their involvement was in the decision making, and the delivery of care. This must be factual.

4.4 The flow of care

Establish a chronology of events through establishing the roles of the members of staff as a whole and record the limits of your involvement. The first step in the analysis is to produce an agreed history of events (check with the person requesting the report as some of this may already be available for you). The starting point will be the point at which the patient entered the hospital. As part of a team, it is important to demonstrate the hand over procedures employed for continuing care provision.

4.5 Care Management Problems

State the tools employed in the provision of the care provided and the outcomes of that care management should be also be stated eg Risk Assessments (Falls/Pressure Sore), Care Pathways. Copies of the assessments may be added to the report where appropriate.

4.6 Contributory Factors

You will find it useful to identify the care management problems and the relevant actions undertaken at the time to remedy the problems encountered.

5.0 Summary

The investigation needs to identify all of the issues involved. Once the issues have been identified, the key people/staff involved will be contacted for their record of events. This will take the form of a statement and interview in the format of a table top review for incidents or a discussion with the Complaints Manager. A record of the interviews will take place and participants will either have submitted their own reports or a final report in the form of an action plan for a red incident will be produced. Sources such as standards, policies, audits recommendations, incidents and previous complaints will all add to the final outcome.

This is not a disciplinary procedure. The Trust will not use disciplinary procedures unless a particular practice is, in the opinion of senior staff, so far below professional standards that it is unacceptable or where an individual has deliberately misled the investigation in anyway eg cover up, deception, altering records, tampering with equipment or coercing others.

Appendix 5

Identifying and Managing Habitual/Vexatious Complainants/Complaints

All complaints should be processed in accordance with the NHS complaints procedure. However, during this process, staff may have contact with a small number of complainants who absorb a disproportionate amount of resources in dealing with their complaints.

In determining how to identify situations where the complaint might be considered to be habitual or vexatious, how to respond to these situations and how to appropriately manage such complaints, the following must be considered:

- That the complaints procedure has been correctly implemented so far as is possible and that no material element of a complaint has been overlooked. It must be appreciated that even habitual or vexatious complaints may have aspects that contain some genuine substance.
- That an equitable approach has been followed.

Definitions

Complainants may be deemed to be habitual or vexatious, where previous or current contact with them shows that they meet two or more of the following criteria:

- **Persist in pursuing a complaint** when the NHS complaints procedure has been fully and properly implemented and exhausted (e.g. When an investigation has been denied as 'out of time', where the Ombudsman has declined a request for independent review).

- **Change the substance of a complaint**, or continually raise new issues, or seek to prolong contact by continually raising further concerns or questions upon receipt of a response whilst the complaint is being addressed.

- **Are unwilling to accept documented evidence** of treatment given as being factual, e.g. Drug Records, hand-written or computer records, nursing records, or deny receipt of an adequate response, despite correspondence specifically answering their questions, or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

- **Do not clearly identify the precise issues** they wish to be investigated, despite reasonable efforts of staff to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate.

- **Focus on a trivial matter**, to an extent that it is out of proportion to its significance and continue to focus on this point (it is recognised that determining what is 'trivial', can be subjective and careful judgement must be used in applying this criterion).

- **Had an excessive number of contacts with the Trust**, in the course of addressing a registered complaint, placing unreasonable demands on staff (a contact may be in person or by telephone, letter or fax and discretion must be used in determining the precise number of 'excessive contacts').

- **Have harassed or been personally abusive or verbally aggressive** on more than one occasion towards staff dealing with their complaint. However, it must be recognised that complainants may sometimes act out of character at times of stress, anxiety or distress and reasonable allowances for this (all incidents of harassment must be documented and logged).

- **Have threatened or used actual physical violence** towards staff at any time. This will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will thereafter only be pursued through written communication (all such incidents must be documented and logged).

- **Known to have recorded meetings, face-to-face or telephone conversations** without the prior knowledge and consent of the other parties involved.

- **Display unreasonable demands/expectation** and fail to accept that these may be unreasonable (e.g. insist on responses to complaints or enquiries being provided more urgently than is reasonable or usual recognised practice).

Options for dealing with habitual/vexatious complainants

Where complainants have been identified by the Complaints Manager as being habitual or vexatious, in accordance with the above criteria, the Chief Executive (or an appropriate deputy in their absence) will determine what action to take. The Chief Executive will implement such action and will notify complainants in writing of the reasons why they have been classified as a habitual or vexatious complainant and the action to be taken. This notification may be copied for information of others already involved in the complaint. A record must be kept for future reference, of the reasons why a complainant has been classified as habitual or vexatious.

The Chief Executive may decide to deal with complaints in one or more of the following ways:

- Try to resolve matters, before invoking this procedure, by drawing up a signed 'agreement' with the complainant, which sets out a code of behaviour for the parties involved if the Trust is to process the complaint. If these terms are contravened, consideration would then be given to implementing other actions as indicated in this section.
- Once it is clear that the complainants meet any one of the criteria above, they should be informed in writing that they may be classed as habitual or vexatious complainants, the policy should be copied to them and they should be advised to take account of the criteria in any further dealings with the Trust. In some cases it may be appropriate, at this point, to suggest that complainants seek advice in processing their complaint, e.g. through ICAS.
- Decline any contact with the complainants either in person, by telephone, by fax, by e-mail, by letter or any combination of these, provided that one form of contact is maintained or alternatively to restrict contact to liaison through a third party.
- Notify the complainants in writing that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint, but there is nothing more to add

and continuing contact will serve no useful purpose. The complainants should also be notified that correspondence is at an end and that further letters received will be acknowledged but not answered.

- Inform the complainants that in extreme circumstances, the Trust reserves the right to pass unreasonable or vexatious complainants to the Trust's solicitors or to the police, if physical violence is threatened.
- Temporarily suspend all contact with the complainants or investigation of a complaint whilst seeking legal advice or guidance from the Strategic Health Authority, or other relevant agencies.

Withdrawing 'Habitual or Vexatious' Status

Once complainants have been determined as 'habitual or vexatious', there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate. Each complaint must be reviewed objectively and assessed on merit.

Staff should previously have used discretion in recommending 'habitual or vexatious' status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate. Where this appears to be the case, discussion will be held with the Chief Executive (or their deputy). Subject to their approval, normal contact with the complainants and application of NHS complaints procedures will then be resumed.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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

POLICY TITLE/SERVICE:	Policy on the Handling of Complaints
ACCOUNTABLE DIRECTOR:	Director of Governance
MANAGER RESPONSIBLE FOR COMPLETION:	Head of Complaints and Litigation
DATE:	19th November 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 the Trust complies with the requirements of the NHS Complaints Procedure and that no difficulties are placed in the way of patients, carers or relatives wishing to complain about the services provided by the Trust.

How will the outcomes be measured?

By reviewing feedback from complainants; from advocacy agencies such as ICAS; and from the Health Service Ombudsman.

Who are the key stakeholders?

All Trust staff; complainants; advocacy agencies; other NHS bodies, local authorities or independent providers involved in joint complaints; the Health Service Ombudsman

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 due to their race, gender, disability, sexuality, age, religion and language? • If yes, please explain, identifying those likely to be affected and detailing evidence sources.		No
Is there any reason to believe that people from the different equality strands, taking into account of interaction between strands, could be affected differently, by the proposed policy/service • If yes, please state reason and those likely to be affected and evidence sources.		No
Is there evidence to suggest that any part of the proposed policy/service could discriminate unlawfully, directly or indirectly? • If yes, please specify • If no, please explain		No
Is there any evidence that some people may have different expectations of the policy/service in question due to their race, gender, disability, sexuality, age, religion and language? • If yes, please specify • If no, please explain		No
Is the proposed policy/service likely to affect relations between some 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.		No

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 : Debbie Dunn Date: 19th November 2009

Signed: *Debbie Dunn*

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Policy on the Handling of Complaints
ACCOUNTABLE DIRECTOR:	Director of Governance
POLICY AUTHOR:	Head of Complaints and Litigation
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 of the plan Head of Complaints and Litigation	Dissemination of the revised policy via e-mail, article in Heartbeat, Team Brief	Within 4 weeks of the policy being approved
Communication and Engagement		
Identify the key messages to communicate to the different stakeholders. • All complaints are treated seriously and sympathetically • The patients treatment will not be affected as a result of making a complaint • Complaints will be investigated in an open, non-defensive way and an honest reply will be given • A clear explanation will be given		
Consider how these messages will be disseminated. Leaflets Complaints form Information on the web-site	Review current documentation/information on the web-site to ensure that it includes up to date information	Within 8 weeks of approval of the policy
Identify which groups or members of staff are affected by the policy, either directly or indirectly. All Trust staff have a role to play in the successful implementation of the policy	Dissemination of the revised policy via e-mail, article in Heartbeat, Team Brief	Within 4 weeks of the policy being approved
Identify which groups of service users are affected by the policy, either directly or indirectly All service users		
Update or produce new patient information regarding the policy Leaflet and form already in use	Review as above	As above
Identify any service users who could contribute to the implementation of the policy		

KEY ACTIVITY	ACTIONS PLANNED TO DELIVER ACTIVITY	PLANNED COMPLETION DATE
Arrange an appropriate engagement exercise where appropriate		
Training		
Identify the training needs arising from the implementation of the policy	Liaise with Learning and Development Department to identify any required changes	Within 4 weeks of the policy being approved
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	Liaise with Learning and Development Department to identify any required changes	Within 4 weeks of the policy being approved
Resources		
Determine the financial impacts of any changes arising from the introduction of the policy	There should not be any financial implications as a result of the changes to 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	This is the amendment of an existing policy, rather than the implementation of a new policy	
Devise a means of confirming that the changes 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	Report to the Trust Management Board	Within 12 weeks of the policy being approved
Consider how lessons learned from the implementation of the policy may be fed back into the organisation		

NEW COMPLAINT REGULATIONS

Handling and consideration of complaints

We must ensure that:-

- Complaints are dealt with efficiently and are properly investigated
- Complainants are treated with courtesy and respect
- Complainants receive, as far as is reasonably possible, assistance to enable them to understand the complaints procedure or advice on where they may obtain assistance
- Complainants receive a timely and appropriate response
- Complainants are told the outcome of the investigation and action is taken if necessary

Responsibility for complaints handling

We must designate:-

- A responsible person (the Chief Executive) to be responsible for ensuring compliance with the Regulations and ensuring that action is taken if necessary following the investigation of a complaint
- A complaints manager to be responsible for managing the procedure and considering complaints in accordance with the Regulations

Who may make a complaint?

A complaint may be made by:-

- A person who receives or has received services from the Trust or a person who is affected/likely to be affected by the action, omission or decision of the Trust
- A representative of a person above who has died; or is a child (under 18 years old); or is unable to complain themselves due to physical incapacity or lack of capacity; or has asked the representative to act on their behalf

Where a representative makes a complaint on behalf of a child we must not consider the complaint unless we are satisfied that there are reasonable grounds for the complaint being made by a representative instead of the child and if we are not satisfied we must notify the representative in writing, giving the reason for the decision.

Where a representative makes a complaint on behalf of a child or a person who lacks capacity and we are satisfied that the representative is not conducting the complaint in the best interests of the person the complaint must not be considered and the representative must be notified in writing, giving the reason for the decision.

Duty to handle complaints

The Regulations apply to complaints made on or after 1.4.09 to the Trust about the exercise of its functions.

Complaints about the provision of health services

If a complaint is made to a PCT about the service we provide the PCT must ask the complainant whether they consent to details of the complaint being sent to us and if consent is given the PCT must send the details to us.

If the PCT considers that it is appropriate for the PCT to deal with the complaint it must notify the complainant and us, and continue to handle the complaint in accordance with the Regulations.

If the PCT considers that it is more appropriate for the complaint to be dealt with by us and the complainant consents the PCT must notify the complainant and us and when we receive it we must consider it in accordance with the Regulations.

Complaints not to be dealt with

We are not required to deal with the following:-

- A complaint made by a local authority, an NHS body (i.e. Strategic Health Authority, PCT, hospital Trust, Foundation Trust), primary care provider (i.e. GP, dentist, optician, pharmacist) or independent provider (i.e. a person providing healthcare but who is not an NHS body or a primary care provider)
- A complaint made by an employee about their employment
- An oral complaint which is resolved to the complainant's satisfaction not later than the next working day after the complaint was made
- A complaint which has previously been made and resolved as above
- A complaint previously investigated under the new Regulations, the 2004 Regulations, or a relevant complaints procedure
- A complaint being investigated by the Ombudsman
- A complaint arising out of the alleged failure to comply with a request for information under the Freedom of Information Act
- A complaint relating to superannuation

Where we decide that we are not required to consider a complaint we must as soon as possible notify the complainant in writing of this decision and the reason for it (except where an oral complaint was resolved the next day).

Duty to co-operate

Where a complaint about our services also contains material about another local authority, NHS body, primary care provider or independent provider, we must co-operate with them to co-ordinate the handling of the complaint and ensure that the complainant receives a co-ordinated response. The duty to co-operate includes:-

- The two organisations should seek to agree which should take the lead in co-ordinating the handling of the complaint and communicating with the complainant.
- Providing to the other organisation information relevant to the consideration of the complaint which is reasonably requested by the other organisation
- Attending or being represented at any meeting required in consideration of the complaint

Time limit for making a complaint

A complaint must be made not later than 12 months after the date the subject matter of the complaint occurred or the date the subject matter of the complaint came to the notice of the complainant.

The time limit will not apply if we are satisfied that the complainant had good reason for not making the complaint within the time limit and, notwithstanding the delay, it is still possible to investigate the complaint effectively and fairly.

Procedure before investigation

A complaint can be made orally, in writing or electronically. Where it is made orally we must make a written record of the complaint and provide a copy to the complainant.

We must acknowledge the complaint not later than 3 working days after the day on which we received it and the acknowledgement can be made orally or in writing. When acknowledging the complaint we must offer to discuss with the complainant, at a time to be agreed with them, the way in which the complaint will be handled; the period within which the investigation is likely to be completed; and when the response is likely to be sent to the complainant. If the complainant does not accept the offer of a discussion we must determine the response period and notify the complainant in writing.

Investigation and response

We must investigate the complaint in a manner appropriate to resolve it speedily and efficiently, and must keep the complainant informed during the investigation as far as is reasonably practicable about the progress of the investigation.

After completing the investigation we must send the complainant a response in writing, signed by the Chief Executive, which includes:-

- A report giving an explanation of how the complaint has been considered and the conclusions reached in relation to the complaint, including any remedial action that is needed
- Confirmation that we are satisfied that any action needed in consequence of the complaint has been taken or is proposed
- Details of the complainant's right to take their complaint to the Ombudsman

If we do not respond within 6 months from when the complaint was received we must write to the complainant and explain why and send a response as soon as possible.

Form of communication

Any communication to the complainant may be sent electronically where the complainant has consented in writing or electronically and has not withdrawn their consent. Any requirement in the Regulations for a document to be signed is satisfied for a document sent electronically by the individual typing their name or producing their name using a computer or other electronic means.

Publicity

We must make information available to the public about our arrangements for dealing with complaints and how information about those arrangements can be obtained.

Monitoring

We must maintain a record of the following:-

- Each complaint received
- The subject matter and outcome of each complaint
- Whether the response was sent within the agreed period or any amended period

Annual report

We must prepare an annual report for each year (12 months ending 31st March) which must:-

- Specify the number of complaints received
- Specify the number of complaints we decided were well-founded
- Specify the number of complaints we have been informed have been referred to the Ombudsman
- Summarise the subject matter of the complaints; any matters of general importance arising out of the complaints or the way in which they were handled; any matters where action has been or is to be taken to improve services

We must ensure that the annual report is available to any person on request.

We must send a copy of the annual report to the PCT which arranged for the provision of the services by the Trust and must send the annual report as soon as reasonably practicable after the end of the year to which the report relates.

Transitional provision

A complaint which immediately before 1.4.09 falls to be handled under the 2004 Regulations will continue under those Regulations except for the referral to the Healthcare Commission. The complainant must be notified of their right to refer their complaint to the Ombudsman.

Where before 1.4.09 the complainant had requested the Healthcare Commission to consider their complaint this will be done by the Ombudsman.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Do Not Attempt Cardiopulmonary Resuscitation
SPONSORING DIRECTOR:	Mr Donal O'Donoghue, Medical Director
AUTHOR:	Dr K-L Kong, Former Chair of the Resuscitation Committee
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The revised DNACPR policy is presented for approval, as one of the policies listed for Trust Board ratification within the Trust's 'Policy on the Development, Approval and Management of Policies'.

Revisions to the policy have taken on board the latest recommendations and publications by the British Medical Association, the Resuscitation Council (UK), the Royal College of Nursing, the Royal College of Anaesthetists, the Royal College of Physicians of London, and the Intensive Care Society.

This Policy has undergone review by our Trust Solicitors as well as Trust wide consultation.

The main changes to the Policy relates to the following areas:

1. Title of the Policy – this has been changed to 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)' Policy to emphasize that the Policy applies only to '*cardiopulmonary*' resuscitation.
2. Mental Capacity Act 2005 – Changes have been made in order ensure compliance with this Act.
3. Appendix 1 – This is a revised DNACPR form which also incorporates a flow chart and functional test for assessment of mental capacity when considering a DNACPR order.
4. Appendix 2 is a completely new Patient Transport Services DNACPR protocol. This addition to the DNACPR policy is necessary in order to protect patients / their families and to provide clear guidance to SWBH Patient Transport Services staff when transporting patients with a DNACPR order including those patients from neighbouring Trusts.

The policy was approved by the Governance Board at its meeting in October, where an implementation date of 1 January 2010 was agreed.

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 policy.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care
Annual priorities	
NHS LA standards	2.4.8 - Resuscitation
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

This policy was approved at the Governance Board meeting on 9 October 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY ON DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) FOR ADULTS

PROFILE	
REFERENCE NUMBER:	SWBH/CLIN/052
VERSION:	4
STATUS:	
ACCOUNTABLE DIRECTOR:	Medical Director
AUTHOR:	Chair of Trust Resuscitation Committee
DATE OF LAST REVIEW/ ORIGIN DATE:	April 2007
DATE OF THIS REVIEW:	2009/2010
APPROVED BY:	Trust Board
DATE OF APPROVAL:	November 2009
IMPLEMENTATION DATE:	January 2010
DATE NEXT REVIEW DUE:	November 2011
REVIEW BODY:	Trust Resuscitation Committee
CATEGORISATION:	Clinical
DATE OF EQUALITY IMPACT ASSESSMENT:	December 2008
APPLICATION:	Trust wide
PRINCIPAL TARGET AUDIENCE:	All clinical staff
ASSOCIATED TRUST DOCUMENTS:	Resuscitation Policy (SWBH/Pt Care/010) Mental Capacity: Policy for Assessing Mental Capacity (SWBH/Pt Care/02)

POLICY ON DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) FOR ADULTS

Contents

1. Introduction

The patient's right to die in peace and with dignity must be respected. It may be against the clearly stated wishes of the patient to prolong what the patient sees as a poor quality of life by attempting cardiopulmonary resuscitation (CPR).

There will inevitably be cases where resuscitation following cardio-respiratory arrest cannot be justified on medical or quality of life grounds, as being in the patient's best interests. Such cases should be clearly identified and health care staff involved in the patient's care should be made aware of action to take in the event of cardio-respiratory arrest.

The Mental Capacity Act 2005 applies, for the purposes of this policy, to people who lack capacity to make a decision about whether or not they should receive CPR. Unless there is a valid applicable advance decision to refuse treatment or a decision has been taken by a personal welfare lasting power of attorney healthcare staff must carefully decide what would be in the person's best interests. Multidisciplinary discussions are often the best way to decide on a person's best interests. Consultation with relatives, carers or other appropriate adults must be undertaken. In addition attempts should be made to ascertain any previous wishes the patient may have expressed with regard to CPR (including the existence of an advance statement/expression with regard to CPR). Where there is disagreement in relation to CPR for a patient who lacks capacity, advice should be taken from the Complaints and Litigation Department as a court order may be required.

If a patient has capacity their wishes must be considered.

This policy document draws on recommendations from the document "Decisions relating to cardiopulmonary resuscitation – A joint decision from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (October 2007)" and the Human Rights Act 1998.

2. Objectives

2.1 To have in place a system for planning patient care and decision making in relation to do not attempt cardiopulmonary resuscitation.

2.2 To provide an easily understood, accessible system for patients, family, carers and staff.

2.3 To ensure decisions relating to do not attempt cardiopulmonary resuscitation procedures are fully discussed, documented and shared with the patient, family and carers where appropriate.

2.4 To ensure all decisions relating to do not attempt cardiopulmonary resuscitation procedures are fully documented in the patient record, the do not attempt cardiopulmonary resuscitation form (appendix 1) and assessment of mental capacity section of the form (part of appendix 1), if appropriate.

2.5 To ensure that procedures in place conform to national guidelines, ethical and legal requirements.

3. Scope

3.1 All staff involved in decisions about whether or not to attempt CPR, must be familiar with the provisions of this policy. If there is any doubt about the legality of an advance decision or the role of the LPA in relation to attempting cardiopulmonary resuscitation, legal advice should be sought. Legal Advice may be gained via the Trust's Complaints & Litigation Department.

4. Definitions and abbreviations

DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
CPR	Cardiopulmonary Resuscitation
IMCA	Independent Mental Capacity Advocate – Someone instructed by a decision maker to support and represent a person who lacks capacity when serious decisions are needed about health treatment.
LPA	Lasting Power of Attorney – Legally appointed representative who is over the age of 18, registered with the Public Guardian, who is nominated to manage health/welfare decisions when an individual loses capacity.
Consultant	The consultant doctor in charge of that patient's care.
'Out of Hours'	The times when least clinical activity takes place: approximately 1700 to 0900 hours Monday to Friday, weekends and bank holidays.

5. Roles and responsibilities

5.1 "Any person who collapses within any area of the Trust must be rendered assistance up to, and including, cardiopulmonary resuscitation according to the skills and ability of the individual staff member. This applies to patients, staff and visitors. Staff who work within the community but are employed by the Trust (such as community midwives) retain this responsibility for the patients in their care away from Trust areas, wherever they may be with their patient" Trust Resuscitation Policy (SWBH/Pt Care/010).

5.2 A decision not to attempt CPR applies only to CPR for an individual patient. It must not be assumed that the same decision will be appropriate for all patients with a particular condition. Decisions must not be made based on assumptions regarding factors such as age or disability. It must be made clear to patients, people close to patients and members of the healthcare team that it does not apply to any other aspect of treatment and that all other treatment and care that are appropriate for the patient will continue. To avoid confusion, the phrase 'do not attempt cardiopulmonary resuscitation' should be used to record DNACPR decisions.

5.3 The withdrawing or withholding of other treatment is a separate issue and should be considered as such. The General Medical Council issues guidance on decisions to withdraw or withhold other medical treatments that have the potential to prolong life. Advice should be sought from the Complaints and Litigation Department if artificial nutrition or hydration is to be withheld or withdrawn.

5.4 Presumption in favour of CPR when there is no DNACPR decision:

5.4.1 If no explicit decision has been made in advance about CPR and the express wishes of the patient are unknown and cannot be ascertained, there should be a presumption that health professionals will make all reasonable efforts to resuscitate the patient in the event of cardiac or respiratory arrest. In such emergencies there will rarely be time to make a proper assessment of the patient's condition and the likely outcome of CPR; so attempting CPR will usually be appropriate. Medical and nursing colleagues should support anyone attempting CPR in such circumstances.

5.4.2 Full resuscitative measures should be initiated unless a DNACPR decision has been made and documented as outlined in this policy. Age is not a bar to resuscitation and the Trust prohibits discrimination on the grounds of age alone in a DNACPR decision. Any doubt should be resolved by taking reasonable steps to preserve life. For patients who lack capacity, the Mental Capacity Act 2005 provides that, in considering whether the treatment is in the best interests of a patient, the decision maker should not be motivated by a desire to bring about their death (Section 4). The starting position should be a presumption in favour of life sustaining treatment.

5.4.3 There may be some situations in which CPR is commenced on this basis, but during attempted resuscitation further information comes to light that makes continued CPR inappropriate. That information may consist of a DNACPR order or a valid and applicable advance decision refusing CPR in the current circumstances, or may consist of clinical information indicating that CPR will not be successful. In such circumstances, continued attempted resuscitation would be inappropriate.

5.4.4 The fact that a decision has been made to attempt CPR in the event of cardiorespiratory arrest does not mean that all other intensive treatments and procedures will also be appropriate. For example, prolonged support for multi-organ failure (such as artificial ventilation, renal dialysis or haemofiltration, and circulatory support with inotropic drugs and/or an intra-aortic balloon pump) in an Intensive Care Unit may be clinically inappropriate if the patient is unlikely to survive this, even though the heart has been re-started. Decisions relating to the application or withholding of such treatments must be made by the Consultant in charge of the person's treatment and fully documented and communicated to all carers. This policy relates to decisions to withhold cardiopulmonary resuscitation only.

6. Guidelines covering the basis of a DNACPR decision.

6.1 It is appropriate to consider a DNACPR decision in the following circumstances.

- Where a patient is in the terminal phase of illness.
- Where CPR is not in accord with the recorded, sustained wishes of the patient who has capacity to make the decision.
- Where CPR is not in accord with a valid applicable Advance Decision (previously known as a living will). A patient's informed refusal, which related to the present circumstances, is legally binding upon health care workers.
- Where successful CPR is likely to result in a quality of life that would not be in the best interests of the patient.

6.2 All patients should be assessed on an individual basis and any decisions made for DNACPR must be in the best interests of the patient. Where possible and if appropriate, this should be discussed with the multi-disciplinary team, the patient, the patient's next of kin or designated decision maker: Independent Mental Capacity Advocate (IMCA) or Lasting Power of Attorney (LPA).

6.3 Where a patient asks for CPR to be attempted where the clinical evidence suggests it will not be effective, sensitive efforts should be made to convey a realistic view of the procedure and its likely success. If the patient still wishes CPR to be attempted, this should be considered in line with the guidance provided in the joint publication on CPR from the BMA, RCN and Resuscitation Council (UK). Doctors cannot be required to give treatment contrary to their clinical judgement, but should, whenever possible, respect patient's wishes to receive treatment even that which carries only a very small chance of success or benefit.

6.4 If any doubt exists, consultation for legal and professional advice can be sought through the Trust's solicitors, British Medical Association or Medical Defence Society. Legal Advice may be gained via the Trust's Complaints & Litigation Department. Whilst professional and legal advice is being sought, resuscitation must be attempted (unless the patient has capacity and does not want CPR to be performed).

7. The Decision making Process

7.1 Responsibility for the DNACPR order lies with the Consultant in charge. It is also their responsibility to enter the DNACPR decision in the patient's medical records including the reason for the decision, any further actions that are required by staff and those others who have been involved in making the decision.

7.2 In exceptional circumstances such as where the patient is unconscious, if the decision is made not to inform the patient of a DNACPR order, the reason must be documented. When a patient lacks capacity clinicians may be asked to justify their decision not to inform the patient, their family or other appropriate person. There will be circumstances where it is not possible to seek the patient's views, for example when the patient is semiconscious or unconscious.

7.3 The patient has the right to be involved in all decisions related to his/her treatment. Where possible, patients should be asked whom they want or do not want to be involved in decision making if they subsequently become incapacitated.

7.4 Where a patient with capacity to make decisions in relation to CPR has been identified as the potential subject of a Do Not Attempt Cardiopulmonary Resuscitation Order there should be full discussion regarding his/her current condition, the likely outcome of any future treatment, and the appropriateness (or inappropriateness) of cardiopulmonary resuscitation. This should be recorded in the patient's notes.

7.5 For patients who lack mental capacity an assessment of mental capacity should be undertaken in accordance with the Trust's Policy for Assessing Mental Capacity (SWBH/Pt Care/02). In order to decide whether an individual has the mental capacity to make a particular decision, a capacity assessment should be made as follows:

- Decide whether there is an impairment of, or disturbance in, the functioning of the person's mind or brain (it does not matter if this is permanent or temporary).
- Does the impairment or disturbance make the person unable to make the particular decision?

- The person will be unable to make the particular decision if, after all appropriate help and support to make the decision has been given to them, they cannot:
  1. Understand the information relevant to that decision or,
  2. Retain that information or,
  3. Use or weigh that information as part of the process of making the decision or,
  4. Communicate their decision (whether by talking, using sign language or any other means).

A patient who lacks mental capacity is entitled to the same confidentiality as a patient with mental capacity. However those responsible for providing care and treatment to a patient who lacks mental capacity must do so in his/her "best interests" and they must ensure that they obtain sufficient information to enable them to do so. This includes attempting to establish any pervious wishes the patient may have held and seeking the views of those involved in the patient's care.

7.6 For an adult who lacks capacity and has no family, friends or other advocate whom it is appropriate to consult, clinicians must make referral to an Independent Mental Capacity Advocate (IMCA) to be consulted before the decision is made, if time permits.

7.7 If a DNACPR decision is needed when an IMCA is not available (for example at night or at a weekend), the decision should be made and recorded in the health record. The decision should be discussed with an IMCA at the first available opportunity. An IMCA does not have the power to make a decision about CPR but must be consulted by the clinician in charge of the patient's care as part of the determination of the patient's best interests.

7.8 A patient being treated under the Mental Health Act does not automatically lack the capacity to decide a treatment issue including a DNACPR order. Equally, a patient detained under the Mental Health Act 1983 (as amended) must be consulted about a DNACPR order in the same way as any other patient in their circumstances.

8. Advance Decisions

8.1 Where there is a valid and applicable Advance Decision made in accordance with the Mental Capacity Act 2005, this must be respected.
It is well established in law and ethics that adults with capacity have the right to refuse any medical treatment, even if that refusal results in their death.

8.2 Advance decisions refusing life-sustaining treatment will need to:

- be in writing (it can be written by a family member, recorded in medical notes by a doctor or on an electronic record)
- be signed (it can be signed by someone else at the person's direction) and witnessed (the witness is to confirm the signature not the content of the advance decision).
- include an express statement that the decision stands 'even if life is at risk'.
- cover the relevant circumstances for which the clinical decision is being made (i.e. CPR).

8.3 A health care worker must consider the validity of an advance decision if:

- the patient has done anything clearly inconsistent with the advance decision which affects its validity. Examples include a change in the patient's religious faith or acceptance of CPR on a previous occasion (but after the advance decision has been made).
- the current circumstances would not have been anticipated by the person and would have affected their decision.
- there has been a recent development in treatment that radically changes the outlook for their particular condition and this does not appear to be covered by the advance decision. In this situation legal advice must be sought.
- it is not clear about what should happen
- there is a dispute about the validity of an advance decision and the case has been referred to court.

8.4 Patients are not obliged to justify their decisions, but health professionals should seek to discuss the implications of a refusal of treatment with patients in order to ensure that the decision is based on accurate information and not on any misunderstanding. However, they must take care not to pressure patients into accepting treatment that they do not want.

8.5 The onus is on patients to ensure that healthcare teams are aware of the existence and content of any advance decision. However, practitioners should make enquiries of a patient (or their representative) to ascertain their wishes or previously expressed views in relation to CPR, if time permits.

9. The documentation of DNACPR decisions

9.1 The DNACPR order must be clearly documented in the case notes AND accompanied by a completed 'Do Not Attempt Cardiopulmonary Resuscitation' form.

9.2 The Do Not Attempt Cardiopulmonary Resuscitation form should be filed at the front of the patient's notes immediately behind the 'Patient Alerts Divider'.

9.3 It is the responsibility of all health care professionals to be aware of the resuscitation status of all patients under their care.

9.4 The Resuscitation status of each patient with an active DNACPR order MUST be communicated at each handover.

9.5 When a DNACPR order is made and there has been no discussion with a patient because he or she has indicated a clear desire to avoid such discussion, this must be documented in the patient's medical records and the reasons given.

9.6 If a DNACPR order is reversed, the appropriate section of the DNACPR form must be struck through clearly with two bold lines, signed and dated. The appropriate section of the DNACPR form must be completed and the form is filed at the back of the patient's notes. This reversal of DNACPR order must be clearly and immediately communicated to the patient, all staff, family and carers involved.

10. Role of the Consultant and other medical staff

10.1 The overall responsibility for making a DNACPR order decision rests with the Consultant in charge of the patient's care. However, where there is disagreement within the treating team, with the patient and/or their representatives about a DNACPR order a second Consultant's opinion should be sought.

10.2 Each Consultant must ensure that the policy is understood by all staff who may be involved, particularly junior medical staff where appropriate.

10.3 The Consultant must document the DNACPR order, and the reason behind it, in the patient/medical record and the DNACPR form. The person making the entry is responsible for ensuring that the decision is effectively communicated to other staff.

10.4 It is expected that DNACPR decisions will be planned and fully discussed events. However, where an emergency admission occurs 'out of hours', DNACPR decisions may be made by:

- Specialist Registrars/Specialist Trainees (at least 3 years post registration) for acute areas (Sandwell/City Hospital sites). These decisions must be verified by a Consultant as soon as possible but within 48 hours and documented in the DNACPR form.

- Associate Specialists/Staff Grade doctors for Community Hospital sites (Rowley Regis). These DNACPR decisions must be verified by a Consultant within 96 hours and documented in the DNACPR form.

10.5 In an 'out of hours' emergency, if a non-consultant doctor completes the DNACPR from, it is his/her responsibility to ensure that the Consultant in charge of care verifies the decision within the time specified.

10.6 Where possible, the patient's family and/or carers should be involved in any DNACPR discussion unless the patient has capacity and has specifically requested otherwise (or it is assessed that it is not in the best interests of the patient to do this or an IMCA has been consulted).

11. Role of nursing, midwifery and other clinical staff

11.1 Each practitioner is accountable for his or her own practice and has responsibilities for individual patients.

11.2 It is, however, the responsibility of each senior nurse/manager to have discussed and agreed a decision regarding a resuscitation process for the patient with the appropriate Consultant. Where possible, all efforts should be made to consider the cardiopulmonary resuscitation status of the severely ill patient by the Consultant in charge of that patient's care rather than the decision be made out of hours.

11.3 When a decision to DNACPR has been made, it must also be recorded in the patient's nursing records by the senior member of the care team.

11.4 It is the senior nurse/manager's responsibility to inform other members of the nursing team and multidisciplinary team of the DNACPR decision.

12. Special Circumstances

12.1 Children and DNACPR: see the Trust's Emergency Care Plan for Children (SWBH/Pt Care/012).

12.2 Resuscitation in the Emergency Department: pre hospital cardiac arrest

12.2.1 The largest group of cardiac arrests within the Emergency Department are the continuation of pre-hospital cardiac arrests. In patients undergoing CPR brought in by ambulance staff, it is appropriate to continue resuscitation following an assessment in an ambulance. Therefore, where an ambulance crew is undertaking CPR, a period of advanced life support within the Emergency Department, is required until an adequate clinical assessment is made.

12.2.2 The work undertaken in an Emergency Department often means that little or nothing is known about the previous medical condition of a patient. In

these circumstances the basic rule is to start resuscitation in persons suffering cardiac or respiratory arrest, unless there is clear evidence of established death, advance decisions, or that CPR is inappropriate such as a patient in the final stages of a terminal illness where death is imminent or unavoidable.

12.3 Transporting Patients with DNACPR orders: see detailed protocol set out in Appendix 2 (SWBH Patient Transport Services DNACPR Protocol).

13. Equality issues

13.1 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.

13.2 All DNACPR orders must be made with sensitivity to the differing needs of religious faiths, diversities of ethnic cultures and any existing bereavement guidelines. In order for this to happen with non-English speaking people, appropriate interpretation services must be provided. Healthcare professionals who do not use competent interpreters will be likely to breach the Human Rights Act that prohibits discrimination in meeting the obligations of a non-English speaking patient's right to life.

14. Review

14.1 Decisions about cardiopulmonary resuscitation must be reviewed regularly and specifically whenever changes occur in the patient's condition or in the patient's expressed wishes.

14.2 The frequency of reviews should be determined by the Consultant in charge of the patient's care and will be influenced by the patient's diagnosis, potential for improvement and response to treatment.

14.3 It is important to note that patients' ability to participate in decision-making may change with changes in their clinical condition.

14.4 It is not usually necessary to discuss CPR with the patient each time the decision is reviewed, although where a patient has previously been informed of a decision and it subsequently changes, they should be informed of the change of decision and the reason for it. Where a patient lacks capacity their family, carer, representative or IMCA should be consulted.

15. Training and awareness

15.1 Training on the process of DNACPR decisions, responsibilities and documentation will be covered during Trust induction and Trust life support courses. Training will include:

- Introduction to the Trust DNACPR Policy and DNACPR form
- Key points regarding the responsibilities of senior medical staff, junior medical staff, nursing staff and other staff members
- The importance of commencing resuscitation in the absence of a DNACPR order
- Introduction to the concept of advance decisions and their legal and professional implications
- How to access the full policy (Trust Intranet)

16. Monitoring and audit

16.1 Reviews of DNACPR documentation will be carried out biannually to ensure that the Trust Policy is being followed. Details will be recorded and compliance will be reported to the Resuscitation Committee and the Trust Governance Board. The bi-annual review of all DNACPR orders will be on a given day undertaken to audit:

- Knowledge of ward and department staff regarding their patients' resuscitation status
- Compliance with Trust Policy in the completion of DNACPR forms
- The reasons for the DNACPR orders, demographical aspects and the involvement of patients, relatives and carers in making the DNACPR orders

17. References, associated reading, useful websites and advice

17.1 References and associated reading

Health Service Circular (HSC) 2000/028

Human Rights Act 1998

Trust adopted West Mercia Guidelines for CPR justification

Decisions relating to cardiopulmonary resuscitation – A joint decision from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (October 2007)

Cardiopulmonary Resuscitation. Standards for Clinical Practice and Training. A Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians of London, the Intensive Care Society, the Resuscitation Council (UK). October 2004, revised June 2008

Resuscitation Council (UK). *CPR guidance for clinical practice and training in hospitals.* London:Resuscitation Council, June 2007.

British Medical Association. *Withholding or withdrawing life-prolonging medical treatment(3rd ed)*. London: Blackwell Publishing, 2007.

Mental Capacity Act 2005 London: HMSO 2005
Department for Constitutional Affairs. *Mental Capacity Act 2005 Code of Practice*. (2005 London TSO)

ALS Course Provider Manual, 5th edition
Resuscitation Council (UK) April 2006

17.1 Useful Websites

Internal web pages:

http://swbhweb/server.php?show=conClinicalGuideline.5455
Resuscitation policy (Pt Care/010)

http://swbhweb/server.php?show=ConClinicalGuideline.10278
Resuscitation Council Guidelines (2005)

http://swbhweb/server.php?show=ConClinicalGuideline.10660
DNAR in Children Policy (Pt Care/012)

http://swbhweb/server.php?show=ConClinicalGuideline.10595
Mental Capacity; policy for assessing mental capacity (Pt Care/02)

External websites:

www.alsg.org
Advanced Life Support Group

www.erc.edu
European Resuscitation Council

www.resus.org.uk
Resuscitation Council (UK)

www.justice.gov.uk
Government advice on legal matters

www.bma.org.uk/ethics
British Medical Association

www.rcn.org.uk
Royal College of Nursing

www.mills-reeves.com/HRC
Mills and Reeves LLP – Trust solicitors client website

17.2 Further enquiries and advice

For any enquiries regarding this policy contact the Trust Resuscitation Committee. Contact one of the Trust Resuscitation Officers in the first instance.

For sensitive issues or medical advice contact the Chair of the Trust Resuscitation Committee.

18. Appendices

Appendices attached to this policy:

(1) SWBH Do Not Attempt Cardiopulmonary Resuscitation Form
(2) SWBH Patient Transport Services DNACPR Protocol

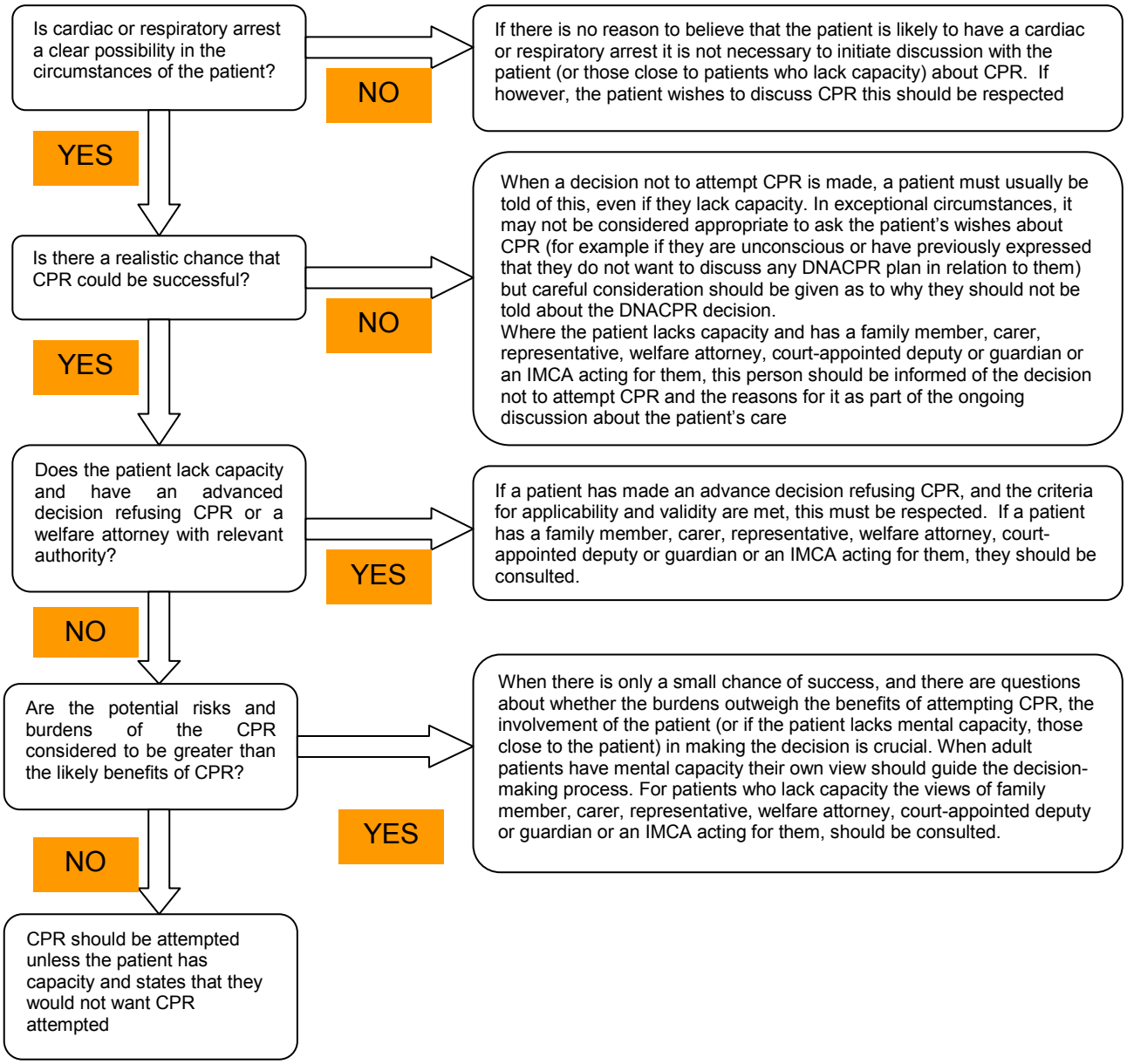
SWBTB (11/09) 231 (b)

Sandwell & West Birmingham Hospitals NHS Trust

Do Not Attempt Cardiopulmonary Resuscitation

This form must be used in accordance with the Trust's current Do Not Attempt Cardiopulmonary Resuscitation Policy for Adults (Policy No. SWBH/CLIN/052)

Surname	Hospital No.	Consultant Name
Forename	Male/Female	
Address		Primary Diagnosis
Date of Birth	Ward Dept	



- Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully in accordance with the DNACPR Policy
- Decisions should be reviewed regularly and when circumstances change
- Advice should be sought if there is uncertainty

Reason for 'Do Not Attempt Cardiopulmonary Resuscitation' decision (indicate more than one if applicable):

- ☐ Where a patient is in the terminal phase of illness.
- ☐ Where CPR is not in accord with the recorded, sustained wishes of the patient who is deemed mentally competent to make the decision
- ☐ Where CPR is not in accord with a valid applicable Advance Decision (previously known as a living will). A patient's informed refusal, which related to the present circumstances, is legally binding upon healthcare workers
- ☐ Where a decision has been made by a Court Appointed Deputy/LPA
- ☐ Where successful CPR is likely to result in a quality of life that would not be in the best interests of the patient

Has DNACPR decision been discussed with the patient? ☐ Yes ☐ No If NO state reason:

Patient's comments:

Signature: Date: Time:

Who was involved in the decision? (Name and designation)	Date & Time	Summary of discussion
Family member/carer: (Document views especially if they disagree with the decision. If there is disagreement where the patient lacks capacity, legal advice should be sought).		- Signature
Other person/health professional:		Signature
Other person/health professional:		Signature
Other person/health professional:		Signature

I _____ declare that if the above named patient suffers a cardiorespiratory arrest, cardiopulmonary resuscitation will not be administered. This decision does not influence the management of any other clinical condition concerning this patient.

Signed: _____ Designation: _____ Date & Time: _____

This DNACPR order will be reviewed on: _____

When a decision is made 'out-of-hours' by a specialist trainee, associate specialist or staff grade doctor it is only valid for 48hours at City & Sandwell Hospitals and 96hours at Rowley Regis Hospital. It is this person's responsibility to ensure the decision is verified by a Consultant within this time period.

Verified by: Signed: Date & time

REVIEW of Do Not Attempt Cardiopulmonary Resuscitation Decisions

Date of Review Time of Review Valid Until	Signed Print Name Print Designation
Date of Review Time of Review Valid Until	Signed Print Name Print Designation
Date of Review Time of Review Valid Until	Signed Print Name Print Designation
Date of Review Time of Review Valid Until	Signed Print Name Print Designation

If a decision not to resuscitate is REVERSED, the reverse side of this page must be struck through clearly with two bold lines, signed and dated. The section below must be completed and this form filed in the current admission section of the patient's notes. This reversal of DNACPR order must be clearly and immediately communicated to all staff, family and carers involved.

Cancellation of DNACPR order.

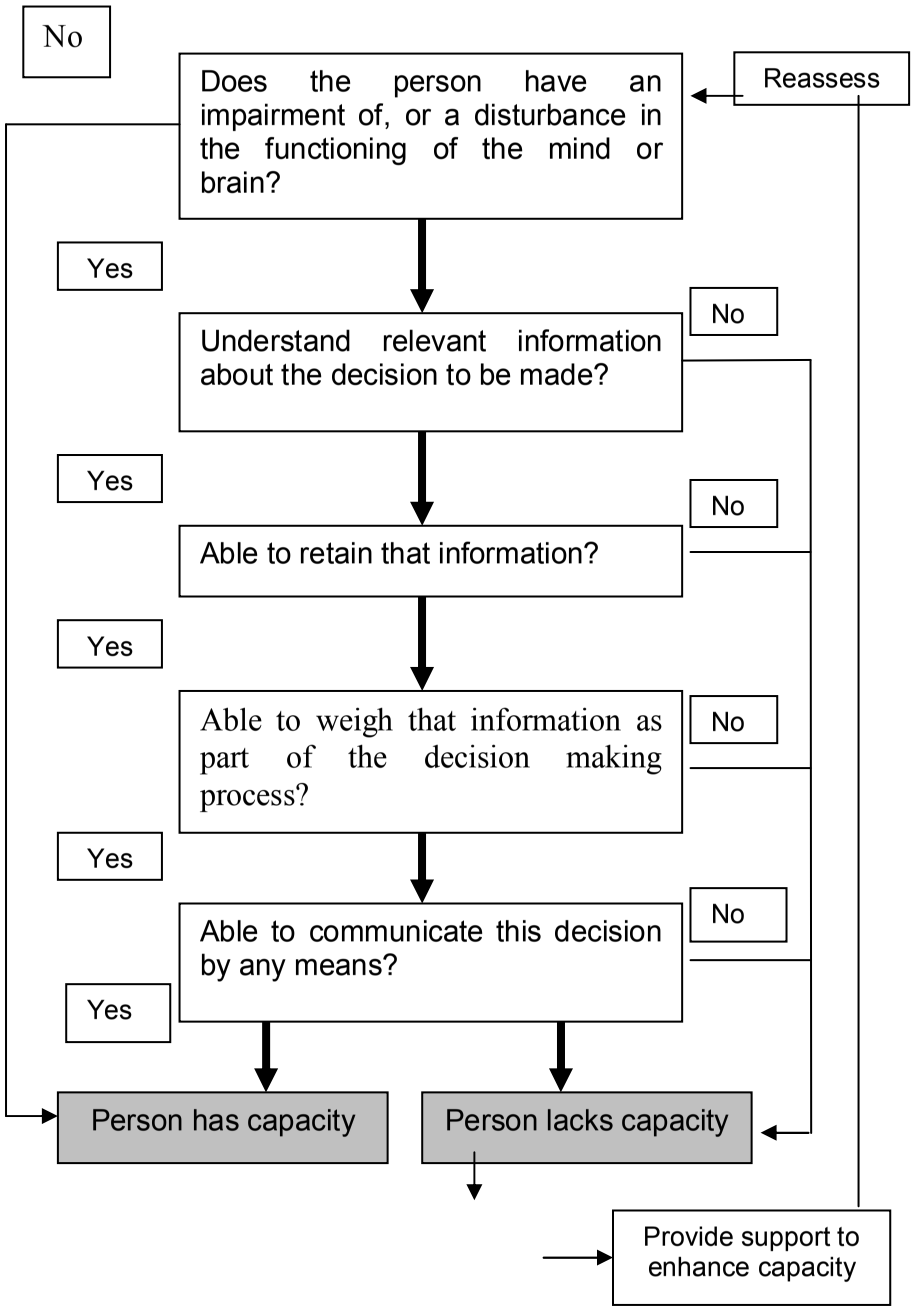
Cancelled by (print name): _____ Designation: _____

Date & time (of cancellation): _____ Signature: _____

Reason for cancellation of DNACPR order: _____

The overall responsibility for making or reversing a DO NOT ATTEMPT CARDIO PULMONARY RESUSCITATION (DNACPR) ORDER rests with the Consultant in charge of the patient's care at that time.

FLOW CHART
ASSESSMENT OF CAPACITY



Potential to regain capacity or gain skills to decide

Assessment of Mental Capacity: Functional test of capacity when considering a DNACPR order.

1. Is there an impairment of, or a disturbance in the functioning of the mind or brain (it does not matter if this is permanent or temporary)?

YES NO

2. Does the impairment or disturbance make the person unable to make the particular decision?

YES NO

Can the person

- Understand the information relevant to that decision?

YES NO

If NO please state reason:

- Retain that information?

YES NO

If NO please state reason:

- Use or weigh that information as part of the process of making the decision?

YES NO

If NO please state reason:

- Communicate the decision (whether by talking, using sign language or any other means?

YES NO

If NO please state reason:

Record of actions taken:

Name: Designation: Date:

Signed: Ward/department

APPENDIX 2 – SWBH PATIENT TRANSPORT SERVICES DNACPR PROTOCOL

PROTOCOL FOR THE TRANSPORT OF ADULT PATIENTS IN POSSESSION OF A "DO NOT ATTEMPT CARDIOPULMANARY RESUSCITATION (DNACPR) ORDER"

---

1. Introduction
2. Do Not Attempt Cardiopulmonary Resuscitation Decisions
3. Responsibility & Accountability
4. Operational Procedure
5. Patient Transport Control Procedure
6. Documentation

Annex 1 – DNACPR Flow Chart
Annex 2 – Patient Transport Services Do Not Attempt Cardiopulmonary Resuscitation Form for Adults

PROTOCOL FOR THE TRANSPORT OF ADULT PATIENTS IN POSSESSION OF A "DO NOT ATTEMPT CARDIOPULMANARY RESUSCITATION ORDER"

1.0 Introduction.

1.1 When the Patient Transport Services (PTS) Control receives a call to transport a patient, it is not uncommon for the person making the request to inform the control that the patient is in possession of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Order.

1.2 A joint statement from the British Medical Association, The Resuscitation Council (UK) and the Royal College of Nursing published in October 2007 states that 'Any decisions about CPR should be communicated between health professionals whenever a patient is transferred between establishments, between different areas or departments of one establishment, or is discharged.'

1.3 During the management and transportation of patients, transport personnel have a responsibility for the continuation of patient care. This would include abiding by 'do not attempt cardiopulmonary resuscitation decisions' if they had been put in place by a hospital prior to discharge / transfer of the patient, or by a General Practitioner prior to the admission of a patient.

1.4 Ambulance staff cannot make DNACPR decisions. Such decisions can only be made by the responsible clinician in charge of the patient's care. This would be the Consultant, Specialist Trainees or the General Practitioner, depending on point of journey origin.

1.5 To enable PTS staff to comply with these guidelines, procedures must be in place to notify the transport staff of the patient's CPR status, and provide them with the necessary documentation, before the journey commences.

2.0 Do Not Attempt Cardiopulmonary Resuscitation Decisions

2.1 Transport personnel should initiate CPR unless a formal DNACPR order and the appropriate documentation is in place

3.0 Responsibility and Accountability.

3.1 The DNACPR order made by the Consultant, General Practitioner or their deputy and which has been appropriately documented in the patient's medical records must be applied whilst the patient is in the care of the patient transport services. The decision not to resuscitate relates to the condition for which the DNACPR order is in force.

3.2 The criteria set out below must be in place before PTS staff can accept an instruction to act in accordance with a DNACPR order:

- The DNACPR decision is recorded in the patient's medical records, and the DNACPR form is completed, is current and is in date.
  (Note in relation to consultation with the patient and relatives / next of kin: if this is not indicated, it does not mean that the DNACPR order is invalid. However, this should be pointed out to the PTS staff).

- The person making the request for patient transport confirms that a DNACPR order has been made for that particular patient and that this order applies whilst the patient is in the care of the patient transport service staff.

3.3 Members of staff following this protocol must ensure that all appropriate documentation is valid and complete.

4.0 Operational Procedures for Patient Transport Services Staff.

4.1 On receipt of a call to transport a patient with a DNACPR order, PTS staff must inform the person making the request that:

- There is a requirement for them to complete the SWBH Patient Transport Services DNACPR form.

- Prior to transportation, the PTS staff will need confirmation that the DNACPR form is signed, dated, current, appropriate to the named patient, and in the patient's medical records.

4.2 The person handing over the patient into the care of the PTS staff must sign the Patient Transport Services DNACPR form to acknowledge the fact that a complete and current DNACPR order is in place within the patient's medical records.

4.3 A member of the PTS staff must also sign the Patient Transport Services DNACPR form acknowledging that the DNACPR status is still current.

4.4 In the event of the DNACPR order not being available or it does not contain the signature of the Consultant, Specialist Trainee or General Practitioner the patient would not be transported, except in emergency situations, until these issues have been resolved.

4.5 Patient transport services staff should refer any concerns to Patient Transport Services Control, who if necessary should contact the appropriate duty manager or (if out of hours) the on-call duty manager.

4.6 Relatives would only be allowed to accompany the patient when they are fully aware of the DNACPR decision.

4.7 Where a patient with a DNACPR order requires transport between hospital sites or other destinations, consideration must be given to ensuring there is an appropriate patient environment during this transportation, e.g. no other patients included in the journey.

5.0 Death of a patient with a DNACPR order during transfer

5.1 At the time of taking the booking, Patient Transport Services Control should agree the arrangements for Certification of Death in the event of the patient suffering cardiopulmonary arrest whilst in the care of the Patient Transport Services.

5.2 The person making the transport request should be informed that this would normally be the nearest A&E Department unless specific arrangements have been made. They should be informed that under no circumstances would the patient transport service be able to take a patient back to the patient's home address for certification.

6.0 Documentation.

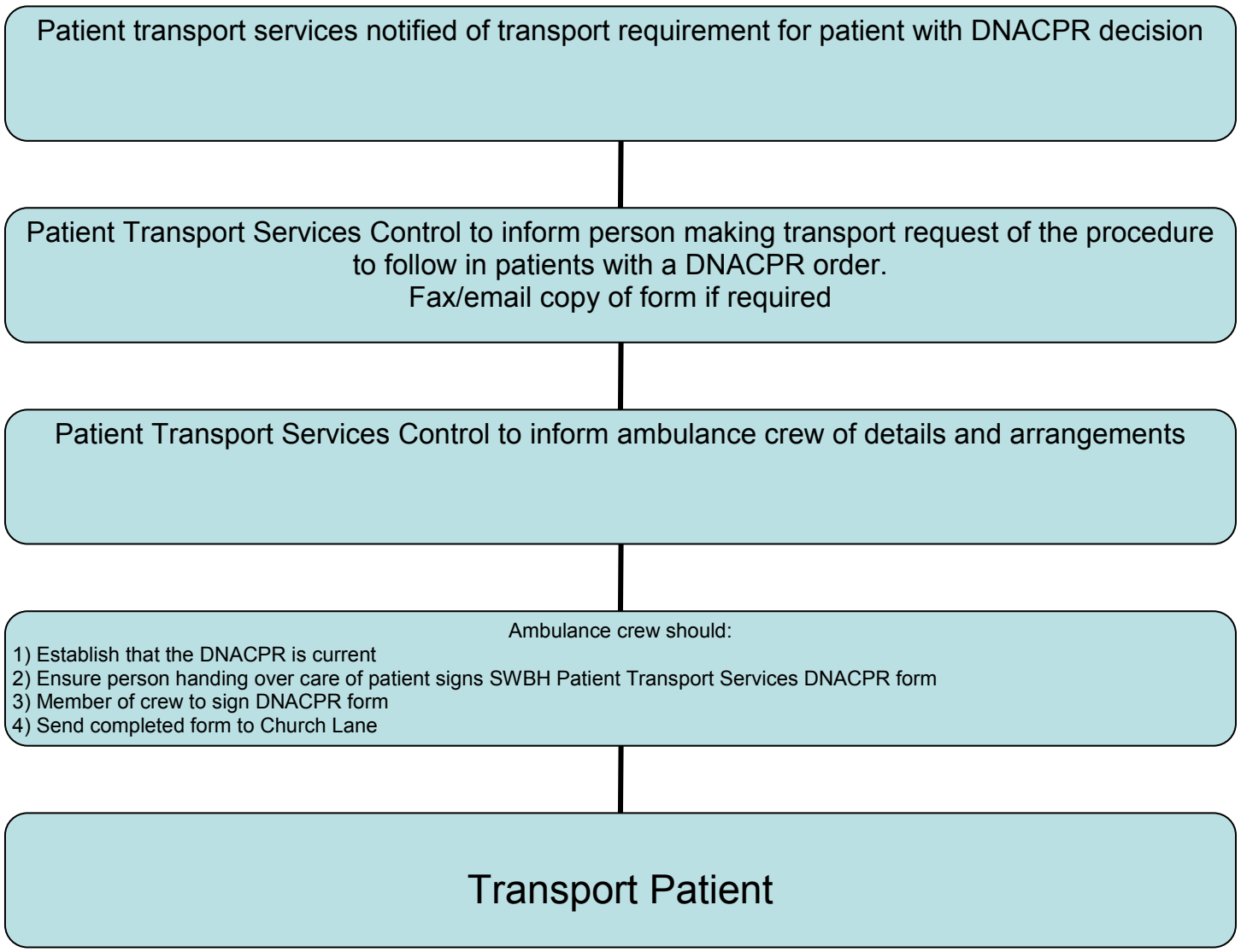
6.1 Patient Transport Services personnel should ensure that the fully completed DNACPR form is forwarded to the Patient Transport Services, Church Lane where the document will be stored for 12 years.

7.0 References

- SWBH/CLIN/052 Policy on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults.
- Decisions relating to cardiopulmonary resuscitation. A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, October 2007.
- Joint Royal Colleges Ambulance Liaison Committee. UK Ambulance Service Clinical Practice Guidelines. London: JRCALC, 2006.

Annex 1

Patient Transport Services DNACPR Flow Chart



Annex 2

Sandwell & West Birmingham Hospitals NHS Trust

SWBH Patient Transport Services DNACPR Form for Adults

In the event of the Sandwell & West Birmingham Hospitals NHS Trust Patient Transport Services receiving a request to transport a patient in possession of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Order the information below must be completed in full by the person handing over the patient into the care of the ambulance crew.

Patient Details – Patient label

Name:

Address

DOB:

Transport Details:
Job number: _____

Convey From:

_____

Convey To:

_____

1. Does the patient have a valid DNACPR order in place that is - applicable to the patient and - is signed and - not past the date of review?	YES	NO
2. Is the patient aware of the DNACPR order?	YES	NO
3. Are the patient's family / next of kin aware of the DNACPR order?	YES	NO

If during transportation the patient suffers a cardiopulmonary arrest where should the patient be transported to for certification purposes? **Note this cannot be the patient's Home Address.**

Nearest Emergency department	Other, please specify:
YES/NO	

Statement and Signatures

I confirm that a valid Do Not Attempt Cardiopulmonary Resuscitation order is in place in respect of this patient. The person making the DNACPR decision or their deputy agrees that the order applies whilst the patient is in the care of the ambulance crew.

It is understood that in the event of cardiopulmonary arrest whilst in the care of the Sandwell & West Birmingham Hospitals NHS Trust Ambulance Crew, the ambulance crew will abide by that order and will not commence cardiopulmonary resuscitation.

Person responsible for checking that the DNACPR order is current for this patient and handing over the patient to the ambulance crew:
Signed _____ Print Name _____ Designation _____ Date _____

Signed _____ Print Name _____ Date _____
Ambulance Crew

Sandwell and West Birmingham Hospitals NHS
NHS Trust

EQUALITY IMPACT ASSESSMENT FOR TRUST-WIDE POLICIES

POLICY TITLE:	DNA CPR Policy
ACCOUNTABLE DIRECTOR:	Medical Director
AUTHOR:	Chairman, Trust Resuscitation Committee
DATE:	5/10/09

1. 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.

2. 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.

CHECK	YES	NO
Will the proposed policy 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.		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 • If yes, please state reason and those likely to be affected.		X
Is there evidence to suggest that any part of the proposed policy could discriminate unlawfully, directly or indirectly? • If yes, please specify • If no, please explain		X
Is there any evidence that some people may have different expectations of the policy in question due to their race, gender, disability, sexuality, age, religion and language? • If yes, please specify • If no, please explain		X
Is the proposed policy 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 and those likely to be affected.		X

3. If any of the questions are answered ‘yes’ then the proposed policy is likely to be relevant to the Trust’s legal duties in relation to race, gender and disability. The author should consult with the Director of Human Resources to develop a more detailed assessment of the impact of the policy and, where appropriate, design monitoring and reporting systems.

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	DNA CPR Policy
ACCOUNTABLE DIRECTOR:	Medical Director
POLICY AUTHOR:	Chairman, Trust Resuscitation Committee
APPROVED BY:	Governance Board
DATE OF APPROVAL	9 October 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 and issues that may arise.*	Resuscitation Committee – no issues			
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 clinical staff affected – representatives of key groups are members of Resuscitation Committee.	Policy has been circulated to consultant body, matrons, heads of departments, divisional directors, divisional managers, nursing and medical directors.		
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.*	Communications department can help disseminate information.	PALS has been asked to comment on revised policy. Patients and relatives will be made aware of the policy as the need arises on a case by case basis.		
Communication • What are the key messages to communicate to the different stakeholders? • How will these messages be	Key issues: Staff training and communication with switchboard.	Staff to be notified by global email,.as part of staff comms Include in Hot Topics and article in Heartbeat.		

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.*		Relevant staff will be informed by email and policy will be available on Trust Intranet. Policy will also be included in the induction of new staff.		
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.*	On-going training by Resuscitation Officers – locally and nationally approved courses. Medical trainers required to teach on approved course need time allocated for this.			
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.*	No additional resource implications.			

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
Securing and sustaining change • Have the likely barriers to change and realistic ways to overcome them been identified? • Who needs to change and how do you plan to approach them? • Have arrangements been made with service managers to enable staff to attend briefing and training sessions? • Are arrangements in place to ensure the induction of new staff reflects the policy? *Initial barriers to implementation need to be addressed as well as those that may affect the on-going success of the policy.*	No significant changes – manage through consultation			
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.*	No main changes			
Other consideration •	None			

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Disciplinary Policy
SPONSORING DIRECTOR:	Lesley Barnett, Acting Director of Workforce
AUTHOR:	Nick Bellis, HR Manager
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The Disciplinary Policy is listed as one of the policies requiring Trust Board approval, according to the 'Policy for the Development, Approval and Management of Policies'.

The purpose of this policy is to ensure that a robust system is in place to investigate and hear allegations of misconduct as swiftly as possible and to provide guidelines to managers of the procedure to be undertaken when suspending and when disciplining staff following a Disciplinary Hearing.

Main revisions to the previous policy procedure include:

- Guidelines as to the involvement of appropriate senior members of the Nursing Division in the Disciplinary process.
- Guidelines to Managers in referring staff members to the Independent Safeguarding authority in connection with procedures or outcomes outlined in this policy.

Details of Disciplinary activity will be reported quarterly to the Trust Management Board.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

It is requested that the Board approves this policy

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Staff side consultation has been completed at JCNC (November 09). PPAC consultation was sought prior to this.

Approval by Trust Management Board on 17 November 2009.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Disciplinary Policy

PROFILE	
REFERENCE NUMBER:	HR/003
VERSION:	3
STATUS:	
ACCOUNTABLE DIRECTOR:	Director of Workforce
AUTHOR:	Nick Bellis, Human Resources Manager
DATE OF LAST REVIEW/ ORIGIN DATE:	October 2007
DATE OF THIS REVIEW:	October 2009
APPROVED BY:	Trust Board
DATE OF APPROVAL	
IMPLEMENTATION DATE:	
DATE NEXT REVIEW DUE:	
REVIEW BODY:	Trust Board
CATEGORISATION:	Human Resources
DATE OF EQUALITY IMPACT ASSESSMENT:	
APPLICATION:	Trust wide
PRINCIPAL TARGET AUDIENCE:	All Trust Employees
ASSOCIATED TRUST DOCUMENTS:	Investigations Guidelines, Disciplinary Procedure for Medical Staff

Disciplinary Policy

CONTENTS

1. Introduction

1.1 Trust policies and procedures, supported by a Disciplinary Policy, help to promote orderly employment relations as well as fairness and consistency in the treatment of individuals.

1.2 The Disciplinary Policy sets down standards of behaviour required of Trust employees and the potential consequences of failing to observe these standards. If an employee breaks specific rules about behaviour, this is often called misconduct.

1.3 The disciplinary procedure contained within this document should be followed to manage situations where employees allegedly break disciplinary rules.

2. Objectives

2.1 The purpose of this policy is to provide the framework whereby all employees are supported and encouraged to achieve and maintain standards of conduct, attendance and job performance which are acceptable to the Trust. The policy is designed to ensure consistent, equitable, and fair treatment for all employees.

2.2 Before deciding on how to manage a problem of poor performance or misconduct by an employee, and whether the use of this disciplinary policy is appropriate, all managers are required to seek advice from the HR Department and to consider the following as appropriate:

- Guidance Notes on Counselling HR/035
- Investigatory Guidance Notes HR/001
- Capability Policy HR/030
- Procedure for Managing Sickness Absence HR/028
- Policy on the Misuse of Alcohol, Drugs and Other Substances by Employees H & S/001
- Dignity at Work

2.3 This policy should only be followed if the issue of concern is deemed to fall under the category of ‘misconduct’ or poor performance, examples of which are provided within this policy, given all the facts available at the time.

3. Scope

This policy covers all staff employed within the Trust with the exception of issues relating to professional misconduct for medical staff which are dealt with in the Disciplinary Procedure for Medical Staff (HR/052).

4. Definitions

4.1 **Gross Misconduct** - The type of misconduct that is so serious a breach of an employee's contractual obligations as to warrant summary dismissal (i.e. dismissal without notice).

4.2 **Sanction –** A level of disciplinary warning issued by a disciplinary panel.

4.3 **Suspension - An** arrangement whereby the employee is suspended from their duties but where the employment relationship continues, pending an investigation/outcome of disciplinary procedure.

5. Roles and responsibilities

5.1 Trust Board

Ensure the effective implementation of this policy.

5.2 Director of Workforce

Executive lead responsibility for ensuring that the policy is implemented appropriately and that disciplinary and appeals outcomes are monitored to ensure that there is no undue bias in accordance with the Trust's Equal Opportunities Policy. Monitor disciplinary outcomes to ensure a consistent and fair approach

5.3 Executive Director/Divisional General Manager

a) Ensure that the policy requirements are observed within their area of responsibility.
b
b) Ensure that line managers receive any appropriate training deemed necessary to discharge their responsibilities under this policy appropriately.

5.4 Line Managers

a) To participate in any Trust training deemed appropriate to ensure that they have the necessary skills to undertake their responsibilities appropriately.
b) Ensure that their staff are made aware of the policy requirements and the standards required of them by the Trust.
c) Ensure systems are in place to minimise the need for the use of this policy, e.g. effective communication, partnership working, compliance with Personal Development Review Policy, Counselling Policy.

5.5 Workforce Directorate - Learning & Development Department

a) To ensure that line managers receive appropriate training to equip them to discharge their responsibilities appropriately.

5.6 Workforce Directorate - Human Resources Department

a) Provide appropriate support and guidance to line managers when dealing with disciplinary matters.
b) Monitoring and reviewing disciplinary and appeal outcomes to ensure there is no discrimination or bias.

6. Principles

6.1 Disciplinary action will not be taken against an employee until the issue(s) of concern has been investigated.

6.2 At all stages of the disciplinary and appeals process the employee will have the right to be represented by an accredited Professional/Trade Union representative or workplace colleague.

6.3 The employee, against whom concerns/allegations have been raised, will be advised of the nature of the complaint and will be given the opportunity to state their case before any decision is made.

6.4 No employee will be dismissed for a first breach of discipline except in the case of gross misconduct or where there has been an irretrievable breakdown in trust and confidence when the penalty shall be summary dismissal, which will be without pay in lieu of notice.

6.5 An employee will have the right of appeal against any disciplinary penalty imposed.

6.6 No disciplinary action or decision to suspend an employee will be taken against a Professional/Trade union Representative until the matter has been discussed with a full time official.

6.7 Advice from the Human Resources Department on the application of this policy will be available to ensure fairness and consistency. When managing issues that may lead to disciplinary action, managers must seek Human Resources advice at the earliest opportunity.

6.8 A written copy of the confirmation of a disciplinary sanction given to an employee will be held on their personal file for the length of the warning and at the end of the warning period the written record will be removed from the individual's personal file.

6.9 Employees are required to take all reasonable steps to attend a disciplinary hearing. In the event that they are required to take sick leave during the application of this policy then any disciplinary meetings/hearings will only be delayed and the delay shall only be for a reasonable period of time, if the Trust's Occupational Health Physician advises that should an employee attend it will be detrimental to their health.

7. Suspension

7.1 Suspension is not in itself a disciplinary measure but an arrangement whereby the employee is suspended from their duties with the employment relationship continuing, pending an investigation/outcome of disciplinary procedure. Any decision to suspend must not be taken lightly and must be discussed with the Director of Workforce (or their nominated deputy) or if taking place out of hours with the Executive lead on-call, before a decision to suspend is taken. A decision to suspend Nursing staff should also be discussed with the Chief Nurse (or their nominated deputy).

7.2 Before a final decision is taken, alternative options to suspension, for example, suitable temporary redeployment or a change of working hours to allow for increased levels of supervision, should have been considered by the relevant manager. If an alternative option is considered appropriate the proposed arrangements should be approved with the Human Resources Department.

7.3 Suspension will normally be with full pay. Suspension without pay will be considered in circumstances when the Trust has established a reasonable belief that the employee is precluded from lawfully fulfilling the terms of their employment contract.

7.4 Prior to a decision to suspend without pay, advice must be sought from the Director of Workforce and the employee must be offered the opportunity of a meeting with the manager responsible for the suspension to discuss the reasons for suspension without pay and to raise any issues that they consider to be relevant.

7.5 The employee is entitled to appeal against the decision to suspend without pay, by registering a request in writing to the Director of Workforce within ten working days of the above meeting.

7.6 If suspension of a medical employee is considered (referred to as exclusion) then the guidelines set out in the Department of Health document, 'Maintaining High Professional Standards in the Modern NHS' and 'Disciplinary Procedures for Medical Staff (HR/052) must be observed.

7.7 Circumstances in which suspension may apply will include:

a) Where the alleged offence is thought to be in the nature of gross misconduct (see section 13);

b) Where the employee's presence constitutes a serious risk to themselves, patients other employees or property of the Trust;

c) Where the employee is under charge or suspicion of a criminal offence that significantly affects their status, role or responsibilities within the Trust;

d) Where the employee's presence would preclude a full and proper investigation from taking place; or

e) Where it is considered necessary to defuse a particular situation.

7.8 A decision to suspend an employee should be confirmed in writing within three working days and should specify the exact nature of the alleged offence, the reason for suspension, the name of the investigating manager and the conditions under which the suspension shall continue.

7.9 The employee will also be informed that they must leave the Trust's premises and not return without prior approval, or at the direct request of management.

7.10 Suspended employees may visit the Trust for hospital treatment, as a visitor to patients, to attend an appointment with the Occupational Health Department or to attend a planned meeting with their Professional/Trade Union Representative.

7.11 Any breach of these conditions may, in themselves, constitute a disciplinary offence. During the period of suspension the employee must be available during normal working hours. Employees must advise their manager of their whereabouts if they cannot be contacted at their home address or on their home telephone number.

7.12 During periods of suspension, an investigation will be conducted with the utmost urgency.

7.13 During a period of suspension an employee may request to take annual leave in accordance with normal procedures. If the period of suspension coincides with the employee's planned annual leave arrangements; permission to take leave should be mutually agreed. This forms part of the employee's annual leave entitlement. Where an employee is suspended the usual provisions regarding carry over of annual leave will apply.

8. Investigation

It is important that the principles of natural justice are adhered to with regard to the disciplinary policy. Disciplinary action will therefore not be taken until an investigation has been completed and the appropriate manager has determined that there is a case to answer requiring a formal disciplinary hearing to be convened. Trust Investigatory Guidelines, HR/001 should be observed.

9. Disciplinary Hearing

9.1 The employee must confirm the name of the representative that has been selected to represent them at a hearing at least five days prior to the date that has been set.

9.2 It the employee's representative cannot attend on the proposed date, the employee may suggest an alternative date that must suit everyone involved and must not be more than five working days after the original date.

9.3 If all reasonable attempts to ensure the employee's attendance at the disciplinary hearing have been exhausted, the case may be heard in the employee's absence, with the employee having an opportunity to forward written representations.

9.4 The employee and their representative will be given at least five working days written notice of the date and time of the hearing. The letter confirming the arrangements should include:

a) the precise nature of the allegation(s);
b) copies of all written documentation relevant to the issues at the hearing;
c) the date, time and venue of the hearing;
d) the name and designation of the manager who will conduct the hearing;
e) the name, designation and role of the management representatives;
f) the possible sanction (up to and including dismissal) if the outcome of the hearing is that the allegations are established; and
g) the name of any witnesses that may be called and copies of the witness statements that form part of the management case.

9.5 The Chair of the panel shall determine, with advice from the Human Resources Department, the constitution of the panel at the Disciplinary Hearing taking into account the case that is to be heard and any circumstances that may require expert or external input. The minimum number of panel members should be two and at least one of the panel members should be a member of the Human Resources Department. If the case involves a member of the Nursing profession then a senior member of the Nursing Division or a nominated Matron should form part of the panel.

9.6 The employee and their representative are required to supply the management representative with copies of all documents and any other evidence they intend to rely upon at the hearing at least two working days (or other mutually agreed date) prior to the hearing.

9.7 The hearing should be conducted in accordance with Appendix 1, and in such a way that all present have the opportunity to say what they wish to say, raise any questions and receive a response to issues that they consider to be appropriate.

9.8 The employee representative has a legal right to address the hearing, but does not have the right to answer questions on the behalf of the employee.

9.9 The disciplinary hearing will concern itself with whatever sanction, if any, should be applied, taking into account all evidence presented and any plea in mitigation.

9.10 The outcome of a disciplinary hearing will be confirmed in writing as soon as practically possible and must be within five working days of the hearing unless an alternative date is mutually agreed. If practically possible panels should also aim to confirm the disciplinary outcome verbally at the conclusion of the hearing.

9.11 The letter confirming a disciplinary sanction should include the following:

First and Final Warnings

a) The precise nature of the poor performance;
b) The level of improvement required;
c) The time limit for achieving the improvements;
d) Review periods during the time period of the warning;
e) The consequences of failure to achieve or maintain improvements (in particular, that any repetition of the misconduct or similar, within the specified timescale could lead to the next level of warning);
f) Confirmation that any repetition of the misconduct or further misconduct on related issues, within the specified timescale could lead to dismissal;
g) Confirmation of the length of the disciplinary warning and that a copy will be maintained on the employees personal file throughout this period; and
h) Procedure for appeal against the decision.

Dismissal

a) Reasons for the decision;
b) The date the contract of employment is to be terminated;
c) Whether the dismissal is considered to be gross misconduct; and
d) Procedure for appeal against the decision.

9.12 It is important in the interests of both the employee and the Trust that written records are maintained during the disciplinary process. Records should include, as appropriate:-

a) Details of the complaint against the employee;
b) The employee's defence;
c) Findings made and action(s) taken;
d) The reason for the action(s) taken;
e) Whether an appeal was lodged;
f) The outcome of the appeal;

10. Witness Evidence

10.1 In normal circumstances, witnesses whose statements are put forward as part of a disciplinary case will be expected to attend disciplinary hearings to provide evidence, unless:

a) there is an agreement by both parties that the witness will not be required to attend the disciplinary hearing;
b) the witness is too ill to attend the disciplinary hearing;
c) the statement is provided by a patient or a member of the public and cannot be required to attend the hearing, and who has failed to agree to attend voluntarily.

10.2 Witness statements submitted as evidence to either a disciplinary or appeal hearing should be dated and signed.

11. Grievances

11.1 If a grievance is lodged relating to an on-going disciplinary matter, advice on the most appropriate course of action should be requested from the Department of Human Resources.

11.2 Normally a grievance related to a current matter should be addressed during the course of a disciplinary hearing or appeal and should not be subject to separate Trust Grievance procedures.

11.3 If the grievance relates to matters of potential discrimination, it may be appropriate for the disciplinary or appeal panel to consider the grievance at a separate hearing either immediately before a disciplinary/appeal hearing or if more convenient at a meeting scheduled prior to the disciplinary or appeal hearing.

11.4 If at any stage during the course of a disciplinary process, an employee raises a grievance that is related to the matter, the chair of the panel, following advice from the Department of Human Resources, may consider suspending the disciplinary procedure for a short period while the grievance is dealt with in accordance with the Trust Grievance Procedure, HR/007. Notwithstanding this, it may also be appropriate to hear the grievance after a disciplinary or appeal hearing has taken place.

12. Sanctions

12.1 Before making a decision on a disciplinary sanction after having considered whether the allegations are proven, the disciplinary panel must take account of the employee's disciplinary and general record, actions taken in any previous similar cases within the Trust, the explanations given by the employee and **most importantly,** whether the intended disciplinary action is reasonable under the circumstances presented to them.

12.2 The following sanctions may be implemented at any stage if the employee's misconduct warrants such action.

12.3 Where multiple allegations have been made against an employee, the panel should confirm the allegation(s) that have been upheld and have contributed to a decision to award a disciplinary sanction.

12.4 First Written Warning

If conduct or performance does not meet acceptable standards the employee will normally be given a formal First Written Warning.

12.5 Final Written Warning

If the offence is serious or if a further misconduct offence occurs, or if there is no improvement or insufficient improvement or it is not maintained the employee should be given a Final Written Warning.

12.6 Dismissal

If there is still a failure to make improvements or sufficient improvement is not made, or the improvement is not maintained or further matters of misconduct occur, the employee will normally be dismissed with pay in lieu of notice. In cases of Gross Misconduct see Section 13.

12.7 Alternative to dismissal

In exceptional circumstances, on occasions where a serious offence has been committed which might justify dismissal, a disciplining manager may decide that it is more appropriate to offer the employee an alternative post in lieu of dismissal.

The terms and conditions relevant to the alternative post will apply and the employee will not be entitled to any protection of pay or existing terms of conditions of employment under any Trust policy or procedure. Any such offer of employment must be voluntarily accepted by the employee.

A final written warning will accompany the offer of alternative employment. If the offer of alternative employment coupled with a final written warning is rejected, the employee shall be dismissed. The employee shall have a period of 5 days in which to accept this offer, which period may only be extended by the employer.

12.8 Length of Warnings

First Written Warning – nine months.

Final Written Warning – eighteen months.

13. Gross Misconduct

13.1 Acts that constitute gross misconduct are those resulting in a serious breach of contractual terms that warrant summary dismissal, i.e. dismissal without notice. The following are examples of gross misconduct (this list is not exhaustive):

a) Theft or unauthorised possession of any property belonging to the Trust, patient, member of the public or other employee;
b) Deliberate damage to or misuse of Trust property;
c) Falsification of a qualification;
d) Fraud, including falsification of reports, accounts, expense claims or self-certification forms, or appointment documentation;
e) Deliberate failure to declare all cautions and convictions on self declaration and CRB Declaration forms as part of the Recruitment and Selection Process (including those deemed as spent under the Rehabilitation of Offenders Act for

those employees caught within these provisions, where their convictions are not treated as spent);

f) Refusal to carry out duties as defined within the employee's contract of employment or failure to follow reasonable instructions;
g) Serious incapability whilst on duty due to the use of alcohol or drugs;
h) In the possession, custody or control of illegal drugs on Trust premises;
i) Serious breach of Trust policy;
j) Violent, dangerous or intimidatory conduct;
k) Sexual, racial or disability discrimination or other harassment of a fellow employee, visitor or patient;
l) Gross negligence;
m) Conviction on a criminal charge, where the conduct is relevant to the employee's employment;
n) Conduct that brings the Trust's name into disrepute and where working relationships have broken down irretrievably;
o) Serious act of insubordination;
p) Physical violence;
q) Serious breach of the Dignity at Work Policy;
r) Serious infringement of Health and Safety regulations & rules;
s) Serious misuse of the internet or computer, including the deliberate access of internet sites containing pornographic, offensive or obscene material;
t) Failure to comply with security/confidentiality requirements in respect to the use of NHS SMART cards;
u) Sexual misconduct at work;
v) Serious breach of confidentiality; or
w) Misuse of the Trust's property or name.

13.2 If gross misconduct is established it shall result in summary dismissal, which will be without pay in lieu of notice.

13.3 In circumstances where it is established that there has been an irretrievable breakdown of the relationship of trust and confidence, the Trust shall also summarily dismiss, without pay in lieu of notice.

14. Authority to Dismiss

14.1 The authority to dismiss an employee rests with the Divisional Director/Deputy Divisional Director, Trust Board Director or Divisional General Manager. An employee may not however be dismissed by a manager to whom they are directly responsible.

14.2 Employees appointed by a sub-committee of the Trust Board may only be dismissed by a sub-committee of the Trust Board.

15. Appeals

15.1 The opportunity to appeal against a disciplinary decision is essential to natural justice. However, it is important to set grounds under which an appeal will be heard, these are:

a) The failure to follow policy;
b) The decision reached was not reasonable in all circumstances; or
c) New evidence coming to light.

15.2 To lodge an appeal the employee must write to the Director of Workforce confirming the grounds of the appeal, within ten working days of the receipt of the written confirmation of the disciplinary decision.

15.3 Appeals will be heard by the following levels of management accompanied by a member of the Human Resources Department:

a) First Written Warning

The senior manager next in line to the disciplining manager (must be as a minimum Band 7 or equivalent).

b) Final Written Warning

The Divisional General Manager, Divisional Director or Deputy Divisional Director

c) Dismissal

The Chief Executive or nominated Executive Director or Non-Executive Director

d) A sub-committee of the Trust's Remuneration Committee will hear an appeal by an Executive Director

15.4 When the employee lodging an appeal is a doctor, a Medical Director or nominated deputy will form part of the appeal panel.

15.5 All reasonable steps will be taken to ensure that an Appeal Hearing is normally heard within two months of the appeal being lodged.

15.6 The employee and their representative will be given at least five working days written notice of the date and time of the hearing and will be expected to take all reasonable steps to attend.

15.7 It the employee representative cannot attend on the proposed date, the employee may suggest an alternative date that must suit everyone involved and must not be more than five working days after the original date.

15.8 Appeal cases of both the employee and management, must be submitted to the nominated manager responsible for organising the appeal by the date provided. Cases will then be exchanged and copies sent to all parties involved in the appeal on the same date.

15.9 An Appeal Panel will have the authority to uphold, dismiss, or reduce the original disciplinary decision.

15.10 The outcome of an appeal hearing will be confirmed in writing within five working days of the hearing.

15.11 The decision of an Appeal Panel will be final.

16. Disciplinary Files

Following the conclusion of the disciplinary and appeals process or related files and documents should be returned to the Department of Human Resources.

17. Duty to Refer Information to the Independent Safeguarding Authority

17.1 From 12th October 2009, there will be a duty on the Trust to refer individuals to the ISA for consideration for barring in relevant circumstances and to provide information to the ISA upon request.

17.2 The duty to refer will apply in the following circumstances:

- In the event the Trust withdraws permission for an individual to continue to carry out a regulated activity, or if the individual has left while under investigation and there is concern that the individual has harmed or poses a risk of harm to a child or vulnerable adult.

Failure to provide information to the ISA is a criminal offence.

17.3 The Trust may also refer individuals to the ISA if they are concerned about their conduct and considers the ISA ought to be aware of it. In these circumstances advice should be sought from the Director of Workforce and relevant executive lead as given in section 13.4.

17.4 Normal investigatory/disciplinary procedures should be undertaken and pursued as far as possible, and all relevant information from these procedures sent to the ISA with the referral.

17.5 Referral decisions should be taken by the executive leads detailed below. Referrals should be made using the ISA referral form with is available from the following webpage (www.isa.homeoffice.gov.uk).

Medical staff – Trust Medical Director
Nursing and Therapy Staff – Chief Nurse
All other staff groups – Director of Workforce

18. 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 a Single Equality Policy Scheme to reflect this. All policies are assessed in accordance with the Equality initial screening toolkit, the results for which are monitored centrally.

19. Review

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

20. Training and awareness

Training and awareness on the application of this policy will be provided by the Human Resources Department.

21. Monitoring

All disciplinary outcomes will be recorded on the Trust's centralised workforce information system and annual monitoring reports will be prepared to ensure that the policy is being applied fairly and consistently and is not adversely affecting any particular staff in accordance with the Trust's Equal Opportunities Policy.

22. References

ACAS Code of Practice
DTI guidance

23. Appendices

Appendix 1 - Disciplinary and Appeal Hearing Process

24. Further Enquiries

For further information on the application of this policy, please contact the Human Resources Department.

Appendix 1

DISCIPLINARY PROCESS

1. Hearings will be chaired, however all panel members will be given the opportunity at the appropriate time to ask any questions they consider relevant.

Hearings will follow the order set out below: -

2. The management side to state their case and accept questions of fact or detail from the employee or employee representative, and from the Panel.

3. Management case witnesses may be called. Witnesses to first take questions from the management side, followed by the employee or employee representative and lastly the panel.

4. The management side to re-examine their witnesses if necessary.

5. The employee or employee representative to state their case and accept questions of fact or detail from the management side and from the Panel.

6. Employee case witnesses may be called. Witnesses to first take questions from the employee or employee representative followed by the management side and lastly the panel.

7. The employee or employee representative to re-examine their witnesses if necessary.

8. The management side to present their summary of case.

9. The employee or employee representative to present their summary of case.

10. Brief adjournments at the request of any party will be allowed at the discretion of the Chair.

11. The Panel may ask questions or request points of clarification at any time.

12. Both management side and employee or employee representative may be asked to elucidate or amplify any statement made.

13. Employee Representatives and management representatives may be questioned.

14. If information, additional to that supplied in the written submissions, is presented at the hearing then either side might seek an adjournment. The Panel may adjourn the hearing to allow further investigation to be conducted.

15. The Panel will deliberate in private and will only recall both parties to clarify points of uncertainty on evidence already presented. If recall is necessary then both parties will be recalled notwithstanding only one is concerned with the issue.

16. The outcome of the hearing will be confirmed in writing within five working days of the hearing and where possible the outcome will be communicated at the end of the hearing.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Initial Equalities Screening Checklist

POLICY TITLE/SERVICE:	Disciplinary Policy
ACCOUNTABLE DIRECTOR:	Director of Workforce
MANAGER RESPONSIBLE FOR COMPLETION:	Nick Bellis, Human Resources Manager
DATE:	November 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?

The purpose of this policy is to provide the framework whereby all employees are supported and encouraged to achieve and maintain standards of conduct, attendance and job performance which are acceptable to the Trust. The policy is designed to ensure consistent, equitable, and fair treatment for all employees.

How will the outcomes be measured?

The details of all disciplinary outcomes will be recorded on ESR and monitored annually.

Who are the key stakeholders?

All staff and line managers.

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 The policy is designed to clearly set out the responsibilities of managers when dealing with matters that require a disciplinary hearing. The HR Department is responsible for overseeing the process and for the provision of training, to ensure fair and consistent application of the procedures contained within the policy. If the policy is applied as intended there should not be any unlawful discrimination occurring as a consequence.		✓

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 Standards of behaviour required of Trust employees are set out within the Trust's Employment Charter and Code of Conduct for Managers and Supervisors and general HR policies. This information is communicated to staff through induction and management training activities. By communicating clearly the Trust's expectations with regard to standards of behaviour, the scope for staff to have differing expectations should be minimised.		✓
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:	Disciplinary Policy
ACCOUNTABLE DIRECTOR:	Director of Workforce
POLICY AUTHOR:	Nick Bellis, 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 a new policy has been introduced that is substantially different to the previous version. This key message needs to be communicated to all Trust managers and all staff responsible for training managers.	Communication timescale to be developed in line with date for Trust Board approval.	HR Manager	From date of Trust Board approval (proposed November 2009)
Engaging staff • Who is affected directly or indirectly by the policy? • Are the most influential staff involved in the implementation? Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made.	This policy applies to all Trust employees. The senior managers within the Trust will be invited to comment on the revised draft of the policy, prior to its submission to the Trust's JCNC.	Consultation has taken place with the following: - Staff Side, via: - PPAC and JCNC Executive Directors, Divisional Directors, DGM's	HR Manager	 PPAC October 2009 JCNC November 2009 October 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	N/A	HR MANAGER	
Communication • What are the key messages to communicate to the different	• That the policy has been amended and is now	Team Brief Policy to be placed on Intranet.	HR Manager	To coincide with Trust Board Approval

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
stakeholders? • 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.*	substantially different to the current version. • Itemise some key areas of change. • Up to date information is available on the intranet or directly from the HR Department. Proposed to communicate the above via team brief and by use of HR intranet site.	Learning and Development Department to be fully informed of all key changes and implications to training provision. Heartbeat article to explain key changes to all staff within the Trust.		(proposed date is November 2009)
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.*	All line managers need to be aware that the policy has been changed and where to access information in the event that they have to deal with a matter that may necessitate using the disciplinary policy. All specific Trust training on disciplinary matters to be amended to bring into line with the new arrangements.	Provision of on-going training programmes and Divisional support via the Learning and Development and HR Department.	Human Resources Manager	From November 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.*	The new policy has been designed to streamline the disciplinary process to ensure effective action is taken more promptly than is our current practice. It is therefore anticipated that the new arrangements will support improvements in staff productivity within the organisation.	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.*	• Managers will need to be trained to manage disciplinary processes using the new policy. Advice and support will be available from the HR Department alongside on-going training provision from Learning and Development.	Learning and Development team fully briefed on new policy requirements. HR team fully understand the implications and requirements of the new policy and process. The staff side have been engaged with the policy development during the consultation process.	Human Resources Manager	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.*	Improvements in timescales to manage a disciplinary process due to reduced stages. All disciplinary outcomes are monitored by the HR Department on an annual basis.	Develop improved monitoring arrangements via the use of ESR.	Human Resources Manager	October 2009 onwards
Other consideration •				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	NHS West Midlands - The Shared Narrative
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	NHS West Midlands with constituent organisations
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The attached 'Shared Narrative' has been developed collectively by NHS organisations across the West Midlands. It is an attempt to set out a set of principles and behaviours which will govern the way in which those organisations respond to the more difficult economic climate that we will all face over the next few years.

The content of the statement is consistent with the principles and objectives agreed by the 'Right Care, Right Here' Partnership over the summer. It also closely reflects the thinking behind the Trust's own Quality and Efficiency Programme.

The SHA has requested that all organisations formally endorse the statement. A 'plain English' version is also being prepared.

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 formally endorse the Shared Narrative.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Previously discussed at SHA events attended by Trust representatives.

NHS West Midlands

Improving the Quality and Value for Money of Healthcare in the West Midlands – meeting the economic challenge together

When we understand *value* in terms of maximising health and quality of healthcare for every £1 spent, then achieving best *value* from NHS resources is an enduring shared goal for all who work in the NHS. This statement will explain the current challenge that the whole NHS faces in terms of ensuring value for money that is affordable and how we will respond to that across the West Midlands.

The NHS in the West Midlands now receives 45% more funding in real terms than it did 5 years ago and the average level of spend per head is now comparable to other European countries. It should come as no surprise that the current recession also means that our country will be unable to afford to sustain significant growth in public expenditure for some years to come. If we simply keep on doing things the way we do them now then changes in the population and changes in technology will rapidly outrun what we can afford. Like every successful organisation in the world we have to continually develop and change the ways we work to both improve our services and live within our means. That challenge has now become much greater.

The responsibility of all of us in the NHS is to demonstrate that we achieve best *value* for the level of resource our society entrusts to us to commission and provide their health services. This includes helping the public to be responsible in how they use NHS resources. We will succeed if striving for best *value* as defined above is our core purpose rather than a short-term expedient or project.

NHS leaders in the West Midlands have jointly agreed to the following propositions in responding to the challenges of the new economic reality:

- Improving the quality and safety of services and care systems is the best way to optimise our use of resources – "getting it right first time"

- "First , do no harm" is a binding principle and that reducing and avoiding errors (improved reliability) and stopping interventions of no clinical value are essential priorities both for the impact on people and better *value*

- We can only really improve *value* if we are prepared to think and act across whole systems (health and social care) and work in partnership to respond to that.

- Equitable services are also better *value* services - the drive to reduce health inequalities within our communities and to assist all to focus on opportunities for prevention is central to delivering best *value*

- "Prevention is better than cure" and our shared objective must be to prevent ill health or to identify health needs early and minimise their impact

NHS West Midlands

- There are indeed major gains to be made from radical transformation of our clinical systems but there are potential obstacles to doing this including the primary/secondary care divide, professional boundaries and alignment of some incentives - we must tackle these

- We need to make it easy 'to do the right thing' on the frontline – clinicians and teams, learning from their patients and their carers, usually know where the best opportunities are for improving the quality of care and removing waste in the care system. We must encourage their ideas and innovation to be liberated.

- The order of priorities are always: - what is right for the patient; what is right for the public interest; what is right for organisations...in that order.

It follows that if we are to deliver the whole system change we need, we will have to adopt a radically different approach. For example, we know that top-down targets and 'command and control' will not inspire joint-working and innovation. We are committed to:

- Strengthening clinical leadership to deliver radical improvement across care systems.

- Working in partnership across organisations to improve whole care pathways and not just parts of them.

- Embracing commissioning for outcomes rather than for just throughput.

- Sharing knowledge of how what we do compares with others; sharing information and giving feedback on how new approaches to delivery of care are working; being open to learning from others.

- Us all backing ideas which collectively pass tests of best *value* and driving rapid adoption of the best ideas on a collaborative, large scale basis

- Aligning incentives to support improvements to the whole system, changing the old 'rules' where they are really getting in the way of achieving best *value.*

- Avoiding behaviours and actions which simply pass the problem from one institution to another.

- Having the courage to advocate together for doing what is right even when it risks being unpopular.

- Making changes to capacity in different parts of the system when we have agreed to new pathways of care (and supporting each other in doing that) – we know that not doing that will undermine the shared effort to improve *value*.

- Acting together to develop and support our workforce to deliver the new ways of working.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated incidents, complaints and claims report Q2 2009/10
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Ruth Gibson, Head of Risk Management Debbie Dunn, Head of Complaints and Litigation Dalvinder Masaun, Head of Health and Safety
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

This report sets out details of incident, complaint and claims trends up to Q2 2009/10.

Summary of Quarter 2 Incident Data

- There were 1827 reported incidents (1867 in Q2 2008/9).
- Reported clinical incidents rose from 1454 in Q1 2008/9 to 1458 in Q2 2009/10.
- Reported health & safety incidents fell from 413 in Q1 2008/9 to 369 in Q2 2009/10.
- There were 37 incident forms received relating to red incidents (2.0% of the total), compared with 34 in Q2 2008/9 (1.8% of the total).

Summary of Quarter 2 Complaints Data

- The Trust received 216 formal complaints, compared with 226 in the same quarter in 2008/09.
- The deadlines for 35% (75) of complaints were re-negotiated. In total there were 107 date changes.
- 0.9% of complaints were graded as red.

Summary of Quarter 2 Claims Data

- 25 clinical negligence and 16 personal injury new claims were received during Q2.
- The Trust has 252 open clinical negligence claims and 91 open personal injury claims.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality of care
Annual priorities	
NHS LA standards	Standard 5 'Learning from Experience'
Core Standards	SfBH Core Standard C1a
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Usual quarterly report. A more detailed report was considered by the Governance and Risk Management Committee on 19 November 2009

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

Integrated Risk, Complaints and Claims Report: Quarter 2 2009/10

1. Overview

This report highlights key risk activity including:

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

2. Introduction

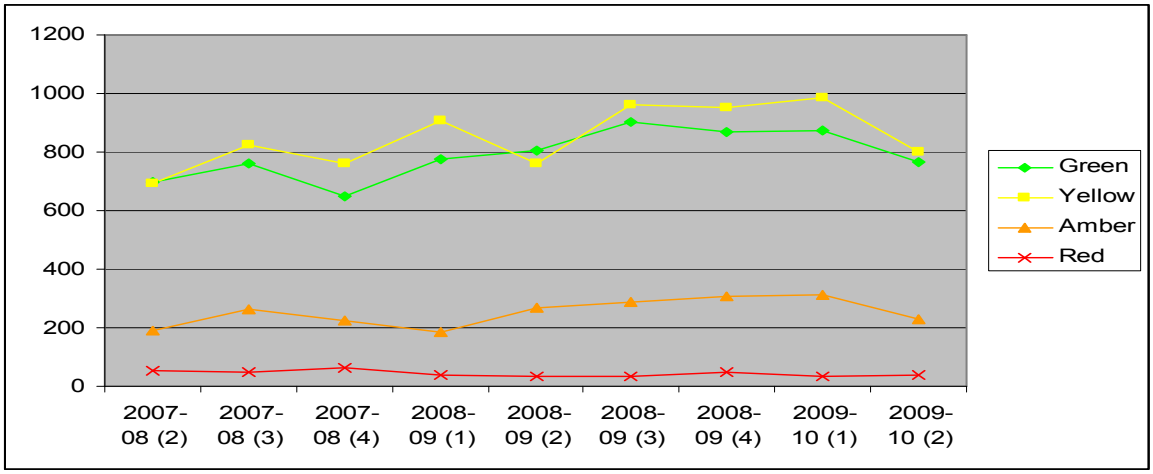
This report combines previous quarterly reports on incident/risk, complaints and claims to implement the Policy for the Investigation, Analysis and Learning of Lessons from Adverse Events and meet NHS Litigation Authority assessment requirements. Where possible, comparisons across these areas of activity will be made to try to identify common trends and actions. More detailed data is considered at Governance Board and the Governance and Risk Management Committee.

3. Key Issues

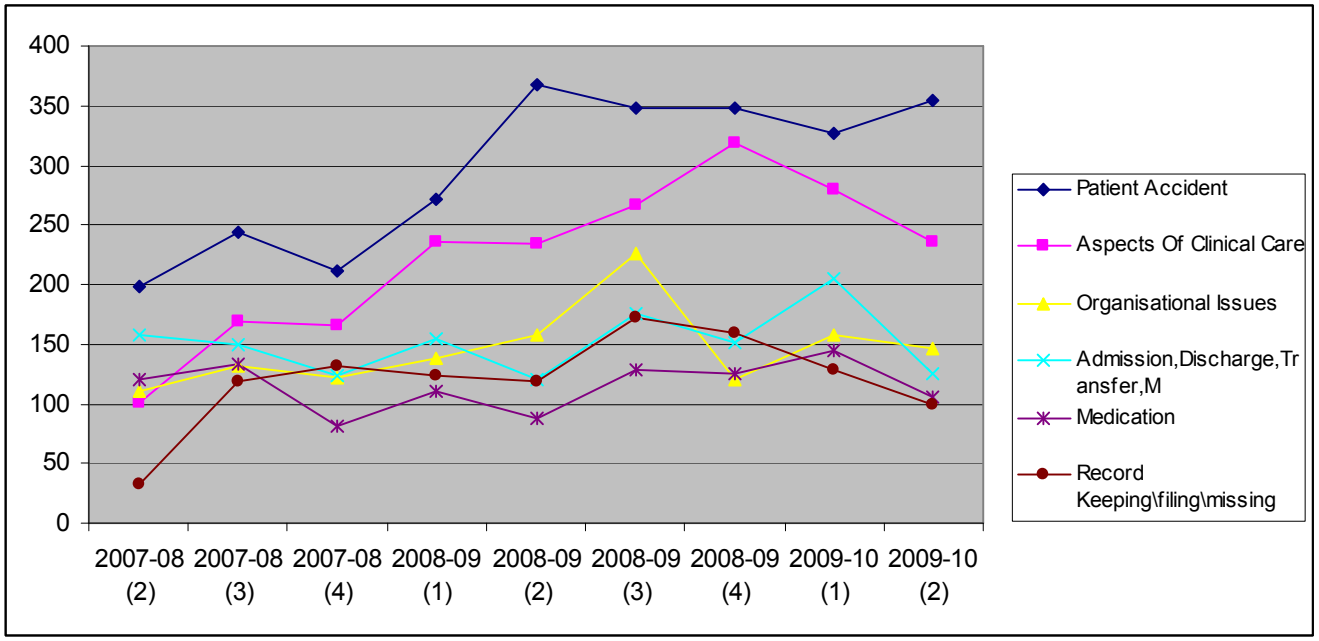
3.1 Review of Quarter 2 Incident Data

- There were 1827 reported incidents (1867 in Q2 2008/9).
- Reported clinical incidents rose from 1454 in Q1 2008/9 to 1458 in Q2 2009/10.
- Reported health & safety incidents fell from 413 in Q1 2008/9 to 369 in Q2 2009/10.
- There were 37 incident forms received relating to red incidents (2.0% of the total), compared with 34 in Q2 2008/9 (1.8% of the total).

Graph 1 - Incident Trends by risk score 1/7/07 – 30/9/09

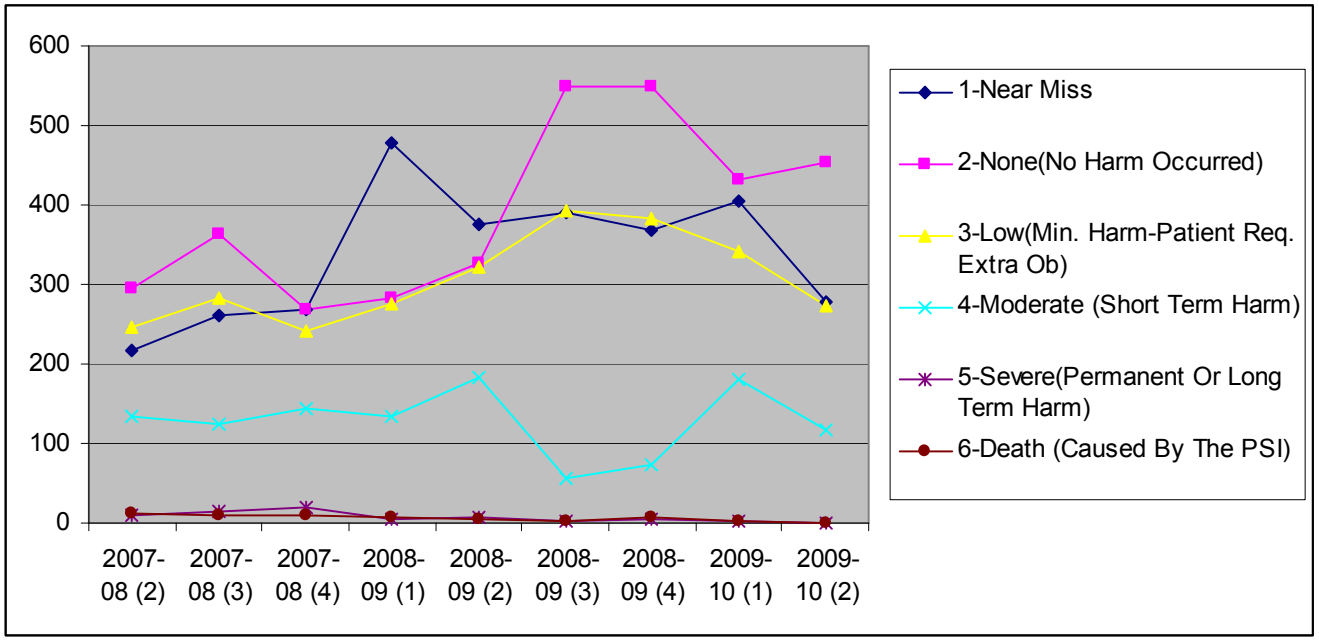


Graph 2 – Top 6 reported incidents by quarter (1/7/07 – 30/9/09)



The top 6 most frequently reported categories are the same as Q2 2008/9. There has been an increase in reported patient accidents on Q1 2009/10, otherwise all other categories have shown a decrease in reported incidents.

Graph 3 Patient Safety incidents by actual impact by quarter (1/7/07 – 30/9/09)



Graph 3 looks at reported actual harm suffered by the patient and allows benchmarking against the six monthly feedback reports provided by the National Patient Safety Agency (NPSA) from its National Reporting and Learning System (NRLS). A more detailed report on NRLS data, in particular alignment with national benchmarking, was considered at November 09 Governance Board.

Examples of lessons learned from root cause analysis and incident reviews are attached at **Appendix 1.**

3.2 Complaints

During the reporting period the complaints team dealt with 258 complaint contacts, a slight rise of 6 (2.3%) over the same quarter for the previous year.

Formal Complaints	216	Formal complaints with negotiated timescales
Can't Accept	2	Concerns not addressed (due to time elapsed since incident etc)
General Query/Feedback	4	Not dealt with formally (concerns/query addressed via letter)
GP/intra NHS Concerns	4	Concerns raised by GPs or other NHS organisations/staff members
Dealt with informally	2	Not dealt with formally (concerns/query addressed via phone or meeting)
Under Review	7	Pathway not finalised (e.g. reviewing records to establish whether a complaint can still be reviewed given time elapsed)
Withdrawn	23	Complaints are typically withdrawn if a relative has made the complaint, but patient consent cannot be obtained. Occasionally complaints are withdrawn as the complainant changes their mind about taking their concerns forward.

The Trust received 216 formal complaints, compared with 226 in the same quarter in 2008/09. This is a slight decrease of approximately 4% (though against the backdrop of a historical high for the period last year). Overall formal complaint volumes in the first half of the year have risen by 12%.

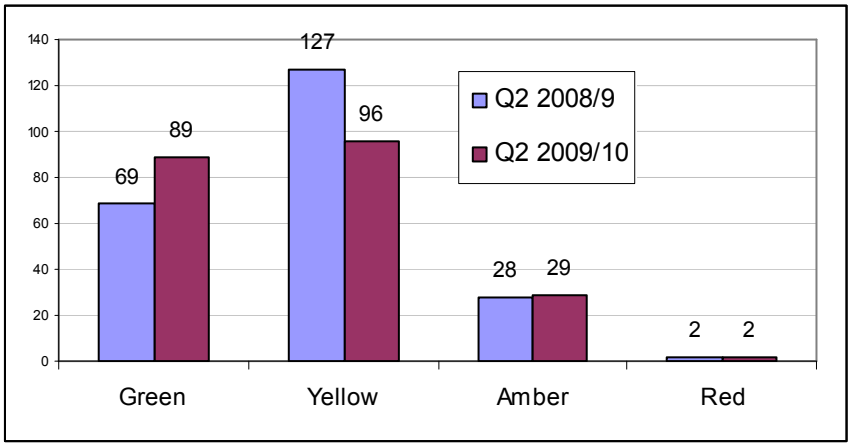
Negotiated target times are an important feature of the new NHS Complaints Procedure that was introduced from the 1st April 2009. The Trust's database has been updated and can now reflect whether - and how often - negotiated target times have been changed. Details of this are shown below. However, this feature was not available for comparison reporting periods.

The deadlines for 35% (75) of complaints were re-negotiated. Some of these timescales had to be extended more than once. In total there were 107 date changes for the following reasons.

Agreed Date Change	23.4%
Clarification/Information Required	10.3%
Consultant Comments (Lead Division)	4.7%
Consultant Comments (Other)	3.7%
Draft Requiring Amendment	1.9%
Medical Records Delayed/Missing	8.4%
Nursing Comments (Lead Division)	6.5%
Nursing Comments (Other)	0.9%
Other Comments (Lead Division)	10.3%
Other Comments (Other)	14.0%
Other Reason	11.2%
Referred To Senior Clinical Advisor	0.9%
Staff Annual Leave	2.8%
Staff Sickness	0.9%

It should be noted that delays in some cases have been caused or exacerbated by continued pressures within the complaints team. This has arisen due to the significant additional workload generated by each case with the new NHS procedure as well as overall increased complaint volumes. The department is planning to recruit two additional staff members, at Band 4 and 7 respectively, to ensure the Trust's complaint handling capacity matches the responsibilities commensurate with the new NHS-wide procedure.

The complaints were graded as follows:-



To date, only 1 (0.5%) of the complaints has been re-opened as the complainant raised queries or concerns with the original response. This is presently significantly below the same quarter last year (April to June 2008 was 8% based on current reports). Given the depth of the investigation reports, it is expected that less complainants will be dissatisfied following the initial response, although it is too early to draw robust conclusions at this stage

The main areas of concern were:-

Category	Q2 2008/9	Q2 2009/10
Clinical treatment	43%	38%
Delays/cancellations	18%	26%
Communication	5%	6%
Staff attitude	9%	12%
Hotel services/food*	2%	1%

Key lessons learned for complaints during Q2 are attached at **Appendix 1.**

3.3 Claims

The claims received are as follows:

	Q4 08/09	Q1 09/10	Q2 09/10
Clinical Negligence	20	22	25
Personal Injury	9	14	16
Total	29	36	41

The allegations for the claims received in Q2 fall into the following categories:

Category	Clinical Negligence	Personal Injury
Burns/scalds/reactions	0	2
Defective Equipment	0	1
Delay In Treatment	2	0
Dissatisfied With Treatment	4	0
Failure Or Delay In Diagnosis	7	0
Failure To Recognise Complications	3	0
Failure To Warn Of Risk	1	0
Fall/slip	1	4
Lifting/moving/handling	0	3
Operation Carried Out Negligently	5	0
Other	0	1
Needlestick Injury	0	4
Treatment Carried Out Negligently	2	0
Violence & Aggression	0	1

At present the Trust has 252 clinical negligence claims and 91 personal injury claims at various stages of the legal process:

Status Type	Clinical Negligence	Personal Injury
Disclosure Of Records	163	0
File In Abeyance	1	0
Interim Payment	1	0
Letter Of Claim	35	57
Letter Of Response	8	1
Liability Admitted	3	12
Liability Being Assessed	5	3
Liability Denied	4	6
Negotiate Settlement	6	0
Part 36 Offer	3	1
Proceedings Issued/served	5	2
Settlement Made	18	9

The ongoing claims fall into the following Directorates:

Directorate	Clinical Negligence	Personal Injury
Anaesthetic/Critical Care	6	3
Estates	0	18
Facilities/Nursing & Therapy	0	23
IM & T	0	2
Imaging	0	4
Medicine And EC (A)	32	13
Medicine And EC (B)	38	10
Pathology	2	0
Surgery (A)	67	9
Surgery B	18	2
Women & Child Health	89	6
Workforce	0	1

The ongoing claims fall into the following categories:

Category	Clinical Negligence	Personal Injury
Burns/scalds/reactions	3	4
Defective Equipment	1	3
Delay In Treatment	17	0
Dissatisfied With Treatment	54	0
Drug Error	2	0
Failure Or Delay In Diagnosis	76	0
Failure To Ob Informed Consent	2	0
Failure To Obtain Consent	2	0
Failure To Recognise Complications	19	0
Failure To Warn Of Risk	2	1
Fall/slip	3	39
Head Injury	0	1
Infection - MRSA	1	0
Infection - Other	2	0
Lacerations/sores	3	0
Lack Of Care	2	1
Late Diagnosis And Treatment	4	0
Lifting/moving/handling	2	8
Moving/falling Objects	0	7
Needlestick Injury	1	16
Operation Carried Out Negligently	37	0
Other	3	2
Road Accident	0	0
Stress	0	1
Toxic Fumes	0	1
Treatment Carried Out Negligently	16	0
Violence & Aggression	0	7

3.4 Aggregated analysis

There was a slight fall in number of incidents and complaints reported in Q2 compared with Q2 2008-9, with an increase in numbers of new claims received (however, claims are often received some months/years after the initial event). A proactive safety culture has reducing numbers of complaints/claims and increasing incidents and so this trend will be monitored.

Aspects of care delivered to patients remains a strong feature across all three areas.

2% of incidents reported were graded as red, with .9% of complaints graded as red.

4. Recommendations

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

Appendix 1

Lessons Learned Q2 2009/10

1. Incidents

37 red incidents were reported via incident forms during this period. Table top reviews are held for each and action plans developed, which are monitored through the Adverse Events Committee, chaired by the Chief Executive.

All amber incidents should be monitored at Divisional Groups, with green and yellow incidents being reviewed and fed back at a local level.

Examples of some of the red incidents and key actions taken/lessons learned:

Incident type	**Lessons Learned/ Improvements/Actions taken**
Loss of manual data	**Root cause** – lack of controls around manual data **Good practice** – authorization to take data off site had been obtained and prompt reporting **Action taken / lessons learned:** Information Governance Policy to be reviewed to incorporate management of manual data Working group to establish scale of issue and potential solutions Awareness raising amongst staff (both those involved and across Trust) Patients to be contacted and provided with support
Inadequacies in application of DNAR process	**Root cause** – lack of clarify of status of DNAR **Action taken/lessons learned :** Amend junior doctor handover sheet to incorporate DNAR review date Issues around use of thrombophropylaxis in stroke patient to be reviewed
Retained swab following surgery (near miss never event)	**Root cause** – error during counting and bagging of swabs compounded by failure to identify source of infection when seen post-operatively with sepsis. **Good practice** – clear documentation of discussion with family, trust policy in line with national practice. **Action taken/lessons learned:** Theatre staff to be reminded of documentation requirements and process for counting swabs Surgeons to be reminded of need to allow time for swab count Policy to be reviewed to consider adding final stage check as backup and reissued Look at move to MDT follow up approach
Security – stolen prescription stationery	**Root cause –** No Trust standard for security of prescription stationery **Action taken/lessons learned:** Develop and implement Trust standards for security of prescription stationery (i.e. incorporate into Medicines Mgmt Policy)

2. Complaints

The complaints received cover a wide range of issues and are spread over many wards/departments. Following investigation, the complaints are reviewed to identify any required action. Examples of actions arising from upheld complaints are as follows:-

- Systems being reviewed in cardiology to limit the number of cancelled appointments
- Further training on falls risk assessment
- Falls interventions and documentation reiterated to ward staff
- Remind staff to keep patients informed of the reasons for delays in clinics
- Regular audits to be undertaken of documentation standards and counselling of individual nurse regarding record keeping

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Annual Health and Safety Report – 2008/9
SPONSORING DIRECTOR:	Lesley Barnett, Acting Director of Workforce
AUTHOR:	Dally Masaun, Head of Health and Safety
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

This report highlights key Health and Safety activity undertaken during 2008/9:

- Training delivered by the Health and Safety /Risk Team
- Summary of Safety Alert (CAS) activity
- Policy review
- Summary of HSE activity with the Trust
- Snap shot of HSE activity in Healthcare Sector
- Analysis of 2008/9 incident data (Focus on V&A and Slip, Trips and Falls)

Key incident data points:
- Health and safety incidents: 3222 (2675 in 2007/8), an increase of 20%
- Red incidents: 35 (22 in 2007/8) an increase of 60% (due to reclassification of Needlesticks
- Top incident type: patient accident (1312)

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality of care
Annual priorities	
NHS LA standards	Standard 5 'Learning from Experience'
Core Standards	SfBH Core Standard C1a
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Governance and Risk Management Committee on 17 September 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

HEALTH & SAFETY

Annual Report to Trust Board

2008/2009

Contents

Dally Masaun Head of Health & Safety
Adrian Seeley Health & Safety Manager

1.0 HEALTH & SAFETY REPORT

1.1 Introduction

This report provides an overview of health & safety management activity in 2008/2009.

Performance against 2008/2009 targets has been measured (Appendix 1) and targets for 2009/2010 have been set (Appendix 2).

1.2 Accountability

The Trust takes its responsibility for Health & Safety and Risk Management seriously and is committed to improving and developing risk management systems in a robust manner.

Mr John Adler (Chief Executive) has overall responsibility for Health & Safety. Mr Colin Holden (Director of Workforce) has Board level responsibility for Health & Safety. Dr Peter Verow is the Director of Occupational Health & Safety Services.

The Health & Safety Department is:

Head of Health & Safety	–	Dalvinder Masaun
Health & Safety Manager	–	Adrian Seeley
Lead Moving & Handling Co-ordinator	–	Sandrea Mosses
Moving & Handling Trainers	–	Karen Morsley, John Rigby, Carol Brown, Sarah Hawthorne
Secretary	–	Jacque Calloway

The Trust's Health, Safety and Welfare Council meets quarterly and functions according to its agreed Constitution and Terms of Reference.

2.0 ORGANISATIONAL ISSUES

2.1 Consultation

The Health, Safety & Welfare Council (HSWC) met quarterly and provides a effective channel for consultation activity. Membership is drawn from Directorate/Divisional management and Staff Side and the Council's objectives are to:

- Promote co-operation between Trust and its staff by creating, developing and implementing measures to ensure the health, safety and welfare at work of all staff
- Study incident and reportable disease statistics and trends
- Produce reports to management on unsafe and unhealthy conditions and practices, together with recommendations for corrective action
- Examine health, safety and welfare reports and make recommendations as appropriate
- Consider reports and factual information provided by Inspectors of enforcing authorities under HASAWA
- Consider reports from staff and management representatives
- Assist in the development of procedures and safe systems of work

- Monitor the effectiveness of the safety content of staff training
- Monitor the effectiveness of health, safety and welfare communication and publicity in the Trust

2.2 Enforcement

No enforcement action.

2.3 Training

Mandatory training

General health & safety training continues to be conducted via corporate & local induction and mandatory refresher sessions. The Content of H&S Corporate Induction and Mandatory training were reviewed.

Medical induction

Health & Safety induction for medical staff is carried out online.

Other mandatory training sessions were delivered as follows:

- Conflict Resolution: 402 staff trained
- Moving & Handling: 3416 staff trained

Non-mandatory courses were delivered as follows:

- Risk Assessment Workshop: 8 sessions
- Managing, Reporting and Investigating Incidents Workshop:5 sessions

2.4 Moving & Handling

Training Facility. The Trust currently has two permanent training venues. These are located on D47 at City and in the M&H training room at Sandwell.

2.5 Communication

Central Alerting System (CAS)

CAS (Central Alert System) is an electronic system developed by the Department of Health, which is used to distribute Medical Device; National Patient Safety Agency (NPSA) and DH Estates & Facilities alerts to all NHS and primary care trusts in England. It incorporates a feedback mechanism to record action taken by trusts following the receipt of alerts. The Trust also distributes its own safety alerts (HSN – Health and Safety Notices) using the CAS internal cascade system.

Activity 1st January 2008 to 31st December 2008

	MDA	NPSA	HSN	DH	Total
Alerts issued	88	10	4	11	**113**
No action required	64	4	0	7	**75**
Action complete	24	3	4	3	**34**
Action ongoing	0	3	0	1	**4**

3.0 PLANNING & IMPLEMENTATION

Risk Assessment

Two new Starter Assessments (Stress & Security) were issued to complement the previous body of eight used in January's HCC Project. It is expected that all wards and departments complete their assessments and incorporate findings into Risk Registers as appropriate.

The Health & Safety File

The Trust introduced a new tool to aid local management of health & safety. The Health & Safety File features five elements which enable the ward/department apply sound management principles to the subject of risk:

- Policy (local responsibilities & arrangements)
- Organisation (control systems, competency, co-operation, communication)
- Planning & Implementation (risk assessment & risk controls)
- Measuring performance (analysis of local inspection, incident, sickness absence data)
- Review (planned and ad-hoc reviews of the system to ensure continuous improvement)

All divisions were invited to take part in a dedicated pilot exercise prior to full roll-out to their wards/depts., together with customized training to support managers through the process.

Sickness Absence

OH Nurse appointed to work closely with HR team on the management of sickness absence

4.0 MEASURING PERFORMANCE

All incidents are graded and colour coded (red, amber, yellow and green in descending order of severity) using a standard Trust Incident Severity Matrix. Yellow and Green incidents are managed locally, i.e. by the ward or department. The divisional/directorate risk leads are involved in the management of amber and red incidents, supported by the corporate risk team.

The total number of Health & Safety incidents reported and entered on to the Trust database was 3222 (20% increase on previous year) for this period. Each incident was risk rated to ensure an appropriate level of local and/or corporate action.

There has been a 75% increase in RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulation) reports. This increase is as a result of issuing an internal Health and Safety Notice explaining the legal duties under RIDDOR.

Graphical analysis for our target cause groups can be found on pages 8 to 19. Slip, Trip and Falls have been included for the first time. Each incident under this category

was reviewed by the Health and Safety Team and meaningful sub causes were allocated.

5.0 AUDIT

Work-related Stress & Sickness Absence Management

The HSE re-visited the Trust on 29 January 2009 as part of their Healthy Workplace Solutions initiative. They reviewed the Trust progress on compliance with standards contained in *Tackling Stress: the Management Standards Approach* (INDG406) and *Managing sickness absence and return to work* (HSG249).

The HSE were satisfied with compliance

- Stress risk assessment
- Formal policies and procedures
- Formal training and awareness

The inspectors were told that the Trust had made a decision not to adopt the HSE format to engage with staff to identify work related concerns, but had already embarked on a Trust Listening in Action (LiA) initiative. They were told about the process, given copies of "Heartbeat" and the LiA DVD. They were both impressed with LiA approach and the enthusiasm demonstrated by staff on the DVD and could see how it was a good mechanism to engage/involve staff and importantly how it appeared to result in real positive collective change..

6.0 REVIEW

6.1 Policy Development

The Following policies were approved:

- New and Expectant Mothers
- DSE (Display Screen Equipment)
- Young Works
- Violence and Aggression

Drafts and revisions were conducted on the following policies:

- Fire
- Risk Assessment
- Control and Restraint

6.3 Legal Update\Examples of HSE Action relevant to the Healthcare Sector

Legislation

Health & Safety Offences Act 2008 becomes enforceable in January 2009. The Act raises maximum penalties that can be imposed by lower courts. It also broadens the range of offences that an individual may be prosecuted for.

Confined Spaces (ACoP) issued by HSE (17 February)

Prosecutions

A gardener climbed onto the roof of the new bowls pavilion Chadderton Hall Park from a grass bank at the rear in order to apply anti-vandal paint . He could have fallen more than 2 metres while working on the roof, but slipped as he was getting down, breaking his arm. Oldham Borough Council failed to properly plan or supervise the work and failed to take suitable measures to prevent their employee falling from the roof. (£1,500 Fine, £5382 Costs)

East Sussex Hospitals Trust fined £8, 000 (plus £8,500 costs) after cleaner suffered electric shock from steam cleaner which left them severe injuries and inability to use right hand. Trust had failed to supply a residual current device for use with the steam cleaner.

Sheffield NHS Foundation Trust fined £18,000 (+ £15,000 costs) for failure to maintain window restrictors

Improvement Notices

<u>Bed Rails/Scolding</u>

Numerous improvement notices issued to care homes in connection with bedrail management and scalds from hot water.

Gwent NHS Trust issued with IN for failing to assess risks of patients sustaining burns/scalds from hot surfaces

<u>Falls From Height</u>

Walsall NHS Trust issued with IN for failing to assess risks of patients falling from windows above 2m

<u>Risk Assessments</u>

Improvement notices served on Sheffield Children's Hospital requiring

- suitable and sufficient risk assessment to be completed in relation to moving and handling within medical records at Western Bank
- risk assessment to be completed in relation to lone working for radiographers working at the Western Bank site

- risk assessment to be completed in relation to lone working for domestic staff working at the Western Bank site, particularly at night

Improvement Notice issued to University Hospital of North Staffs for failure to undertake COSHH assessments

Management Systems

Improvement notices served on Sheffield Children's Hospital requiring

- adequate arrangements to be put in place to manage contractors across the Trust
- system to be put in place to ensure that sling inspections occur across the trust at intervals not exceeding 6 months
- written plan to be put in place to manage the risks of exposure to asbestos across the Trust.

Improvement Notice issued to Sheffield Primary Care Trust for lack of management system for key risks (Latex, Manual Handling & Asbestos)

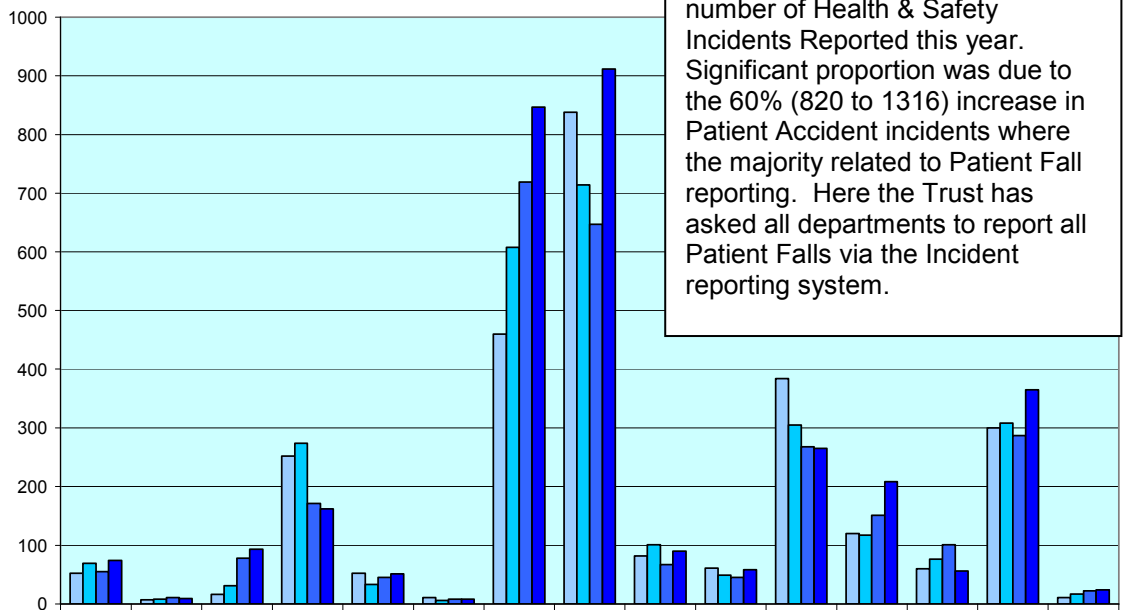
Improvement Notice issued to Sheffield Teaching Hospitals Foundation Trust for DSE workstation users not being in receipt of adequate training

Sheffield PCT issued with IN for lack of health & safety management system and management of risks associated with latex, Moving & Handling and asbestos

Lancashire NHS Foundation Trust issued with IN for lack of management system for violence risks

2.0 Performance Indicators

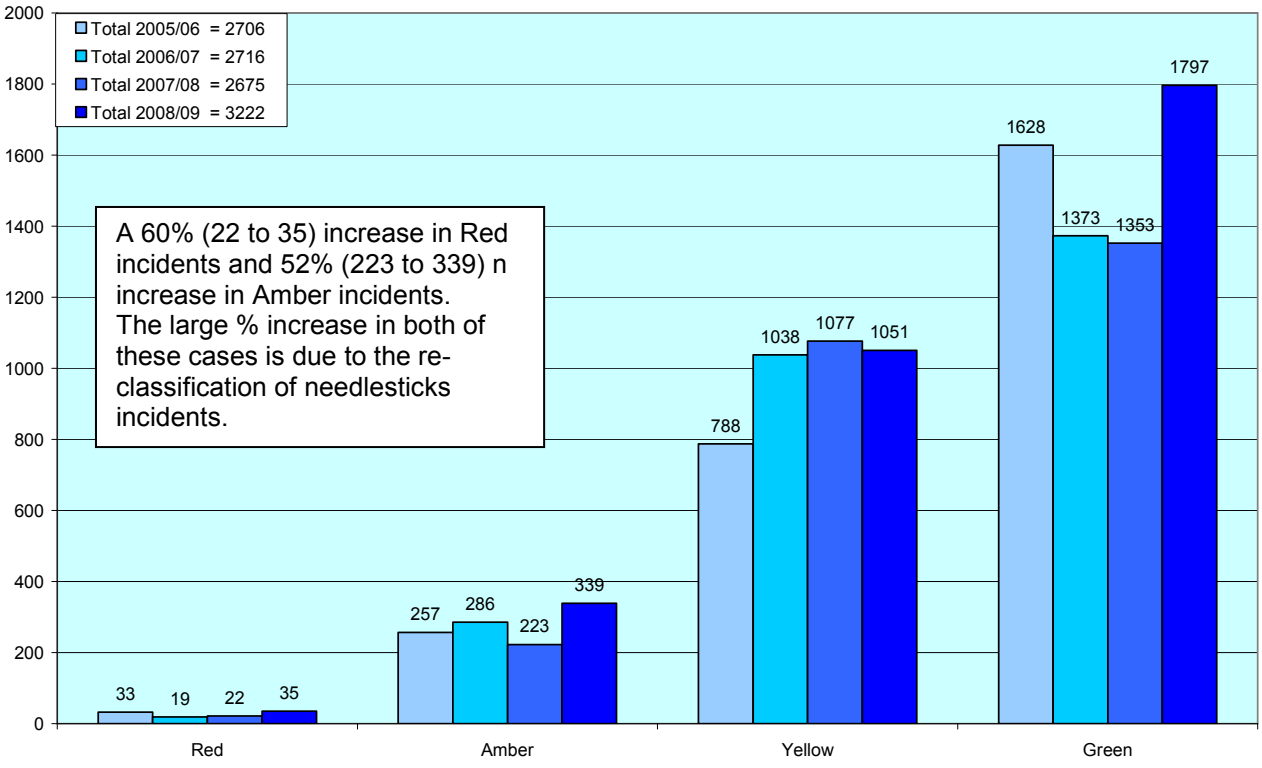
Graph 1 **ALL INCIDENTS**



20% (2676 to 3222) increase in the number of Health & Safety Incidents Reported this year. Significant proportion was due to the 60% (820 to 1316) increase in Patient Accident incidents where the majority related to Patient Fall reporting. Here the Trust has asked all departments to report all Patient Falls via the Incident reporting system.

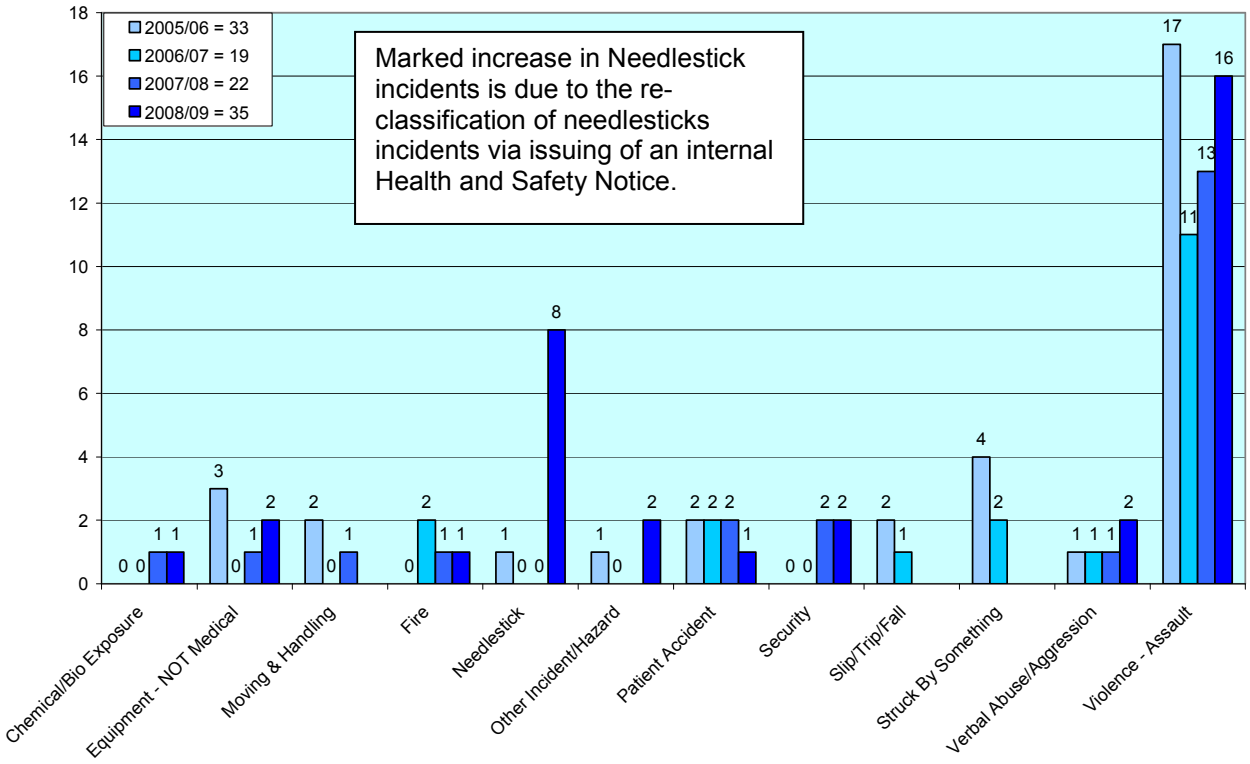
	A&CC	Dev/Str a	Est	FN&T	Imag	IM&T	Med & EC (A)	Med & EC (B)	Ops	Path	Surg A (C)	Surg A (S)	Surg B	W&C Hlth	WF/Fin
2005/06 = 2706	52	7	16	252	52	11	460	838	82	61	384	120	60	300	11
2006/07 = 2716	69	8	31	274	33	6	608	714	101	49	305	117	76	308	17
2007/08 = 2675	55	11	78	171	45	8	719	647	67	45	268	151	101	287	22
2008/09 = 3222	74	9	93	162	51	8	847	912	90	58	265	208	56	365	24

Graph 2 **RISK RATINGS FOR ALL INCIDENTS**

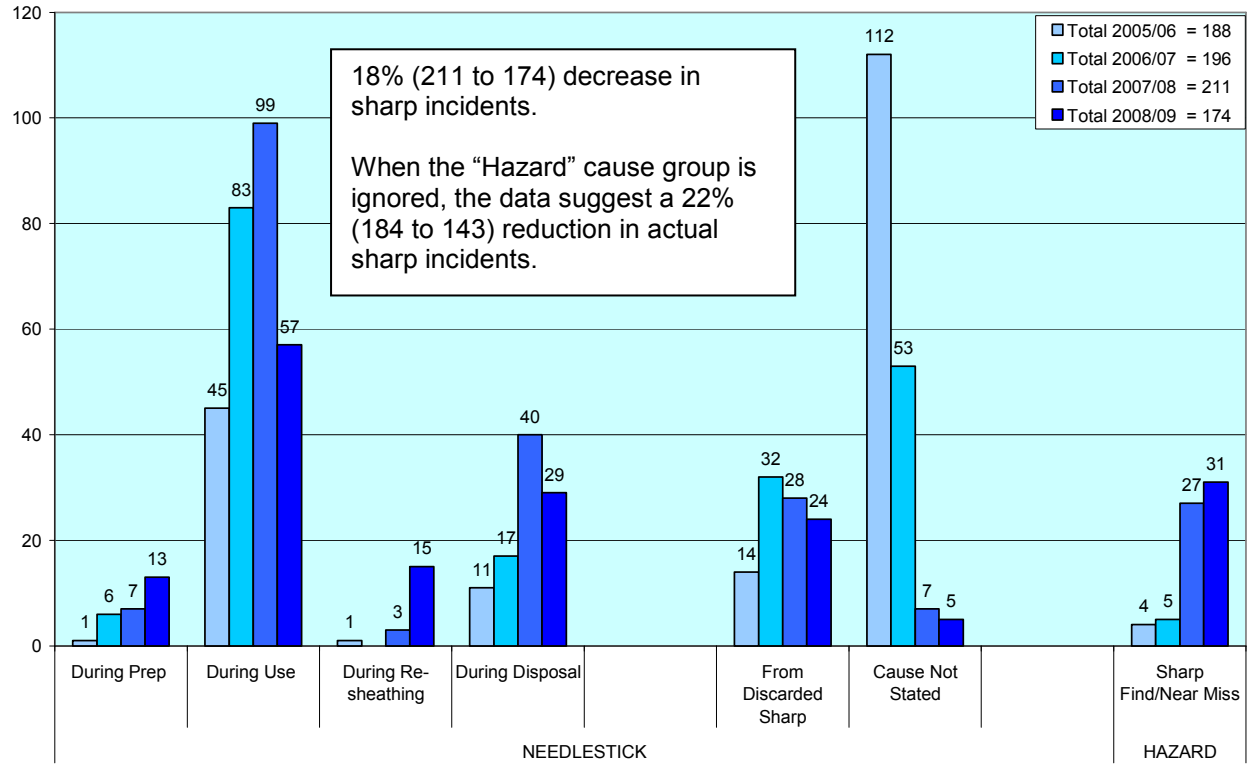


A 60% (22 to 35) increase in Red incidents and 52% (223 to 339) n increase in Amber incidents. The large % increase in both of these cases is due to the re-classification of needlesticks incidents.

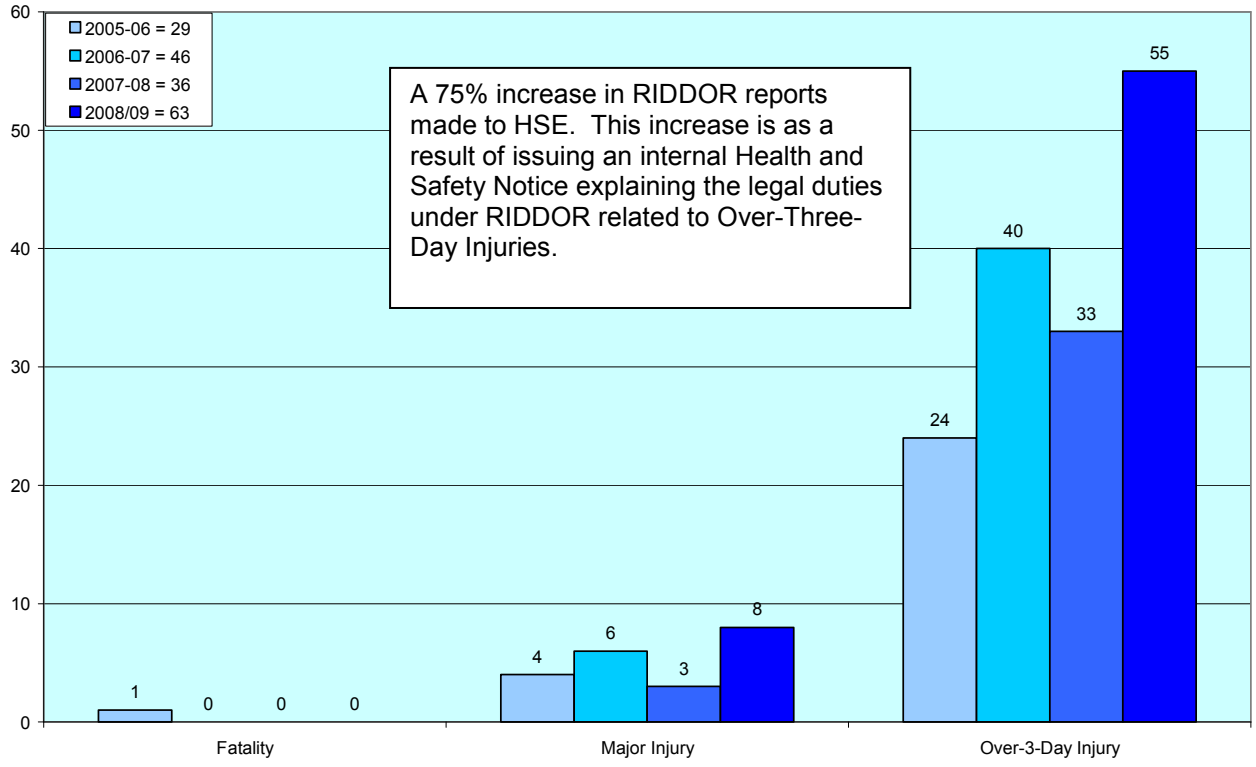
Graph 3 **RED INCIDENTS BY CAUSE GROUPS**



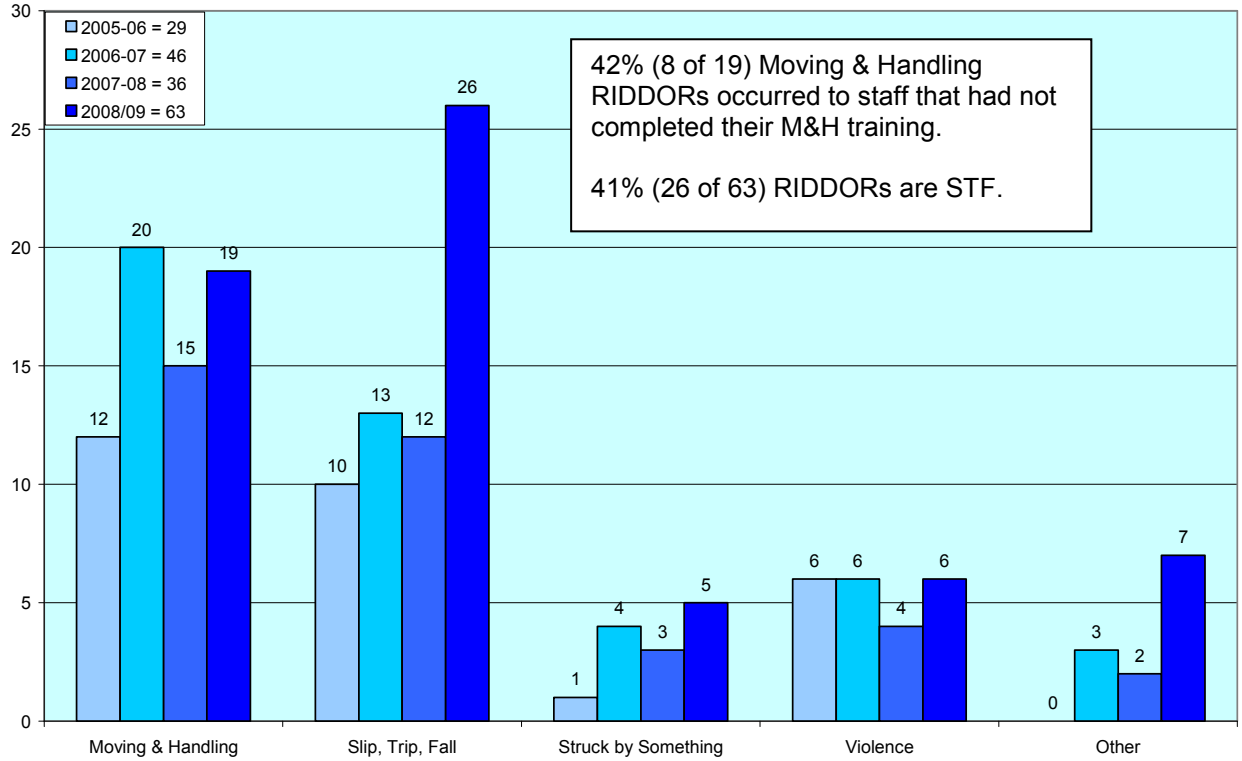
Graph 4 **Sharps**



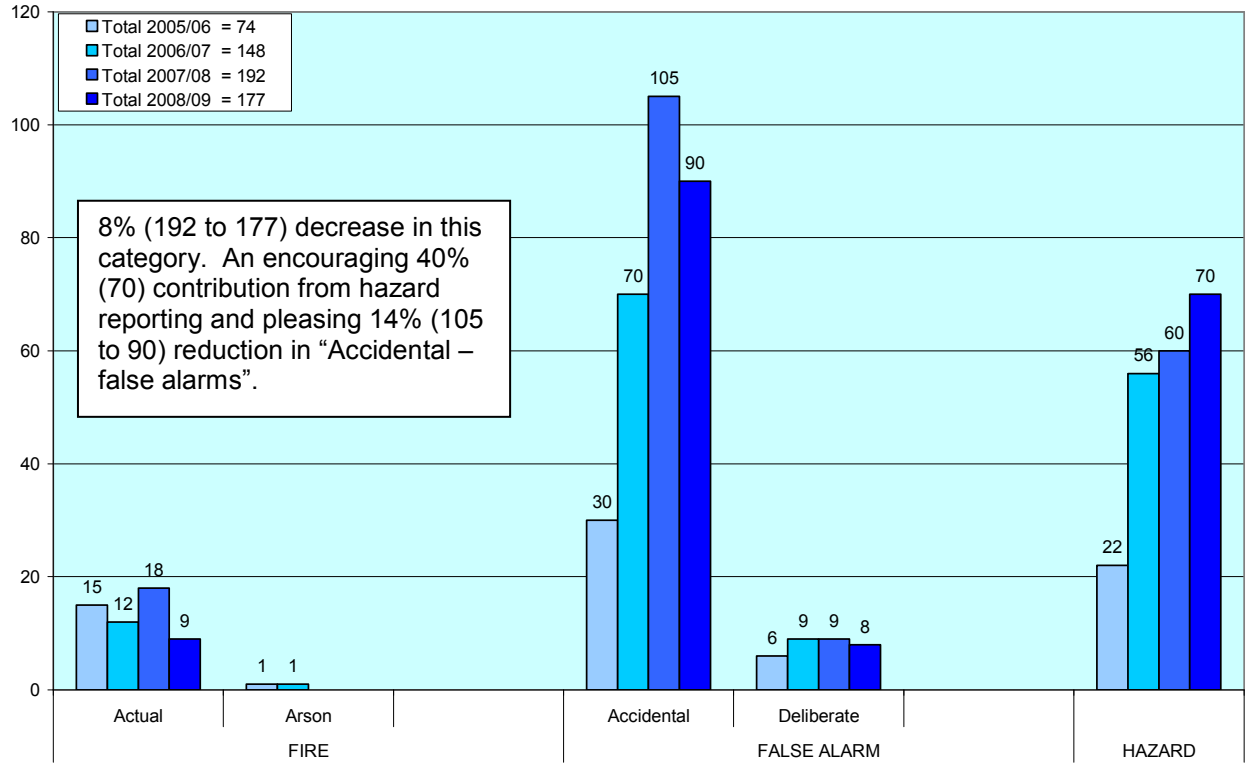
Graph 5 **RIDDOR-reportable by HSE Category**



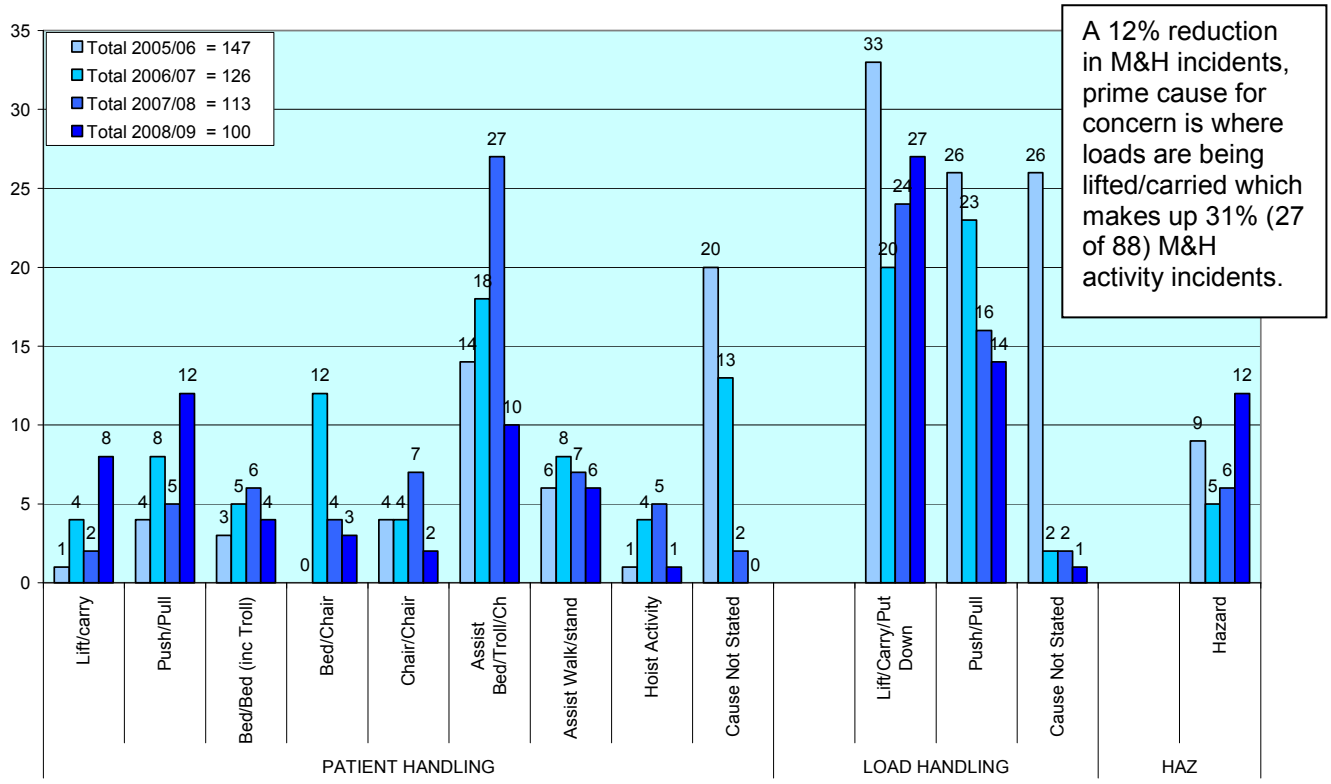
Graph 5a **RIDDOR-reportable by Cause Group**



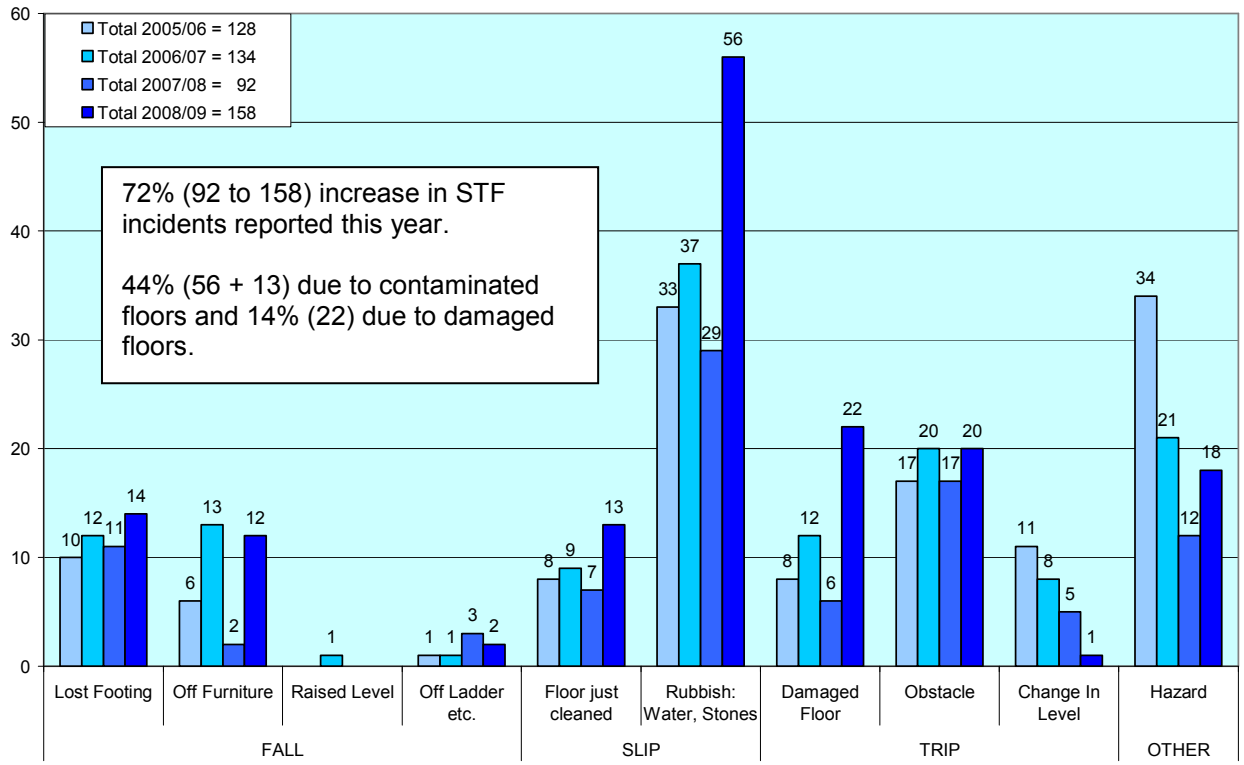
Graph 6 **Fire**



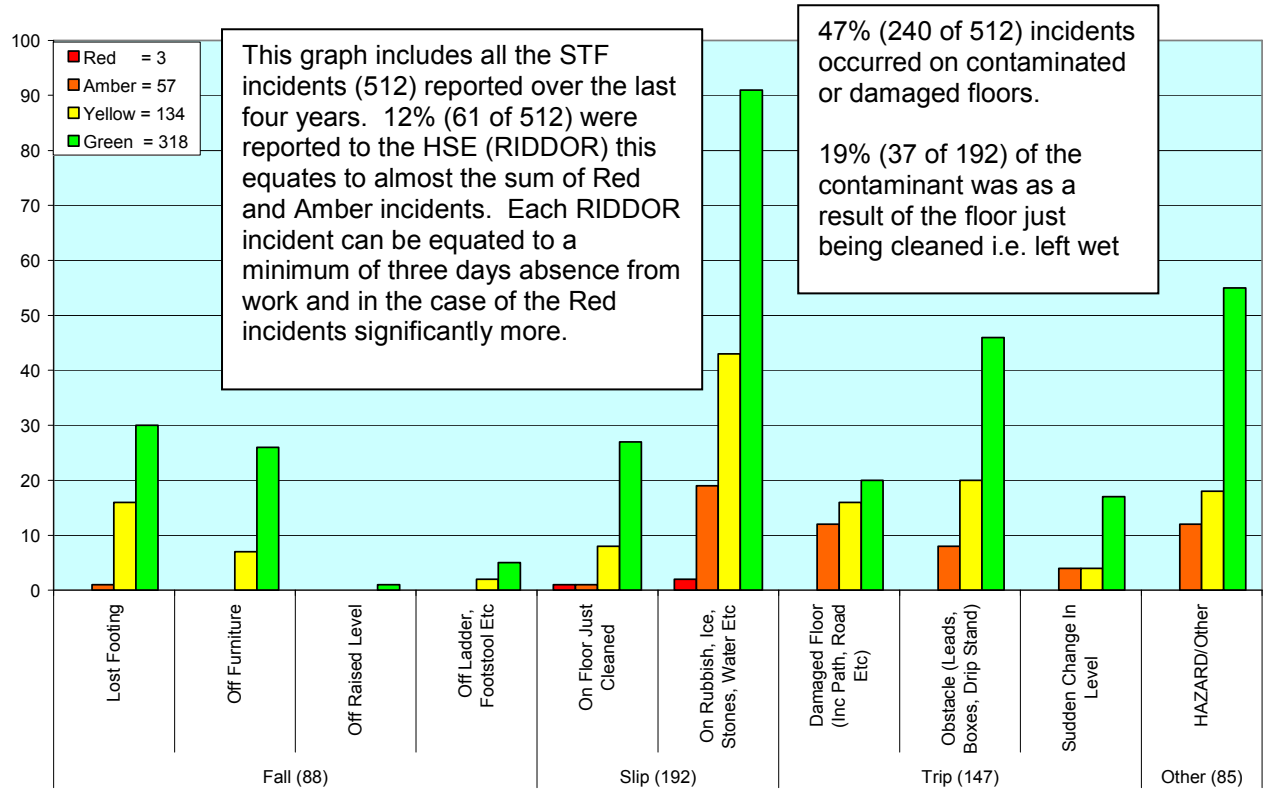
Graph 7 **Moving & Handling**



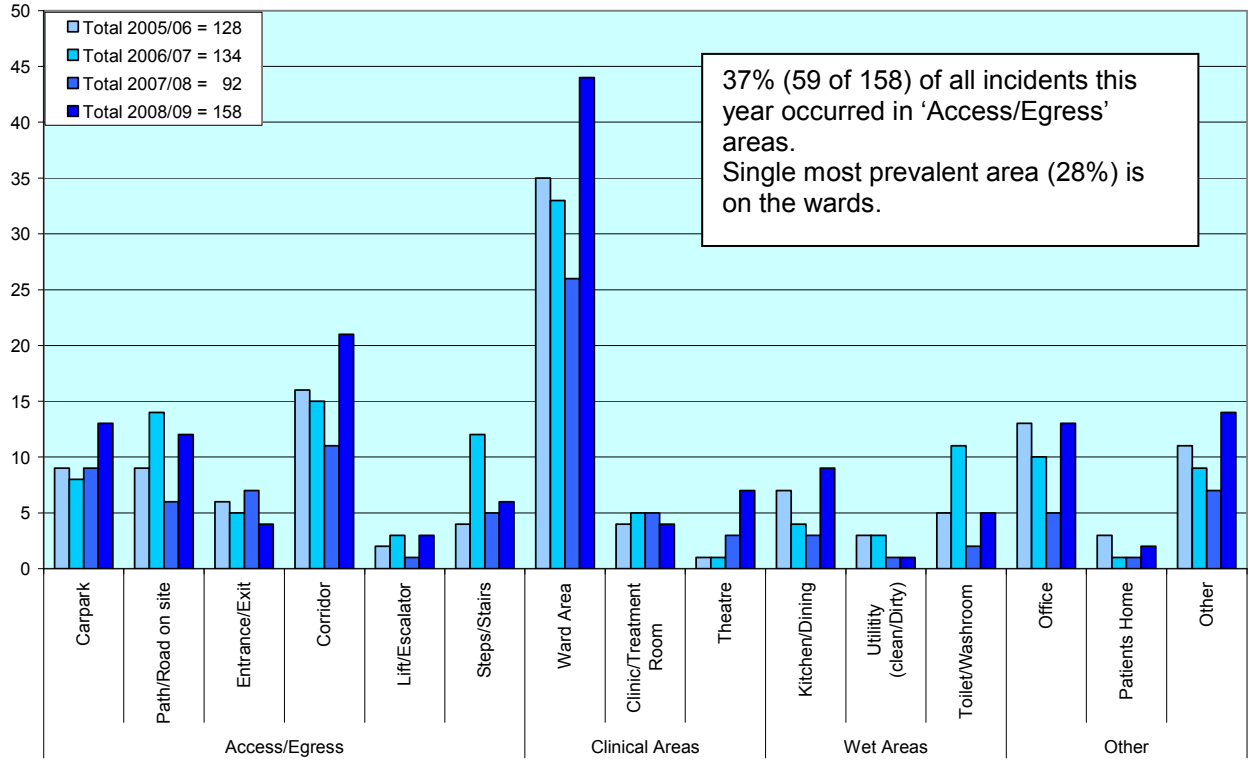
Graph 8 **Slip, Trip Fall (by Sub-Cause Group)**



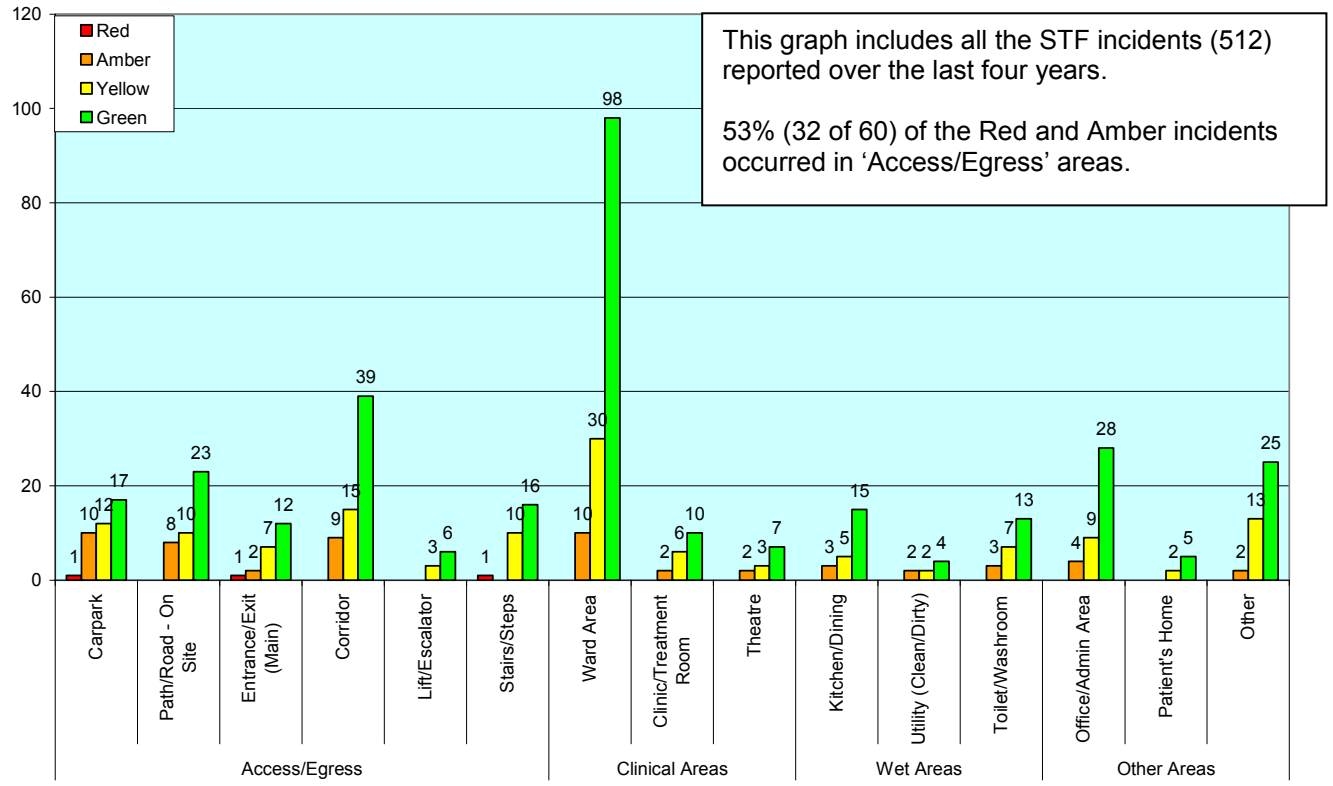
Graph 8a **Slip, Trip Fall (Grade by sub-Cause Group) April 2005 to March 2009**



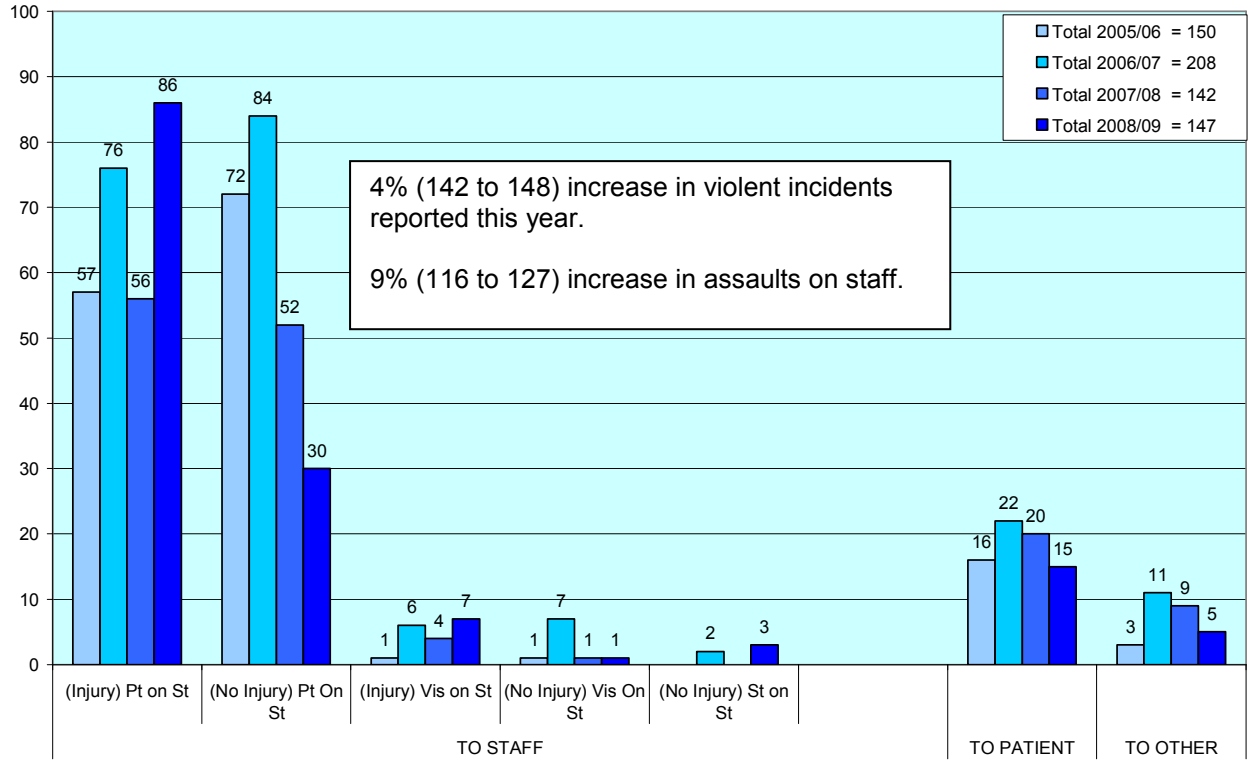
Graph 8b **Slip, Trip Fall (by Location)**



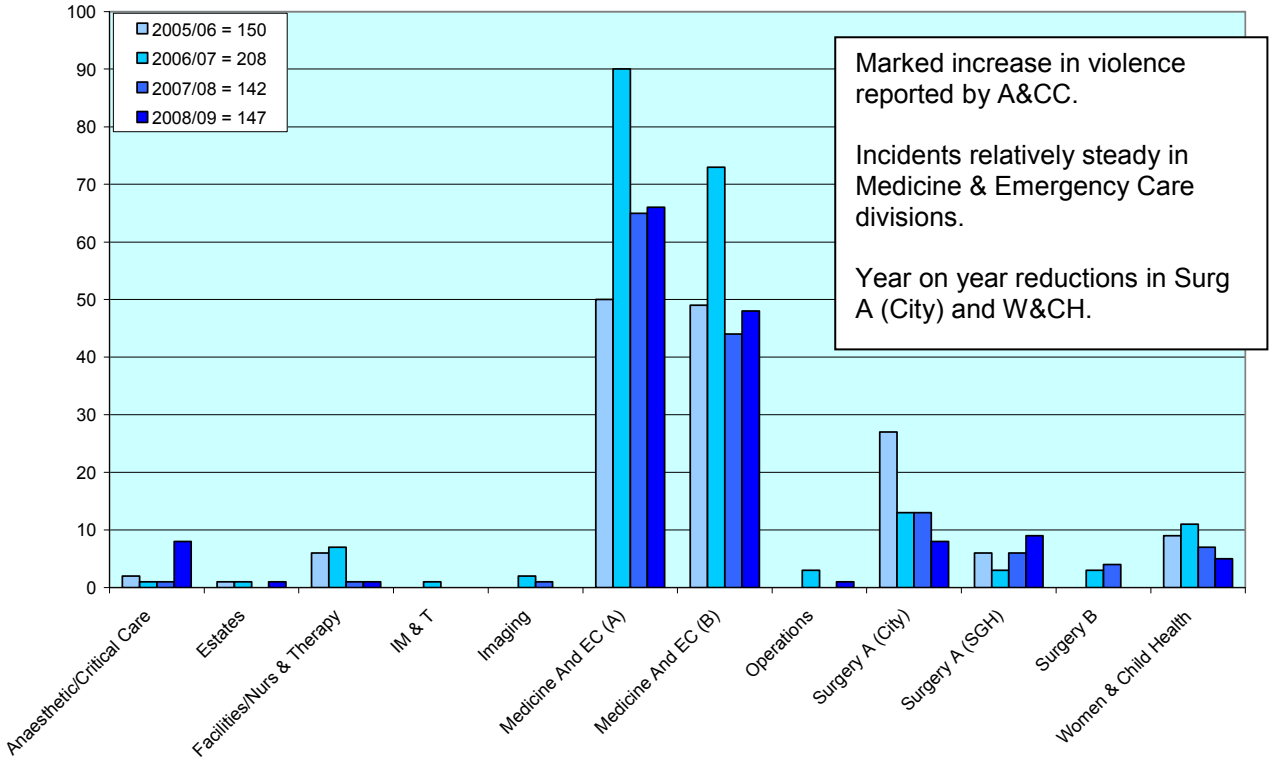
Graph 8c **Slip, Trip Fall (Risk Rating by Location) April 2005 to March 2009**



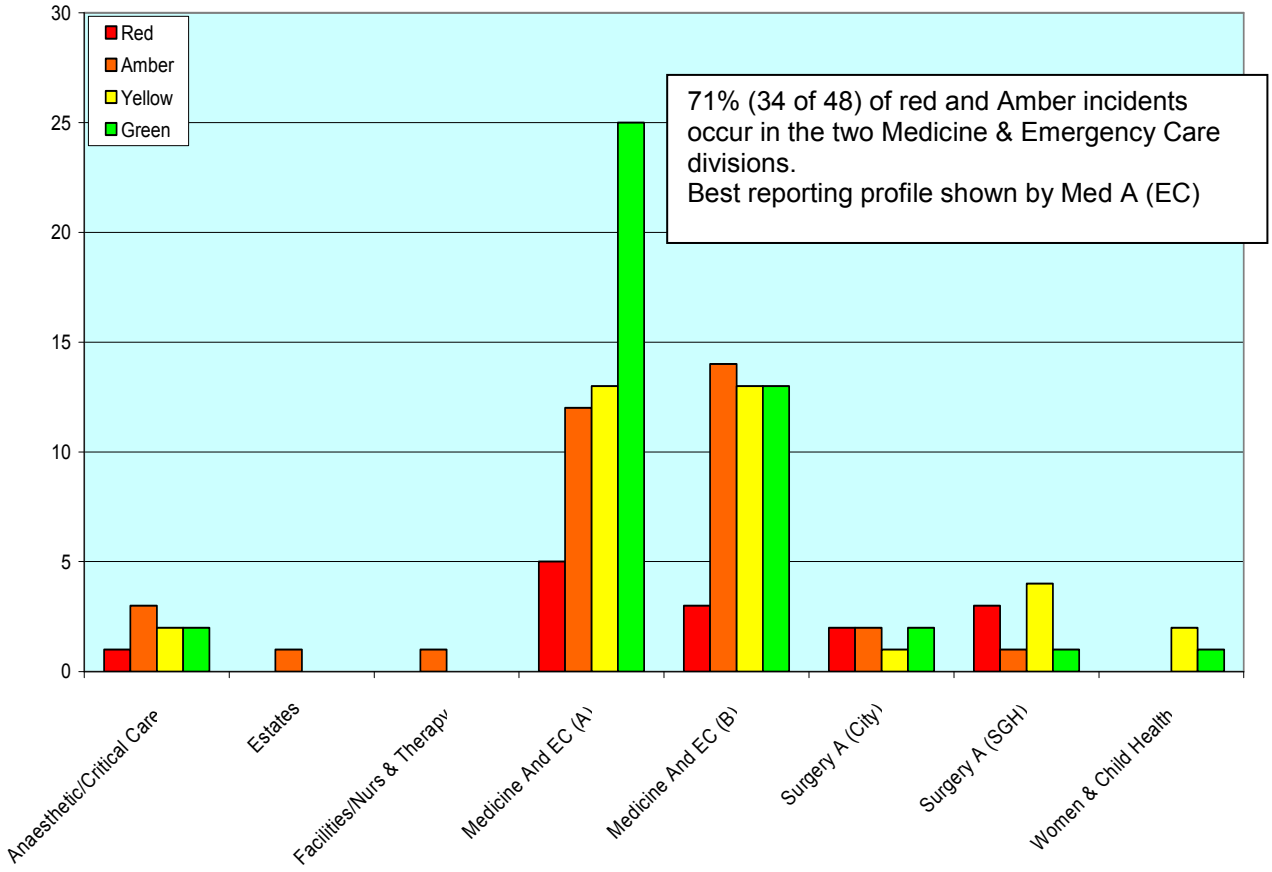
Graph 9 **Violence**



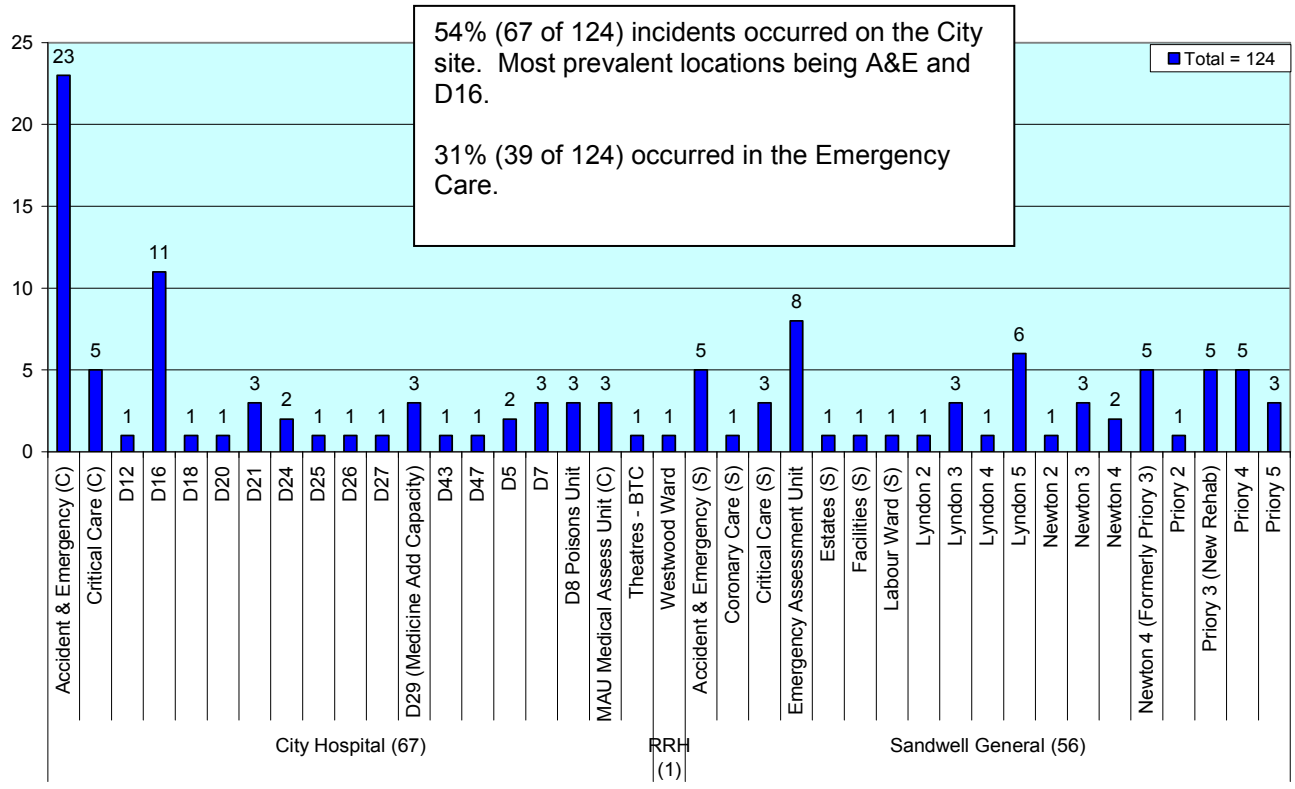
Graph 9a **Violence (Incidents by Division)**



Graph 9b **Violence (Grade by division)**

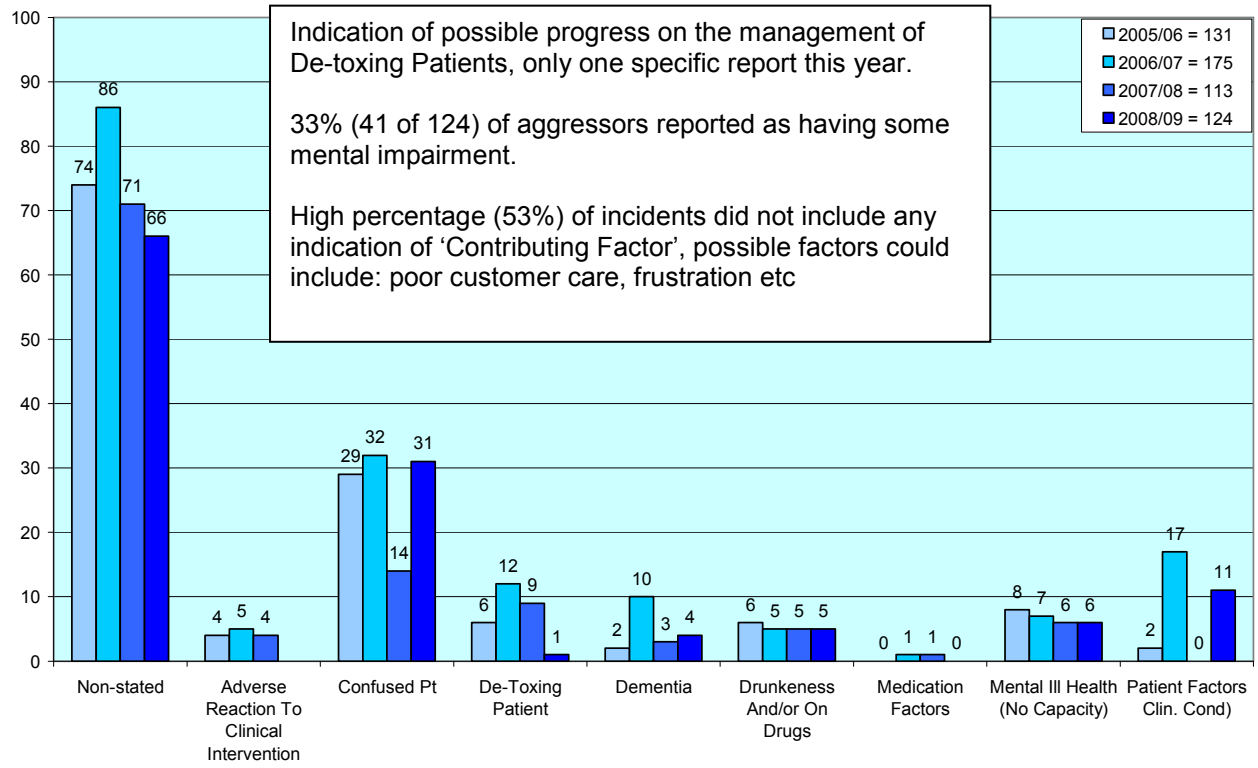


Graph 9c **Violence (On staff* by Department)**



** by visitors and Patients on staff only;*

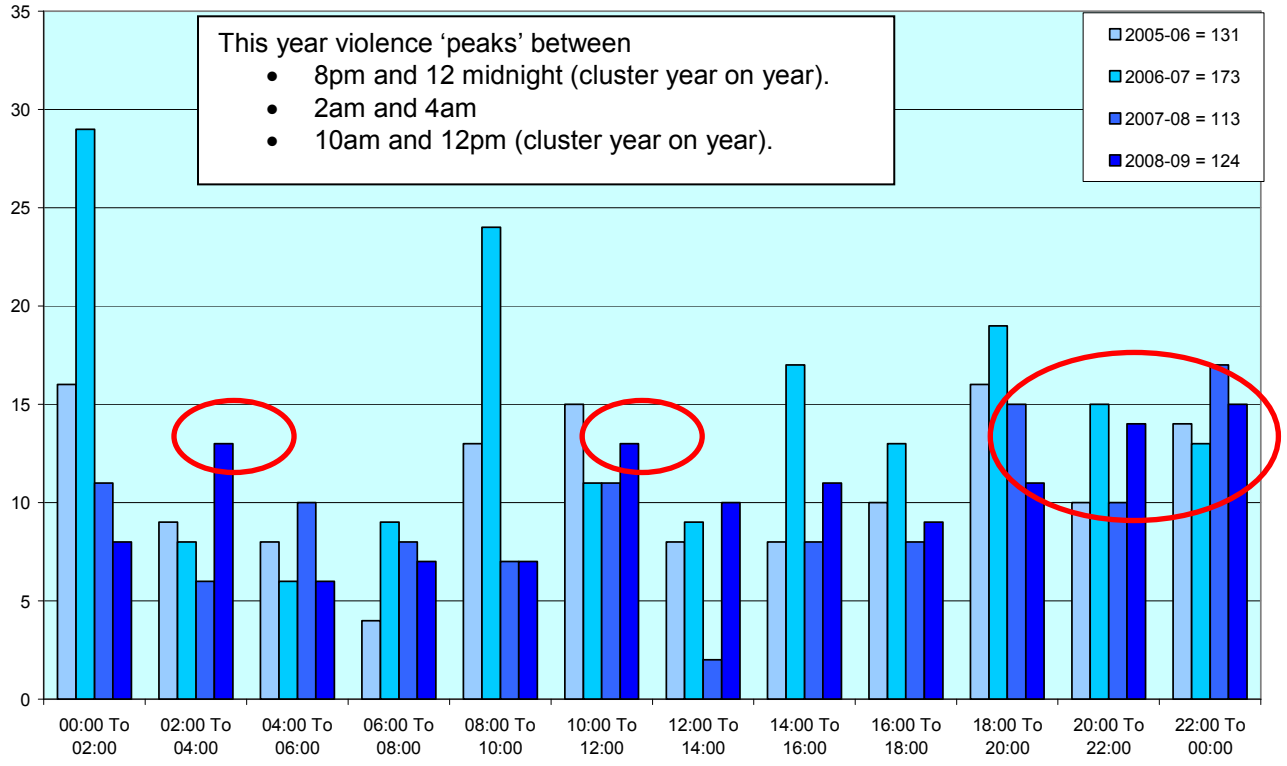
Graph 9d **Violence (On staff* by Contributing factor**)**



** by visitors and Patients on staff only; **Contributory Factors are taken directly from the incident form*

"The MCA 2005 makes it clear that capacity is decision specific; just because I might not have capacity to consent to a surgical procedure that does not mean that I lack the capacity to recognize that lobbing missiles at nurses is not the right thing to do". Angus Mackenzie

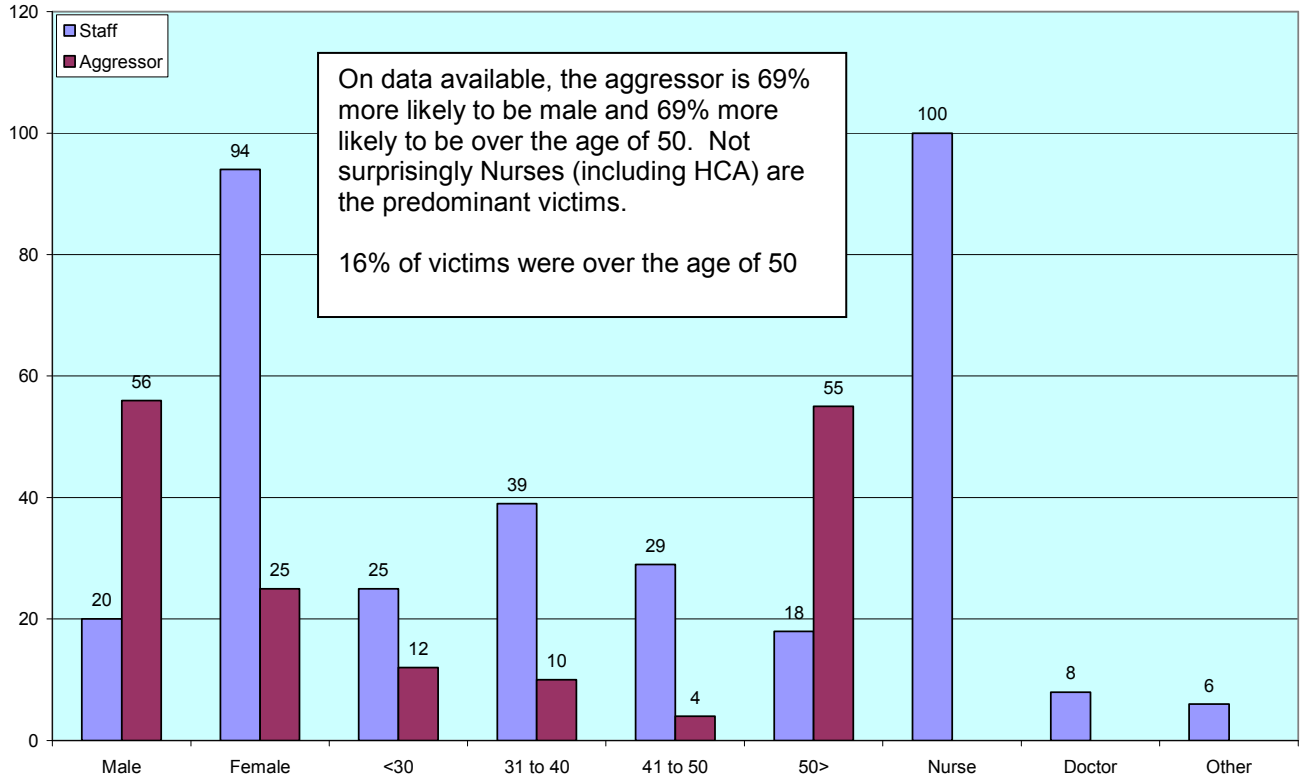
Graph 9e **Violence (On Staff* by Time of Day)**



** by visitors and Patients on staff only;*

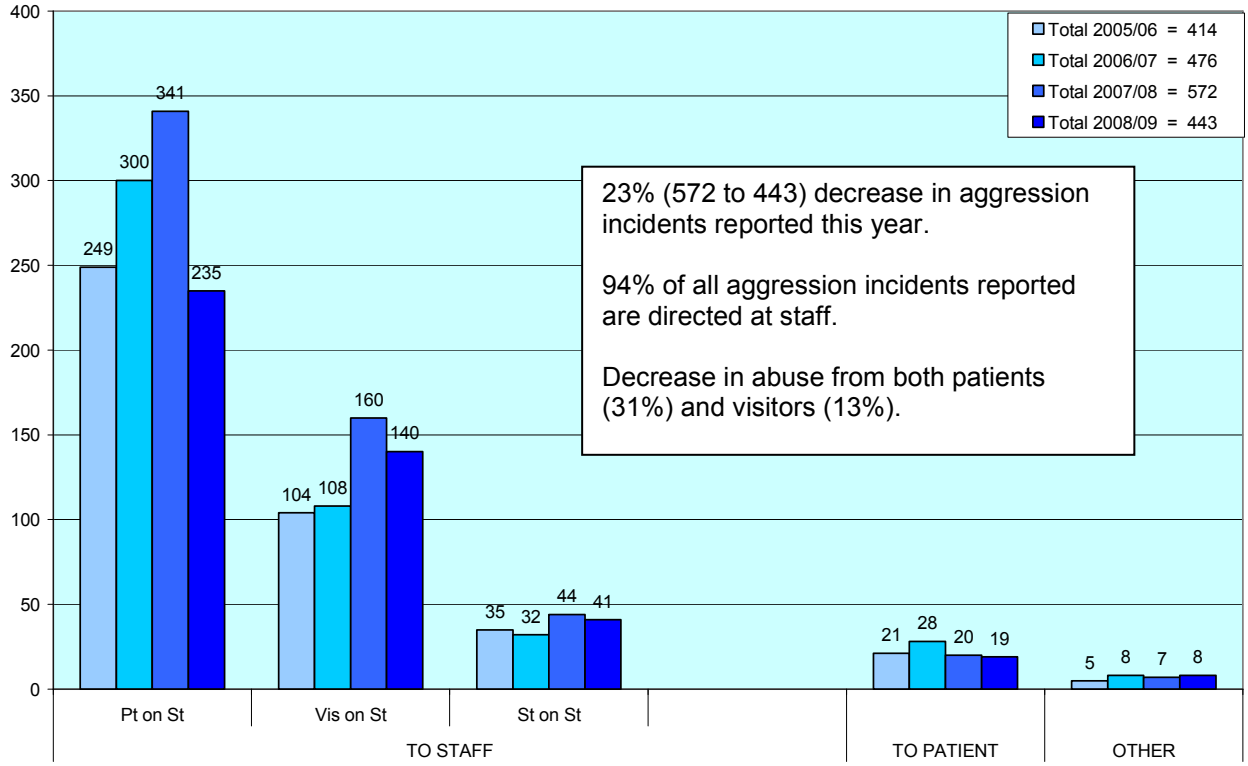
Graph 9f **Violence (Staff* v Aggressor** profile)**

Data complied by hand extracted from the 124 attacks on staff

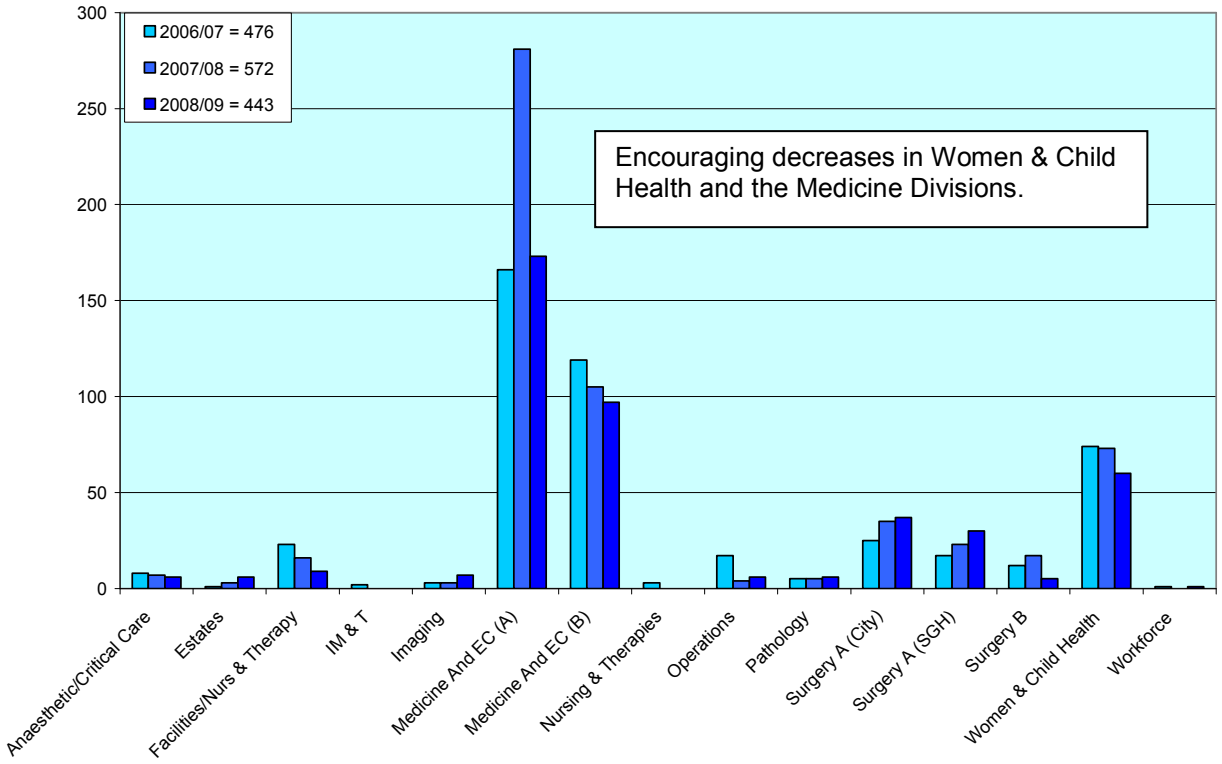


**Staff 10 records incomplete, **Aggressor 43 records incomplete*

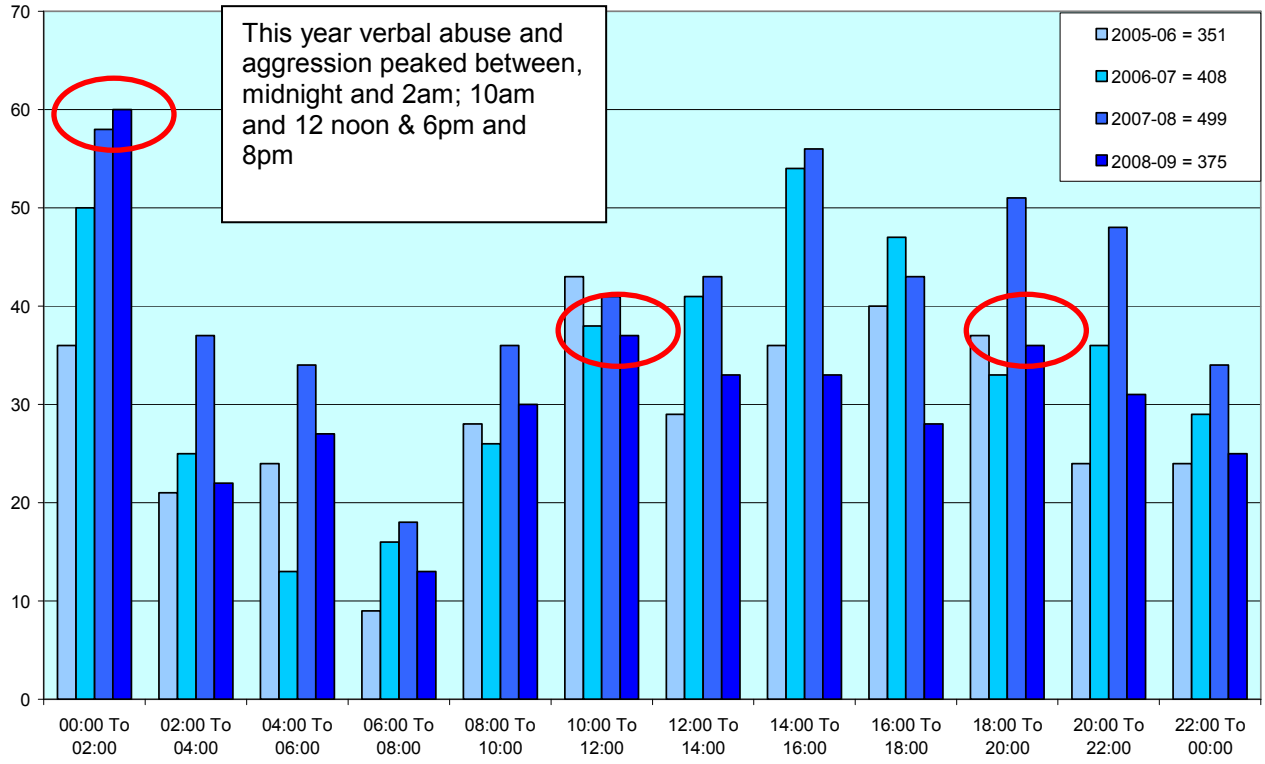
Graph 10 **Verbal Abuse/Aggression**



Graph 10a **Verbal Abuse/Aggression by Division**



Graph 10b **Verbal Abuse/Aggression (On Staff* by Time of Day)**



** by visitors and Patients only;*

Graph 11 **Security**

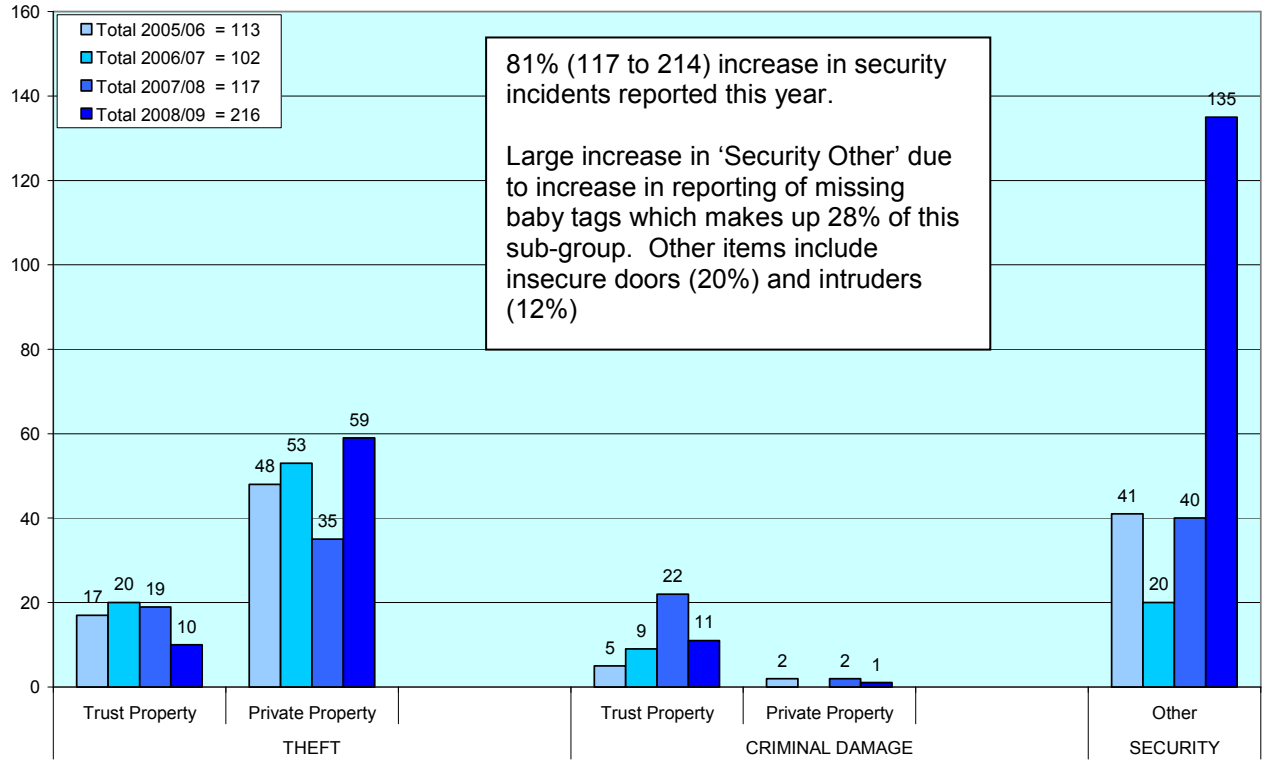


Table 1: **Reported Incidents (Cause Group/Grade & Division) 2008/09** Appendix1

	A&CC	D/S	Est	FN&T	Imag	IM&T	Med A-EC	Med B-EC	Ops	Path	Surg A C	Surg A S	Surg B	W&CH	WF/F	Total
Electricity (Contact)											1				1	**2**
Equipment (Other)	1	1	9	16	4		18	9	11	7	7	9	4	45		**141**
Exposure Substance	8		1	2	1		6	6	6	11	7	5	2	5		**60**
Fire	6	3	13	26	8	3	36	11	10	3	15	7	6	28	2	**177**
Harassment/bullying	2				1		7	4				1				**15**
Moving & Handling	4		3	19	4	1	15	18	6	1	14	5	1	8	1	**100**
Needlestick (Sharp)	10		5	4	2		35	29	5	9	19	20	4	32		**174**
Other Incident/Haz	10	1	7	12	1	2	16	11	5	2	12	11	2	21	1	**114**
Patient Accident	8	1	1	4	13		399	607	15	1	120	83	20	44		**1316**
Security	1		7	19	2	1	36	35	9	10	10	8		74	4	**216**
Slips, Trips & Falls	5	2	18	22	3		24	17	11	6	7	10	7	20	6	**158**
Struck by Something	5	1	22	26	5	1	16	20	5	2	8	9	5	22	7	**154**
Vehicle				2								1		1	1	**5**
Verbal Abuse	6		6	9	7		173	97	6	6	37	30	5	60	1	**443**
Violence (Assault)	8		1	1			66	48	1		8	9		5		**147**
Totals	**74**	**9**	**93**	**162**	**51**	**8**	**847**	**912**	**90**	**58**	**265**	**208**	**56**	**365**	**24**	**3222**
	A&CC	**D/S**	**Est**	**FN&T**	**Imag**	**IM&T**	**Med A-EC**	**Med B-EC**	**Ops**	**Path**	**Surg A C**	**Surg A S**	**Surg B**	**W&CH**	**WF/F**	**Total**
Red	1				1		11	7	1		3	5		6		**35**
Amber	10	2	12	14	4		83	59	5	10	35	36	5	63	1	**339**
Yellow	11	3	32	44	9	5	248	277	25	19	92	78	22	177	9	**1051**
Green	52	4	49	104	37	3	505	569	59	29	135	89	29	119	14	**1797**
****TOTAL****	**74**	**9**	**93**	**162**	**51**	**8**	**847**	**912**	**90**	**58**	**265**	**208**	**56**	**365**	**24**	**3222**

ABBREVIATIONS

A&CC	Anaesthetics & Critical Care	**FN&T**	Facilities & Nursing, Therapies
D/S	Development/Strategy	**Ops**	Operations
Est	Estates & Capital Projects	**Path**	Pathology
WF/F	Workforce/ Finance	**Surg A C**	Surgery A (City)
IM&T	Information Management & Technology	**Surg A S**	Surgery A (Sandwell)
Imag	Imaging	**Surg B**	Surgery B
Med A-EC	Medicine A & Emergency Care	**W&CH**	Women & Child Health
Med B-EC	Medicine B & Emergency Care		
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations		

Appendix 1
Health & Safety Objectives 2008/09 - Achievements

OBJECTIVE	TARGET (by quarter end)	STATUS
Policy		
Review, draft (in accordance with new format) and implement any H&S policies that need to be reviewed as necessary	4	Archived
Review the SABS alert management system	3	Archived
Organisation		
Produce quarterly H&S reports	2, 3, 4 and Qtr 1 2008	Achieved
To offer 2 Managing, Reporting & Investigating Incidents courses per month	4	Part-Achieved
To offer 1 Risk Assessment workshop per month	4	Not Achieved
To offer 1 Accident/Incident investigation workshop per Month	4	Not Achieved
To offer 1 DSE Assessors course per two months Trainer (OH Nurse) changed role	4	Part-Achieved
Planning & Implementation		
Implement web-based incident reporting system	4	Not Achieved
Support the collection of H&S evidence for CNST Assessment Assessment date changed to December 2009	3	Carry forward to next year
Develop and launch ward/department H&S folder	4	Achieved
Measuring Performance		
Monitor reactive performance indicators	4	Achieved
Monitor non-attendance trends in M&H training course delivery	4	Achieved
Monitor pro-active performance indicators	4	Not Achieved

Health & Safety Objectives 2009/10

OBJECTIVE	TARGET (by quarter end)
Policy	
Review, draft (in accordance with new format) and implement any H&S policies that need to be reviewed as necessary	4
Organisation	
Produce quarterly H&S reports	2, 3, 4 and Qtr 1 2008
To offer 1 Risk Assessment workshop per month	4
Planning & Implementation	
Implement web-based incident reporting system	4
Support the collection of H&S evidence for CNST Assessment Assessment date changed to December 2009	4
Measuring Performance	
Monitor reactive performance indicators	4
Monitor non-attendance trends in M&H training course delivery	4
Monitor pro-active performance indicators	4

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	High Impact Actions Nursing, Department of Health
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The purpose of this report is to brief the Trust Board on the High Impact Actions for Nursing announced by the Chief Nursing Officer of England and developed as the Nursing professions response to the quality, improvement, efficiency and productivity national agenda.

Many hundreds of suggestions were put forward to the DoH from nurses throughout England. At a shortlisting event these suggestions were themed and 8 actions identified. Each action is supported by a range of evaluated projects, research where available and the financial argument.
Expectations are on Trust Chief Nurses, supported by Trust Boards, to consider how delivering improvements against each action can be achieved.

Within the Trust
Each action has been assigned to a relevant Assistant Director of Nursing. The ADN's will review the DoH submissions to ensure any lessons from projects elsewhere are incorporated into our plans. All plans will be refreshed and re-launched as a result of the national focus. Where there is not an existing plan the ADN will develop one.
All actions will be monitored through the renamed Patient Experience and Nursing Quality Forum and reported to FMB as part of the Trust's QuEP process.

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 attached DoH paper and accept the Trust's initial response.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care
Annual priorities	
NHS LA standards	C13a - staff treat patients, their relatives and carers with dignity and respect
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Not previously considered

SWBTB (11/09) 221 (a)

The Royal College of Midwives

DH Department of Health

Royal College of Nursing

Nursing & Midwifery Council NMC

NHS Institute for Innovation and Improvement

High Impact Actions for Nursing and Midwifery

Background
to the High Impact Actions

Nurses and midwives care passionately about improving the care they provide to their patients. Proof of that ambition was demonstrated when nurses and midwives posted 600 submissions on the High Impact Actions web site in just three weeks. These actions, and the engagement of nurses and midwives throughout the country, have the potential to not only transform the care patients receive, but importantly, to also reduce costs. Nurses and midwives have seized the opportunity to lead the way in meeting the quality and productivity challenge.

A large group of experienced nurses and midwives have identified the eight high impact actions that are outlined in this document from the website submissions. In addition, a number of academic experts have provided references to best practice and some initial economic analysis has been undertaken. More detailed work will take place over the coming months to explore the good practice linked to these eight areas and to further quantify the potential impact if these actions were replicated throughout the NHS.

Each high impact action sets out the scale of the challenge and the potential opportunity in terms of improvements to quality and patient experience and reduction in cost to the NHS.

The good practice examples that we have highlighted demonstrate this. For each action the gains could be huge and nurses and midwives are able to lead on each of these actions which could have significant gains for the NHS.

Space only allows for a limited example from the website submissions for each high impact action. There were many submissions made for each of the areas and more examples can be viewed at www.institute.nhs.uk/hia.

For nurses and midwives working across a range of NHS provided care this is the opportunity to drive up quality and reduce costs in a difficult economic environment. Commissioners of services, strategic health authorities and regulators will want to see nurse leaders engaged in focusing on these high impact areas and demonstrate the outcomes we know can be achieved.

Katherine Fenton
Chief Nurse,
Director of Clinical Standards & Workforce
NHS South Central
On behalf of the SHA Chief Nurses

Dr Lynne Maher
Interim Director of Innovation
NHS Institute for Innovation and Improvement

This work is being led by the chief nurses from the 10 strategic health authorities in collaboration with the Royal College of Midwives, Royal College of Nursing, the Nursing and Midwifery Council, the NHS Institute for Innovation and Improvement and the Department of Health.

Your skin matters

Action

No avoidable pressure ulcers in NHS provided care.

Extent of the problem

Pressure ulcers represent a major burden of sickness and reduced quality of life for patients and create significant difficulties for patients, their carers and families. Even a grade one pressure ulcer is very painful. New pressure ulcers are estimated to occur in 4–10% of patients admitted to acute hospitals in the UK, with one study putting this as high as 20% (Clark M, Bours G, Defloor T; 2004). New pressure ulcers affect an unknown proportion of people in the community, as reliable data is not available, but it is estimated that up to 30% of patients may suffer and 20% of patients in nursing and residential homes may be affected.

Pressure ulcers can occur in any patient but are more likely in high risk groups such as the elderly, obese, malnourished and those with certain underlying conditions. The presence of pressure ulcers has been associated with an increased risk of secondary infection and a two to four fold increase of risk of death in older people in intensive care units (Bo M, Massaia M *et al*, 2003).

Benefits for patients and benefits for NHS

The impact of pressure ulcers is psychologically, physically and clinically challenging for both patients and NHS staff.

Treatment costs vary depending on the grade of ulcer, from £1,064 for a grade 1 ulcer to £24,214 for a grade 4. The cost of preventing and treating pressure ulcers in a 600 bed acute trust has been estimated at between £600,000 and £3m a year (Touche R; 1993).

The total cost in the UK is estimated to be £1.4-£2.1 billion annually, comprising 4% of total NHS expenditure.

HIA Front-line Submission

The Tissue Viability Service at NHS Newham appointed a nurse to tackle the increasing incidence of pressure ulcers in nursing home patients, many of which resulted in hospital admission. This included increased frequency of visits for patient reviews and an educational programme for all nursing home staff. Data from acute providers showed a decrease in the number of patients admitted from the community with pressure ulcers by 50% for the period April-August 2008/09. Results show that in 2008 there were 25-45 admissions compared with 0-12 patients admitted in 2009. Based on admission costs of £199 per night with an average stay of 9 nights the cost saving is £59,100 based on the highest number of admissions.

References

Bo, M., Massaia, M. *et al*. (2003) Predictive factors of in-hospital mortality in older patients admitted to a medical intensive care unit. *Journal of the American Geriatrics Society;* 51 (4): 529-33.

Clark, M., Bours, G. & Defloor T. (2004) *The prevalence of pressure ulcers in Europe. In Recent Advances in Tissue Viability*. Quay Books, Salisbury.

Touche, R. (1993) The Cost of Pressure Sores. *Report to the Department of Health.* London: Department of Health.

Staying safe - preventing falls

Action

Demonstrate a year on year reduction in the number of falls sustained by older people in NHS provided care.

Extent of the problem

Falls affect approximately 60,000 people per year in the UK and result in up to 14,000 deaths in total (Help the Aged; 2008). It was found that every day, 2,300 people in the UK fall. 28–33% of the population over 65 years, and 32–42% of the population over 75 years will fall each year.
The National Patient Safety Agency (NPSA) found that in an average 800 bed acute hospital trust there will be around 24 falls every week and over 1,260 falls every year representing the highest volume patient safety incident reported in hospital trusts in England (NPSA; 2007). 28,000 falls were reported from community hospitals.

Falls are a major cause of disability and mortality for older people in the UK and the problem is likely to increase with an ageing population. 10% of all people that fall will die within a year according to Help the Aged (2008). However, research estimates that up to 30% of falls can be prevented.

Benefits for patients and benefits for NHS

According to the Royal College of Physicians (2008) falls present a huge problem for the health and independence of older people. The associated mortality and morbidity from a fall is high with individual consequences ranging from distress, pain, physical injury and loss of confidence to complete loss of independence which impacts on relatives and carers.

Financial costs can include extra home healthcare, social care or residential care. Research by the NPSA has found that even a fall (or falls related incident) that results in only minor injury is responsible for an extended patient stay of 1-2 days. Overall direct healthcare cost to the NHS is estimated at £15m every year representing a cost of £92,000 a year for an 800 bed acute hospital trust (NPSA; 2007).

HIA Front-line Submission

Ipswich Hospital has introduced the Seven Simple Steps Programme across its complex care wards. Multidisciplinary training and raising awareness were key to this programme and incorporated into mandatory training, junior doctor and pharmacy staff training. The pilot project demonstrated a 68% reduction of patient falls over first 3 months of implementation within a complex elderly care ward. The use of the seven simple steps will enable the trust to reduce falls by at least 25%, thus identifying savings of as least £32,891.

References

Help the aged (2008) Falling Short. Help the Aged. London

National Patient Safety Agency (2007) *Slips, trips and falls in hospital. The third report from the Patient Safety Observatory.* London: National Patient Safety Agency

Royal College of Physicians (2008) National Falls and Bone Health in Older People accessible via http://www.rcplondon.ac.uk/CLINICAL-STANDARDS/CEEU/ CURRENTWORK/FALLS/Pages/Audit.aspx#nfbhop (Accessed 9th November 09).

The Patient Safety First Campaign have recently issued a 'How to' Guide for reducing harm from falls. http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/FALLSHow-to%20Guide%20v4.pdf

Keeping nourished - getting better

Action

Stop inappropriate weight loss and dehydration in NHS provided care.

Extent of the problem

Three million people are at risk of malnutrition in the UK; of these, 3% are in hospitals or other NHS settings (BAPEN; 2009). In 2006, it was found that around 10–40% of patients in the community (at home and in care homes) and in hospital have malnutrition (NICE 2006). Currently, 40% of patients admitted to hospital are undernourished. (British Nutrition Foundation, 2009).

Malnutrition is associated with poor recovery from illness and surgery (Stratton *et al* 2003). Yet NICE (2006) found that only about 1/3 of patients were screened for malnutrition on admission to hospital. Subsequently, patients at risk of malnutrition are not recognised and referred for treatment (Elia *et al* 2005).

Lack of adequate hydration has been noted by the NPSA, the RCN and Water UK (2007) as a common problem in hospitals. Dehydration increases length of hospital stay and is linked to a number of serious conditions, such as coronary heart disease (CHD) and stroke. In one study adequate hydration has been shown to reduce the risk of CHD by 46% in men and 59% in women. Conversely, dehydration increases the mortality of patients admitted to hospital with a stroke two-fold.

Benefits for patients and benefits for NHS

A study by the British Association for Parenteral and Enteral Nutrition (BAPEN) (2009) found that malnourished patients stay in hospital longer, succumb to infection more often, visit their GP more and require longer-term care and more intensive nursing care. They also identified additional consequences of malnourishment, such as muscle wasting, increased risk of infection, predisposition to falls and pressure ulcers, delayed recovery and reduced quality of life.

BAPEN estimated in 2005 that malnutrition costs the NHS £7.3 billion annually. Of this, 52% (£3.8 billion) relates to malnourished patients in hospital, and a further 36% (2.6 billion) to patients in long-term care facilities. Proper hydration alone could lead to savings of £0.95 billion (NPSA, RCN & Water UK).

HIA Front-line Submission

Enhancing Care for Vulnerable Patients is a new scheme to prevent dehydration at Milton Keynes Hospital NHS Foundation Trust. The red water jug scheme helps staff identify patients who require help with their fluid intake. Any patient who is vulnerable or at risk of dehydration is given a red jug and mug to highlight their specific hydration requirements. Devised and implemented by nursing staff, the scheme is helping ensure that patients are adequately hydrated. Results include: reductions in length of stay, earlier discharge for those patients involved in the scheme and reduction or elimination of the need for IV fluids. As patients are adequately hydrated the risk of contracting an infection, e.g. UTI, or as a result of intravenous access, is also reduced.

References

British Association for Parenteral and Enteral Nutrition (2009) *Combating Malnutrition: Recommendations for Action Worcester:* BAPEN.

British Nutrition Foundation (2009) Undernutrition in the UK. Available at: http://www.nutrition.org.uk/home.asp?siteId=43&sectionId=463&subSectionId=341&parentSection=303&which=6#1163 (Accessed on 3rd November 2009).

Elia, M., Zellipour, L., Stratton, R.J. (2005) *'To screen or not to screen for adult malnutrition'*, Clinical Nutrition, 24, 867-84.

NICE and the National Collaborating Centre for Acute Care (2006) *Nutritional Support for Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition (Clinical Guideline 32)*. Available at: http://www.nice.org.uk/ nicemedia/pdf/cg032fullguideline.pdf (Accessed 5th November 2009).

NPSA, RCN and Water UK, *Hospital Hydration Best Practice Toolkit.* Available at: http://www.rcn.org.uk/newsevents/campaigns/nutritionnow/tools_and_resources/hydration (Accessed on 3rd November 2009).

Stratton, R.J., Green, C.J., Elia, M. (2003) Disease related malnutrition, UK: CABI Publishing.

Promoting normal birth

Action

Increase the normal birth rate and eliminate unnecessary caesarean sections through midwives taking the lead role in the care of normal pregnancy and labour, focusing on informing, educating and providing skilled support to first-time mothers and women who have had one previous Caesarean section.

Extent of the problem

Maternity statistics for 2008/09 show that, in England, around 60% of women who had their baby in hospital had a normal birth (HES Online; 2009). In the past 15 years the proportion of births by Caesarean section (CS) has been increasing steadily in England. In 1989/90 the rate of CS accounted for 12% of all births in England, whilst by 2005/6 the rate had doubled to 24%. Currently the rate stands at 24.6% for 2008/9. The rate has remained largely static for the past three years and, whilst the fact that there is no significant increase is positive, the challenge remains that there is no active national reduction in CS rates.

The overall increase in babies born by CS has not been accompanied by a measurable improvement in outcomes for the baby and has been shown to carry an increased risk of morbidity for the mother when compared to normal delivery.

Benefits for patients and benefits for NHS

For women, the benefits of a normal birth include improvements in morbidity rates and a quicker return home to their families. The reduction in the level of unnecessary interventions also results in a reduction of unnecessary complications.

In the UK, Caesarean sections have been found to cost an average of £1,701 while a vaginal delivery costs an average £749. The Audit Commission has estimated that a 1% rise in Caesarean section rates costs the NHS £5m per year (Parliamentary Office of Science and Technology ; 2002).

Women with spontaneous vaginal deliveries spend on average 1 day in hospital after delivery, women with instrumental deliveries 1 or 2 days and CS deliveries is 3 or 4 days (Hospital Episodes Statistics; 2004).

HIA Front-line Submission

The ambition at Kettering General Hospital NHS Foundation Trust is to promote normal childbirth and reduce the Caesarean section rate. They did this by providing information to enable mothers to make a more informed choice. One of their focus areas was to spend time with mothers who had previously given birth by Caesarean section. They were able to highlight the rational for normal birth and provide advise about the mother's choices for their next pregnancy. The results of this effective intervention have been impressive: a reduction in costs as Caesarean sections have been reduced by 2.2% for 2009 demonstrating an overall saving of £820 per case and the average in-patient stay has been reduced by 1day equalling £2,630 per month. Total annual savings amount to £101,030.

References

HES Online. Available at:http://www.hesonline.nhs.uk/Ease/servlet/ContentServer;jsessionid=btn7olj2z1?siteID=1937&categoryID=1060 (Accessed on 9th Nov 09).

Hospital Episodes Statistics (2004) *NHS Maternity Statistics.* England.

Parliamentary Office of Science and Technology (2002) *Caesarean Sections.*

The Royal College of Midwives have published 10 top tips for normal birth available at: http://www.rcmnormalbirth.org.uk/ these pull together the actions most likely to promote a normal birth.

NHS Institute (2007) Focus On:Caesarean Section (online). Available at: http://www.institute.nhs.uk/option,com_joomcart/Itemid,194/main_page,document_product_info/cPath,71/products_id,334.html (Accessed on 4th November 2009) and http://www.institute.nhs.uk/quality_and_value/high_volume_care/focus_on%3a_caesarean_section.html (Accessed 9th November 2009).

Important choices – where to die when the time comes

Action

Avoid inappropriate admission to hospital and increase the numbers of people who are able to die in the place of their choice.

Extent of the problem

People in the UK are now living longer. Of the half million people who die each year in England alone, 2/3 are over 75 years old and the number of annual deaths is forecast to increase from 512,000 in 2005 to 585,000 in 2030 (Hatziandrew; 2008). 50-60% of deaths currently occur in acute hospitals with patients experiencing an average of 18 days as an inpatient spread over 2-3 admissions in the last year of life.

Evidence from the National Audit Office shows that many people wish to be cared for and die in a location other than hospital (NOA 2008a). The study found that in one locality, 40% of patients who died in hospital did not have medical needs which required them to be in an acute setting and could have been cared for elsewhere such as their own home or other appropriate setting (NOA; 2008b).

The ability for people to choose where they die varies across the country. It is often influenced by factors such as where people live and the medical condition they have. The National Care of the Dying Audit (Marie Curie Cancer Care; 2007) notes that 55% of patients with cancer would prefer to die at home but in fact only around 25% actually achieve this.
The Gold Standards Framework (2004) states that people who are nearing the end of life or known to be needing end of life care are admitted to hospital rather than supported at home. This is not only expensive but is often inappropriate and is preventable. People at the end of life and their families should be able to choose to have this care closer to home.

Benefits for patients and benefits for NHS

Patients and families would benefit by having an opportunity to discuss preferences and choices of where to die and have this supported and recorded.

Of the 1.8 billion spent annually on treating cancer patients in the last year of their life the National Audit Office calculates that £104 million could be redistributed to meet people's preferences for place of care by reducing hospital admissions by 10% and the average length of stay following admission by three days. There is also scope to extend this kind of best practice to other conditions (NAO; 2008a).

Approximately half of all complaints made to acute trusts relate to an aspect of end of life care.
The estimated cost for a complaint of average complexity is just under £2,500. It is calculated that a typical acute trust will have total complaint costs of £2,220,300 per year of which around £1,110,150 will be associated with end of life care.

HIA Front-line Submission

The City Healthcare Partnership in Hull, has established a health and social care team to complement end of life care provided by community services.
The responsive team is specifically skilled in providing essential end of life care, offers instant access, and is able to provide support multiple times a day if needed, or 'round the clock' through working in conjunction with other care services. In the four months the service has been operating data indicates that 76% of end of life care patients referred to the team die at home. The death at home rate prior to the service introduction was less than 20%.

References

Hatziandrew E *et al* (2008) The potential cost saving of greater use of home and hospice based end of life care in England. RAND Europe

Marie Curie Palliative Care Institute Liverpool (2007) *National Care of the dying audit.*

National Audit Office (2008a) *End of life Care.*

National Audit Office (2008b) *A review of the provision of End of Life Care services in Sheffield Primary Care Trust.*

National Gold Standards Framework (2004) via http://www.goldstandardsframework.nhs.uk/FocusonNurses/ (Accessed on 9th November 2009).

Fit and well to care

Action

Reduce sickness absence in the nursing and midwifery workforce to no more than 3%.

Extent of the problem

The CIPD Annual Survey of Absence Management highlighted that more than 45,000 NHS staff call in sick every day resulting in the loss of over 10 million working days (CIPD; 2009). The proportion of working days lost to sickness absence varies between trusts from 2.8% to 6% (NHS Employers; 2009). The National Audit Office (2006) found that in 2004-05 the average rate of sickness absence for nursing staff is 7.5% (16.8 days per year)

There is wide variation in absence rates for nurses by wards, specialties and grades. The CBI (2007) found the greatest levels of absence are within services that have a high proportion of older patients such as stroke units, rehabilitation units, geriatrics and general medicine. There is less sickness absence in departments that provide specialist services, such as coronary care units, cardiothoracic surgery, intensive therapy units and paediatrics although rates are still comparatively high.

Benefits for patients and benefits for NHS

Reduced sickness absence results in increased continuity of staff which leads to increased continuity of care and has a positive impacton the experience of patients and their relatives. Sickness absence also has a major impact on the stress levels of those staff who are working to cover absent colleagues.

The average acute trust (800 beds) spends £2.5 million on agency staff, which is equivalent to 5.1% of its staffing costs. This has risen rapidly from 2.9% just seven years ago (Health & Safety Executive; 2007). There is a large variation in the level of nursing hours lost, for example the variation within acute Trusts is between 5% and 10%.

The NHS Health and Wellbeing report found that if absence was reduced by a third this would equate to savings of 3.4 million working days a year equating to an extra 14,900 WTEs and a cash figure of £555m (DH; 2009).

HIA Front-line Submission

Leeds Partnerships NHS Foundation Trust, a mental health trust, reviewed its skill mix and focused on strengthening the leadership on wards in response to a survey on sickness absence. The result has been: a reduction in sickness, a reduction in bank/agency costs, a reduction in patients going AWOL which has also impacted on use of police service resources - and overall reduction in errors which in turn has reduced the time investigating these errors. This has clear benefits for the quality of care and overall integrity and financial balance of the organisation.

References

CBI (2007) *Annual absence and turnover survey* accessed via http://www.cbi.org.uk/ndbs/press.nsf/0363c1f07c6ca12a8025671c00381cc7/1032fea0526c09df802572b3003ea789?OpenDocument (Accessed on 9th November 2009).

CIPD (2009) *Annual absence survey* accessed via https://www.cipd.co.uk (Accessed on 9th November 2009).

Department of Health (2009) *NHS Health and Wellbeing review: Staff perception research.* Accessed via http://www.nhshealthandwellbeing.org/pdfs/Interim%20Report%20Appendices/Staff%20Perception%20Survey%20(Quantitative).pdf (Accessed on 9th November 2009).

Health and Safety Executive (2007) *A pilot study into improving sickness absence recording in national health service acute trusts.* Accessed via http://www.hse.gov.uk/research/rrpdf/rr531.pdf (Accessed on 9th November 2009).

National Audit Office (2006) *Good practice in managing the use of temporary nursing staff.* NHS Employers - Shared Learning (2009) *Reducing sickness Absence.* Accessed via https://www.nhsemmployers.org (Accessed on 5th November 2009).

Ready to go - no delays

Action

Increase the number of patients in NHS provided care who have their discharge managed and led by a nurse or midwife where appropriate.

Extent of the problem

Simple discharges make up approximately 80% of all discharges (Lees; 2004). The Department of Health (DH 2004) states that changing the way in which discharge occurs for this large group of patients would have a major impact on patient flow and effective use of the bed capacity. This will in turn both reduce delays and improve patient experience by helping to ensure that patients are fully informed about the process for leaving hospital.

The move towards nurse led discharge has been, in part, a response to an overall shift in discharge activity brought about by shorter lengths of stay, increasing patient throughput and the increasing acuity of patients admitted to hospital. The importance of nurse led discharge has been highlighted in government plans to overhaul the NHS discharge process (Chatergee 2004).

Benefits for patients and benefits for NHS

Benefits of nurse led discharge include a more timely planned discharge for the patient with fewer delays leading to a more positive patient (and family) experience as well as a lower risk of healthcare associated infections.

The 2009 Annual Health Check, published in October 2009 by the Care Quality Commission, has revealed the proportion of hospitals failing to hit a target to reduce delayed transfers has increased by 12% in the past two years. Nearly a quarter of trusts (24%) failed to meet the required standard for delayed transfer of care, up from 21% in 2006-07 http://www.cqc.org.uk.

It is estimated that for an average patient on an NHS surgical ward it costs up to £400 per day, indicating real financial benefits to reducing length of stay (Webber-Maybank & Luton; 2009). It is estimated that a reduction in length of stay of between two and six days per patient could save NHS trusts £15.5m-£46.5m a year in total (NAO; 2000).

HIA Front-line Submission

The establishment of THREADS (Taunton Hospital Early Assisted Discharge Scheme) has meant that patients admitted to hospital with an exacerbation of chronic obstructive pulmonary disease (COPD) are discharged home early and cared for by a dedicated team until well. Patients are educated comprehensively about their disease and they are offered pulmonary rehabilitation. The national average length of stay in an acute bed is 6 days. THREADS reduces this to 0-3 days (60% of patients of which 25% less than 2 days) 4-7 days 33%. Over a year period taking into account all costs and the reduction in bed days resulted in a cost saving of £42,550.

References

Care Quality Commission (2009) Annual Health Check. Performance Ratings. Accessed via http://www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/annualhealthcheck2008/09.cfm

Chatterjee, M. (2004) Nurses to take over simple discharge. *Nursing Times;* 100: 35, 2.

Department of Health (2004) *Achieving timely simple discharge from Hospital. A toolkit for the multidisciplinary team.* Accessed via http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4088367.pdf

Lees, L. (2004) Making nurse-led discharge work to improve patient care. *Nursing Times*; 100: 37, 30.

National Audit Office (2000) *Hip Replacements: Getting It Right First Time.* London: NAO.

Webber-Maybank, M., Luton, H. (2009) Making effective use of predicted discharge dates to reduce the length of stay in hospital. Nursing Times; 105: 15.

Protection from infection

Action

Demonstrate a dramatic reduction in the rate of Urinary Tract Infections (UTIs) for patients in NHS provided care.

Extent of the problem

In 2000 the Public Accounts Committee estimated that there were at least 100,000 cases of hospital-acquired infection annually – (The NAO (2009) stated that this remains the best estimation of costs available). Urinary tract infections are the second largest single group of healthcare associated infections in the UK and make up 20% of all hospital acquired infections (Health Protection Agency; 2009). In primary care, UTIs make up between 1-3% of all GP consultations with the condition affecting women significantly more than men at a ratio of 50:1 in the age group below 60 years. 80% of urinary tract infections occurring in hospital can be traced to indwelling urinary catheters (Kelsi *et al*; 2003).

Benefits for patients and benefits for NHS

UTIs lead to longer stays in hospital for patients. Up to 5% of hospital acquired UTIs develop into secondary bacteraemia; this is often painful and can be life-threatening. For pregnant women the development of a UTI can be especially problematic leading to pre-term delivery, anaemia and a low birth weight baby.

Adults with hospital acquired infection stay in hospital 2.5 times longer, incur hospital costs 3 times higher and incur higher general practitioner, district nurse and hospital costs after discharge than uninfected patients.

UTIs have been found to extend the average length of hospital stay by 6 days (NAO; 2004) UTIs may account for an extra 798,000 bed days annually (Memorandum by Bard Limited to the Select Committee on Science and Technology (2003)).

It was estimated that the 1994/5 costs of treating UTIs in the NHS were in the order of £124 million (Plowman *et al*; 2000) and the extra financial cost of urinary infection has been estimated at £1,122 per patient (UTI Care Bundle).

HIA Front-line Submission

Winchester and Eastleigh Healthcare NHS Trust has developed UCAM care. UCAM stands for urinary catheter assessment and monitoring. It is a form used to record and document all insertion and ongoing urinary catheter care. This proposed idea was born out of the results from a trust wide audit on urinary catheter care. The approach aims to: prevent unnecessary catheterisation, prompt daily review of patients with catheter and removal of catheter ASAP, and provide evidence of quality of patient care (insertion & ongoing care) as per High Impact Intervention No.6 catheter care bundle*.
The projected impact on cost reduction is prevention of costs from treating catheter associated urinary tract infections.

**The urinary catheter care bundle (DH 2006, DH 2007), as part of the DH Saving Lives programme, summarises best practice in relation to urinary catheter care and has an accompanying compliance tool. It has been developed for use both in primary care and the acute sector.*

References

Health Promotion Agency (2009) *Trends in rates of Healthcare Associated Infection in England 2004 to 2008* London: NAO.

Kalsi *et al* (2003) *Hospital-acquired urinary tract infection.* Institute of Urology and Nephrology London: University College London.

Memorandum by Bard Limited (2003) Memorandum to the Select Committee on Science and Technology (online) http://www.publications.parliament.uk/pa/ld200203/ldselect/ldsctech/23/23w07.htm (Accessed on 9th November 2009).

National Audit Office (2004) *Improving patient care by reducing the risk of hospital acquired infection A progress report* London: NAO.

National Audit Office (2009) *Reducing Healthcare Associated Infections in Hospitals in England* London: The Stationery Office.

Plowman R, *et al.* (2000) *The socio-economic burden of hospital acquired infection* London: PHLS.

Public Accounts Committee (1999) *The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England*

HC 306, Session 1999-2000 1-2.

SWBTB (11/09) 221 (a)

NHS Institute for Innovation and Improvement
Coventry House
University of Warwick Campus
CV4 7AL
Tel: 0800 555 550

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:	26 November 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:

Usual quarterly report

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

EXECUTIVE INFECTION CONTROL BRIEFING PAPER RE CLEANLINESS & PEAT

3RD NOVEMBER 2009

National Standards of Cleanliness (NSoC)

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

	April 09		May 09		Jun-09		Jul-09		Aug-09		Sep-09	
	V High	High	V High	High	V High	High	V High	High	V High	High	V High	High
	%		%		%		%		%		%	
City	95	95	93	96	94	95	97	96	96	95	97	98
Sandwell	98	97	98	97	97	97	98	98	98	97	98	97
Rowley	N/A	97	N/A	97	N/A	97	N/A	98	N/A	95	N/A	97
BTC	98	96	97	97	98	97	97	98	98	98	98	97
Target	98	95	98	95	98	95	98	95	98	95	98	95
Overall Average	**97**	**96**	**96**	**97**	**96**	**97**	**97**	**98**	**97**	**96**	**98**	**97**

PEAT

- **PEAT External Inspections 2010**

  Programme

  The 2010 Patient Environment Action Team (PEAT) programme will commence on the 4th January 2010. There are some changes to the detail of the assessment form based on a review carried out over the summer. The main changes are as follows:

  - National Specification score weighting has increased for the excellent bracket, a minimum of 92% is needed to achieve an excellent score in the environment section. All other scoring brackets remain the same.
  - Inclusion of a 'mixed site' option on site type for those offering multiple service types.
  - The 'Food and hydration services continued' section will be scored this year.

  Timescales

  As in previous years, all sites will undertake a self-assessment using the standard assessment form produced by the NPSA.

  Midlands & Eastern and Southern Strategic Health Authorities are asked to begin assessments on 11th January 2010 and enter the reports by the 5th March 2010.

  Patient & Public Involvement

  The PEAT assessment should be carried out from the patient's perspective. Involving members of the public and/or patients is an important part of the PEAT process. This allows our Trust to be able to demonstrate a commitment to the principles of public/patient involvement and provides an opportunity for members of the local community to have increased confidence in the process.

- **PEAT Expenditure 2008/09**
  PEAT expenditure budget was set from April to September, review of continued funding required, no current activity or expenditure.

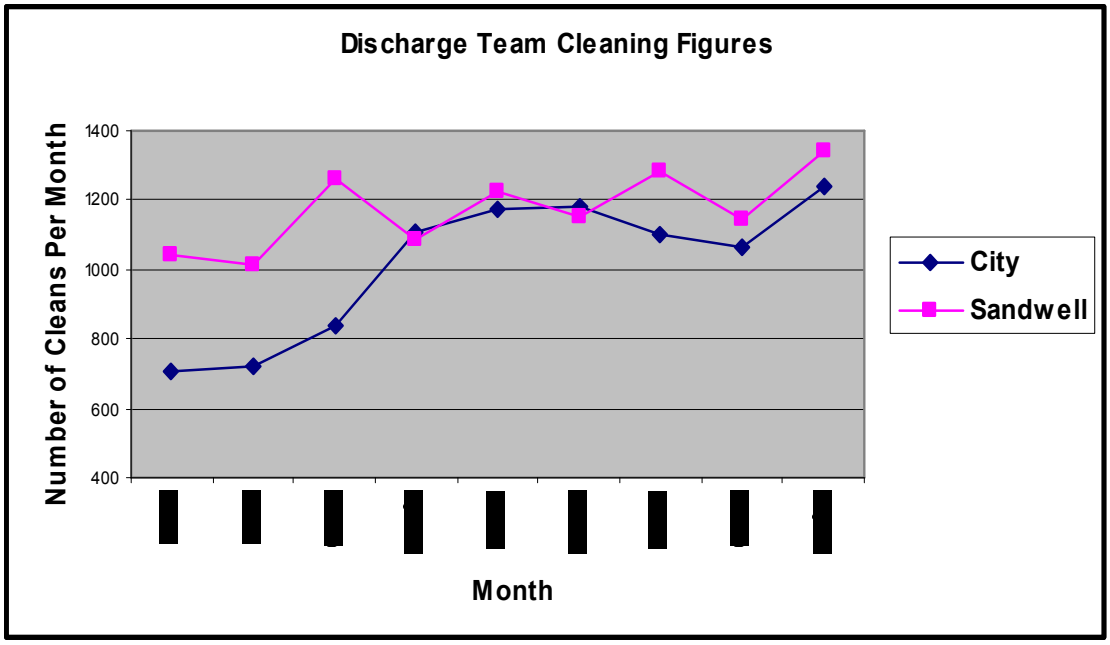
(£000's)	Funding	Expenditure
Extra Maintenance Staff (Agency)	0	225
Patient Equipment/Optimal/LIA	0	60
PEAT Expenditure		
PEAT Funding	480	202
Total	**480**	**487**

- **PEAT Internal Inspections**
  The responsibility for the PEAT inspections has now been devolved to the relative Matron/Ward Managers. The first reports are being generated and the relative action plans produced. It has been agreed that the inspection will take place bi-annually.

  The total number of inspection returns for the Trust by site are as follows:

  - City - 32
  - Sandwell - 11
  - Rowley - 3

Discharge Cleaning Teams – Performance 2008/09
Although the service is still 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.



National Standards of Cleanliness – C4C

A hand-held data capture system has been purchased for the NSoC audits. The current room data and cleaning

schedules are being transferred and the system should go live in the New Year.

Decontamination
City bed store complete. Sandwell decontamination /bed store, paper to be presented at November SIRG.

Sterinis (Decontamination Clean)
10 Steam cleaners have been purchased, training has been undertaken and the machines will be utilised across all 3 sites from Monday 2nd November 2009, the initial programme will concentrate on public areas.

Waste
Appointment of new waste contractor subject to inspection of premises and recycling plant, 70/80% of general waste recycled at the plant.

Patient Dignity
New range of nightwear, Sunlight to trial at Sandwell in New Year. Other alternative solutions are being investigated.

STEVE CLARKE
DEPUTY DIRECTOR - FACILITIES

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:	26 November 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.
Work has commenced at City with handwash stations on the main spine and increased stations on refurbished wards. Janitorial cupboards have all been refurbished.

In addition the Trust Board are asked to note that the Trust underwent its annual unannounced Hygiene Code inspection on 10th November. A report should be received within the next few weeks.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Ensure continued improvement in infection control and achievement of national and local targets
Annual priorities	
NHS LA standards	2.4.9 - Infection control
Core Standards	C4a - the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA;
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Usual quarterly report to Trust Board

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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

REPORT TITLE:	Quarterly Infection Prevention and Control Report – July - September 2009
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Dr Beryl Oppenheim Director of Infection Prevention and Control
DATE OF MEETING:	26 November 2009

KEY POINTS:

EXECUTIVE SUMMARY

Organisational structures continue to work well and joint working with community partners is yielding improvements in many areas

Numbers of cases of MRSA bacteraemia and *Clostridium difficile* infections remain 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 linking of the mandatory training programme in infection control with the Top 10 Rules is resulting in wide familiarity with these and improvements in audit results.

PURPOSE OF THE REPORT:

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

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Ensure continued improvement in infection control and achievement of national and local targets

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUARTERLY INFECTION PREVENTION AND CONTROL REPORT JULY-SEPTEMBER 2009

Management and Organisation

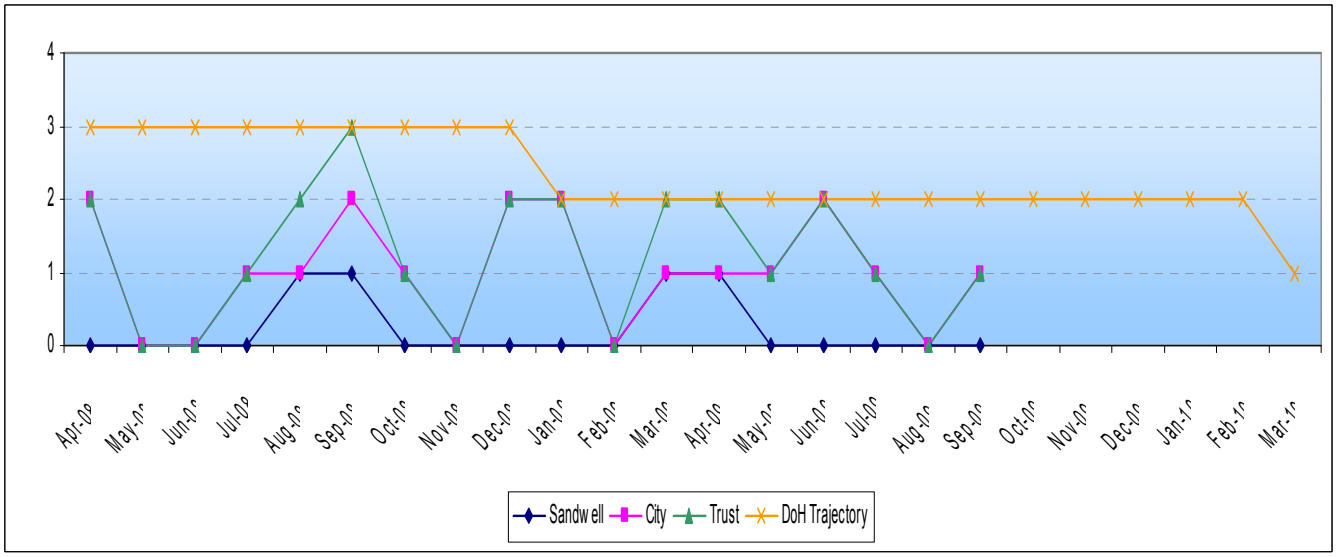
Working arrangements both within the Trust and with community partners continue to progress well. A particular strength of the arrangements has been joint tabletop reviews around critical incidents related to MRSA bloodstream infections and *Clostridium difficile* related problems, where learning points have resulted in actions designed to improve identified issues. We have also been working closely with community colleagues to consider the best ways of preventing admission and delayed discharges during the norovirus season, as a combination of increased cases of norovirus and influenza could severely impact on patient throughput.

MRSA

Mandatory Reporting of MRSA bloodstream infections

There were a total of 2 MRSA bacteraemias during this quarter (Figure 1), with our threshold for that period being 6. This brings a total of 7 cases in 6 patients for the first 6 months of the year of which 2 were diagnosed more than 48 hours after admission and the remaining 5 were in samples taken within the first 2 days of admission from patients originating from 3 different Primary Care Trusts.

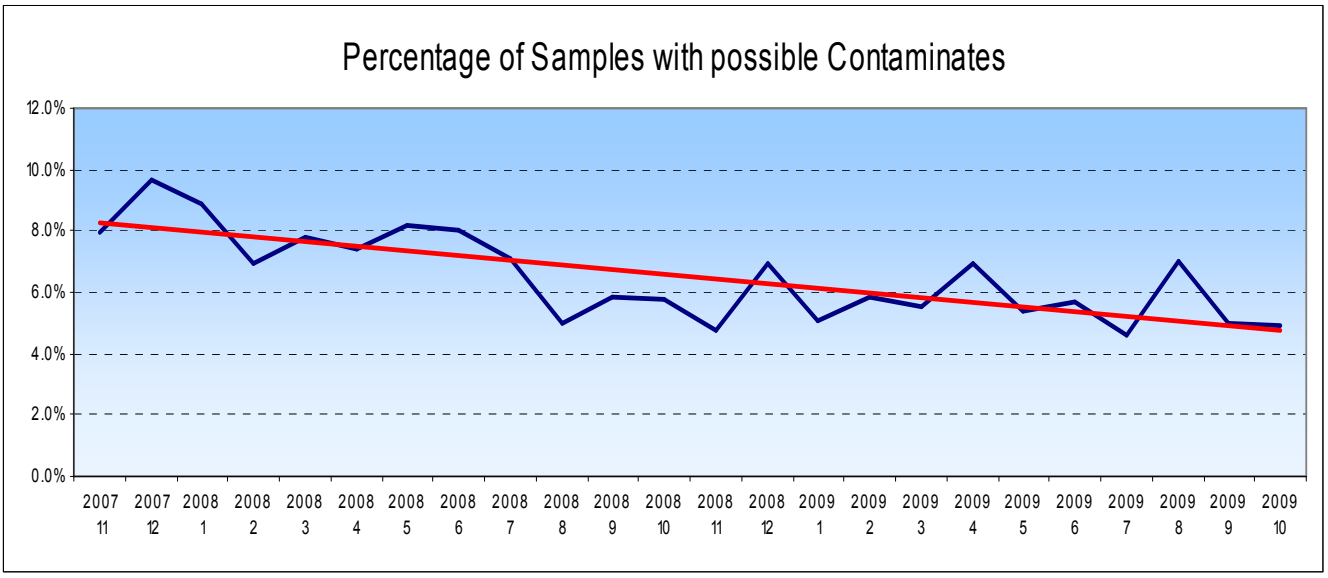
Figure 1. Total MRSA bacteraemias



No particular themes have emerged from review of these cases but we continue to work on all aspects of prevention and control of serious MRSA infections. One concern remains contaminated blood cultures which not only pose a risk to maintaining numbers within our threshold but are also costly and may result in unnecessary treatments and further investigations for patients.

Our approach has been to train all staff who regularly take blood cultures, with a particular drive to train junior doctors in recent months, with feedback and re-training for staff who have taken blood cultures subsequently identified as contaminated. The overall reduction in the proportion of contaminated blood cultures over the last two years (Figure 2) has been gratifying but since the literature suggests that it is possible to achieve rates of around 3%, we feel that further work should be done in this area.

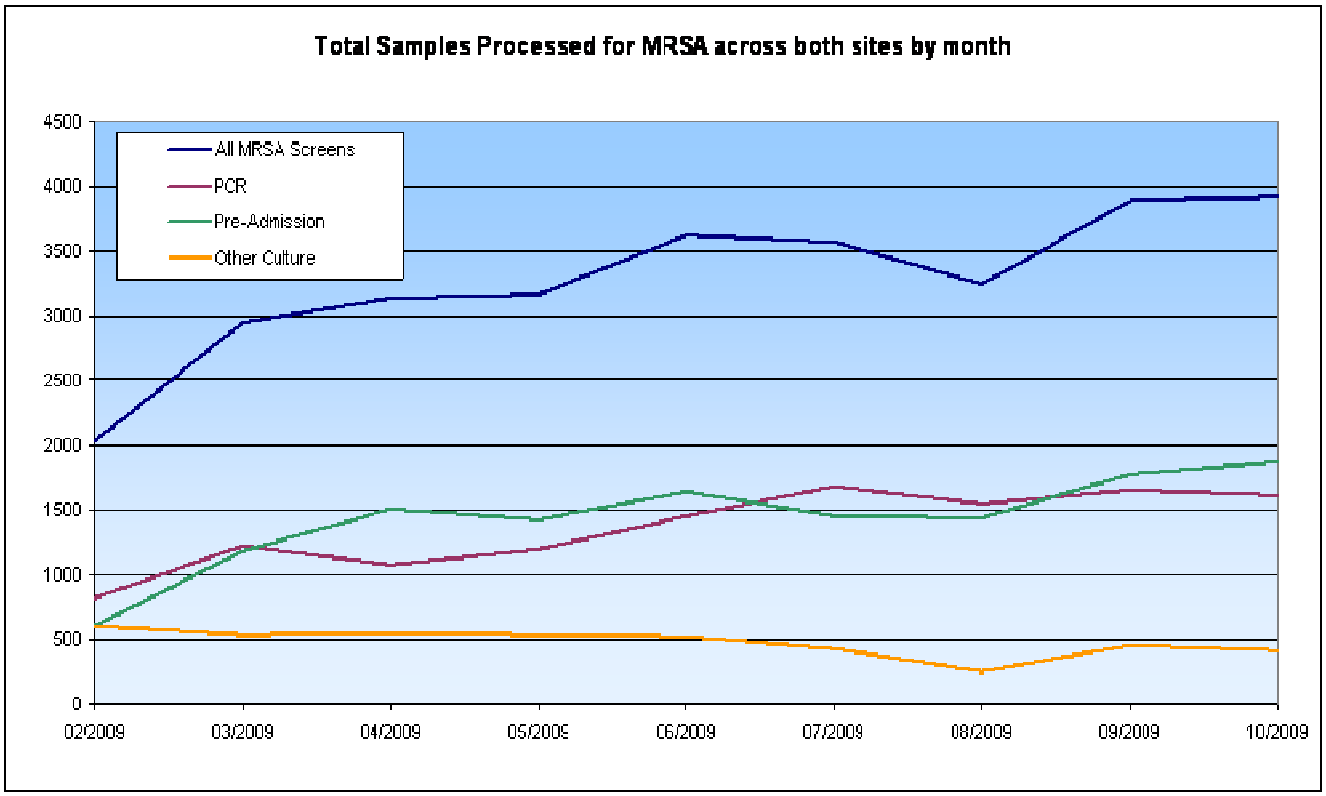
Figure 2.



MRSA screening and decolonisation

We continue with our programme for screening both elective and non-elective admissions and the number of screens performed has continued to rise (Figure 4) although we feel that there is still some way to go to achieve full compliance. A programme of audits of adequacy of screening and also follow-up care is underway and findings from the audits are being fed back to teams to improve wherever possible.

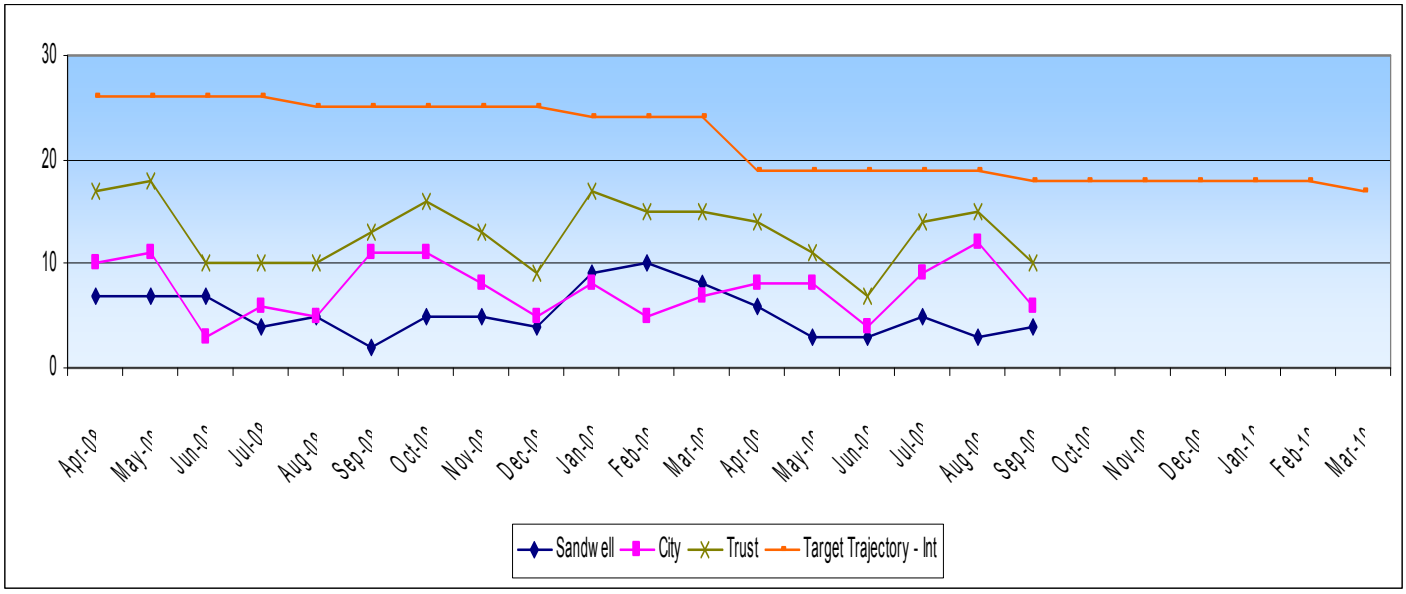
Figure 3.



Clostridium difficile **infections (CDI)**

There were 66 cases of CDI in patients admitted to the Trust during the period July to September 2009, of which 39 were diagnosed after 48 hours and are attributable to our trajectory (Figure 4). This is well within our threshold of 56 cases for that quarter.

Figure 4. CDI > 48 hours after admission



Antibiotic stewardship

This has been a particularly active period for the Antibiotic Management Group, working closely with community colleagues and focussing on areas identified through table top reviews of critical incidents. Reviews of cases of *Clostridium difficile* infection diagnosed or acquired in the community highlighted the need for further education of colleagues in primary care and a highly successful and well-evaluated Protected Learning event for General Practitioners in Sandwell focussed on antibiotic and other medicines management and the diagnosis, prevention and treatment of CDI. The development of rapid methods of feedback to practices around antibiotic use together with clearer understanding of the importance of restriction of certain antibiotic classes is already yielding improvements in many areas.

A number of table top reviews highlighted the problems of antibiotic usage in vulnerable elderly patients who, because of repeated admissions and contact with the healthcare environment are particularly susceptible to infections due to antibiotic resistant bacteria and to CDI has resulted in the development of a new Trust-wide guideline for antibiotic treatment of commonly encountered infections which has specific regimens for this high risk group, with major input from physicians with special interest in the care of elderly patients. Similarly, the requirement for a dedicated pathway for the identification, diagnosis and management of soft tissue infections in diabetic patients was identified following MRSA bloodstream infections in this setting and a multi-disciplinary group has met to develop a policy for addressing this problematic issue.

Audit and training

We have continued to focus attention on training of junior doctors, highlighting specifically antibiotic usage and taking of blood cultures and we feel this has resulted in a particularly knowledgeable and confident group of doctors for this year and we are especially grateful for the outstanding co-operation from the Postgraduate Tutors who have made this possible.

The improved uptake of mandatory training in general has contributed to staff becoming more familiar with the Top 10 Rules, and we feel that this is reflected in improvements for example in hand hygiene audits. We continue to monitor our progress against the infection control programme and are confident that this is on target.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Right Care Right Here Progress Report
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Jayne Dunn, Redesign Director – Right Care Right Here
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The paper provides a progress report on the work of the *Right Care Right Here* Programme as at the end of October 2009 and includes a copy of the *Right Care Right Here* Programme Director's report to the Right Care Right Here Partnership.

It covers:

- Progress of the Programme including performance data for exemplar projects against targets for April – August 2009.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. NOTE the progress made with the Right Care Right Here Programme.
2. NOTE that the Trust submitted a proposal to the Heart of Birmingham teaching PCT outlining options for the Trust's involvement in the further development of Greet Health Centre as an Outpatient and Diagnostic Centre.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Care Closer to Home: Ensure full Trust participation in the delivery of Right Care, Right Here programme exemplars project
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Usual monthly update to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT NOVEMBER 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 October 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 – August 2009/10 (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 – August 2009.

There are four projects with 'Green' status – Urgent Care– HoB, Rehab Beds - Sheldon, Respiratory and ENT, all of which are exceeding targets.

Four of the projects are rated as 'Amber' are:
Urgent Care, HoB: activity just below target (1% under). Request for project closure expected at Final Review process in November
Rehab Beds, Rowley: No data has been provided for the STAR service and the Step Up bed provision is underperforming (30% under).
Musculoskeletal: there are areas of underperformance for Community Orthopaedics and Pain Management and no primary care data for GP led Rheumatology.
Dermatology: the Consultant-led outpatient activity for August is an estimate which requires confirmation.

Four projects are rated 'Red':
Urgent Care, Sandwell: this is operating at 6% below target due to reduced UCC hours of operating. Sandwell PCT indicates that patients may be attending Parsonage Street Walk In Centre but as yet figures have not been provided to prove or disprove this.
Ophthalmology: last month's report showed 21% below target. The project lead has left and no data or report has been submitted. The project support lead at SWBH has been asked to provide the data but is also on leave.
Cardiology: The project lead post remains vacant and no reports are being submitted. Project support leads have been asked to provide this data but it has not yet been received.
Diabetes; Actual activity is 9% below target. The project lead has indicated that some activity was double counted into the target but this has not before been raised with the Programme and they are therefore working to a target which is not recognized or agreed.

The issues relating to the projects rated as red and amber continue to be pursued by the Programme Delivery Group.

Service Redesign Activity - The Strategic Model Of Care Steering (SMOCS) Groups continue to present their three key deliverables (Clinical Strategy, Overall Model of Care and Priorities for Service Redesign) to the Clinical Group. Once approved by the Clinical Group the SMOCS deliverables will be presented to the Trust's RCRH Implementation Board with Planned Care being presented to the November meeting.

Review of the Programme - A revised Overall Programme Plan will be presented to the November RCRH Partnership Board. The intention is to hold initial meetings of the three new service redesign work streams in December.

Programme Workforce Team – The SHA initially agreed in principle to support the Programme Workforce Team until March 2011. This no longer appears to be the case. The Programme has identified sufficient funding to support the team until September 2010 and further discussions are being held to identify other sources of funding.

Greet Health Centre - The Trust submitted a proposal to the Heart of Birmingham teaching PCT (following an invitation to do so from the PCT) outlining options for the Trust's involvement in the further development of Greet Health Centre as an Outpatient and Diagnostic Centre. This includes options for transferring clinical outpatient services to Greet Health Centre in line with the priorities of local GPs and also options for developing 'front of house' clinical support services.

RECOMMENDATIONS

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.
2. NOTE that the Trust submitted a proposal to the Heart of Birmingham teaching PCT outlining options for the Trust's involvement in the further development of Greet Health Centre as an Outpatient and Diagnostic Centre.

Jayne Dunn
Redesign Director – Right Care Right Here
19th November 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, 26th October 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
- Agree to receive the SMOCS Groups' reports after they have been received by partner organisations (Section 3.1)

2. Project Performance

2.1 April to August 2009

Given at Appendix 1 is the Project Performance report for April to August 2009.

There are four projects with 'Green' status – Rehab beds, Sheldon, Respiratory, ENT and gynaecology, all of which are exceeding targets.

The reasons for the four projects rated as 'Amber' are:
Urgent Care, HoB: activity just below target (1% under). Request for project closure expected at Final Review process in November
Rehab Beds, Rowley: No data has been provided for the STAR service and the Step Up bed provision is underperforming (30% under)
Musculoskeletal: there are areas of underperformance for Community Orthopaedics and Pain Management and no primary care data for GP led Rheumatology
Dermatology: the Consultant-led outpatient activity for August is an estimate which requires confirmation

Four projects are rated 'Red':
Urgent Care, Sandwell: this is operating at 6% below target due to reduced UCC hours of operating. Sandwell PCT indicates that patients may be attending Parsonage Street Walk In Centre but as yet figures have not been provided to prove or disprove this
Ophthalmology: last month's report showed 21% below target. The project lead has left and no data or report has been submitted. The project support lead at SWBH has been asked to provide the data but is also on leave.
Cardiology: The project lead post remains vacant and no reports are being submitted. Project support leads have been asked to provide this data but it has not yet been received.
Diabetes; Actual activity is 9% below target. The project lead has indicated that some activity was double counted into the target but this has not before been raised with the Programme and they are therefore working to a target which is not recognized or agreed.

These issues were discussed by the Programme Delivery Group on 19th October. It was agreed to ask one of the Project Support Leads for Cardiology and Ophthalmology to take responsibility for leading the projects in the Final Review Process, established for early November.

3. Service Redesign Activity

3.1 SMOCS Update

Progress continues to be made with all the SMOCS Groups. Since the last meeting, it has been agreed that the Maternity and Newborn SMOCS Group report will be re-submitted to the November Clinical Group meeting.

The October Clinical Group received reports from Children's Services and Planned Care. The Group did not feel able to approve the Children's Services report and asked for further work to be undertaken, particularly about the priorities for service redesign, which need further development into specific areas for attention, on a timed basis between now and 2015/16.

The Planned Care report was approved with no changes, and its recommendations for future action were accepted in full. The report provides a very clear exposition of the principles to be adopted in organising planned care activities (defined as all activity except immediate emergencies and urgent care). The recommendations include the adoption of Map of Medicine for care pathway planning and development and a review of Choose and Book to make it an effective tool to support clinical activity rather than simply a mechanism for booking appointments.

The Programme Delivery and Strategy Groups have agreed that as SMOCS Group reports are agreed by the Clinical Group, they should be submitted to each of the PCTs' PECs and the SWBH Right Care Right Here Implementation Board. They will also be forwarded to the Chief Executives of the Mental Health Trusts and the lead Directors for social care services in the local authorities.

It is proposed that these should be received at the Partnership Board after they have been received in the organisations as identified above, so that any comments made can be taken into account.

3.2 First and Second Wave Projects Final Review Process

The Final Review Process for the First and Second Wave Projects, as agreed last month, has now been organised for the 6th, 9th and 11th November.

4. Review of Programme

4.1 Development of Overall Programme Plan

The Programme Manager and I have met with Active Plan Solutions to agree the approach to re-developing the Overall Programme Plan, which was first presented to the Partnership Board in November last year. Given the changes to the Programme through the Review and pending the final outcome of the review of the physical infrastructures in the PCTs and acute trust, this will require major revision. It is intended to provide the next iteration of the plan to the Partnership Board in November.

4.2 Establishment of New Workstreams

The new Finance and Capacity Group met for the second time on 16th October with the intention of confirming the revised financial affordability analysis and then to agree how this is allocated to each service line. Given a range of competing priorities in finance departments, it has not been possible to complete the financial affordability analysis and this is now being developed for completion by Friday, 23rd October. It is intended then to identify the impact on service lines and to produce Version 5.1 of the Activity and Capacity Model by the end of October

For the three major service redesign workstreams, organisations are identifying colleagues to work within these as Project Leads, Project Managers, and Clinical Leads. In addition, I have asked HR and Communications colleagues to nominate lead individuals in these functions. The Programme Team has now decided how Programme Management, Workforce and Admin Support will be provided to these workstreams. When colleagues are nominated, the first meetings of each workstream will be arranged.

Following the advertisement of the three additional posts in the Programme Team as secondment opportunities, four expressions of interest have been received for the Map of Medicine Manager post, four for the Admin Manager post and one for the Admin Support post. Interviews for these are being held on 21st October and I will provide an update at the meeting.

4.3 Presentation to Joint Overview and Scrutiny Committee Meeting

As members will recall, we agreed that an essential initial activity in promoting the outcome of the Programme Review would be to present the detailed revised Programme Plan, including details of the PCT and acute trust physical infrastructure reviews to a Joint Overview and Scrutiny Committee meeting. A date had been agreed of 3rd December for this to take place, but I have been notified that one of the chairs is now unable to attend on that date ands so the meeting is being rearranged. This is likely to be later in December.

5. Funding of Workforce Team

Members will recall that the SHA had agreed in principle that the Workforce Team should continue for a further year, beyond the originally intended conclusion date of March 2010. It was agreed to support the team for a further year, to March 2011. In further debate with the SHA, they have demonstrated reluctance to identify additional funding from their resources, other than that which they have already provided to the Programme. By carrying forward underspends and changing the nature of the work being undertaken, Karen Scott has been able to identify sufficient funds to guarantee the continuation of the team to September 2010. We are also meeting Moira Dumma, the Chair of the Locality Stakeholder Board on Friday 23rd October to identify if there is any additional funding which can be provided from this source. If this is not successful, I will return to the SHA and ask them to make good the remaining shortfall. If this is not aqreed, we will need to agree which elements of work can be completed by the Team through to September 2010.

6. Development of Risk Register

Members will recall that we have agreed the severe and high risks for the Partnership. I am meeting with all of the risk owners (13 groups in all) to identify existing controls, gaps in controls, mitigation plans and to undertake a rescoring of each risk. This process, because of colleagues' availability, is taking longer than originally anticipated. I now predict that this will come to the Partnership Board for agreement at the December meeting.

7. Recommendation

The Partnership Board is recommended to:

- Note the content of the report
- Agree to receive the SMOCS Groups' reports after they have been received by partner organisations (Section 3.1)

Les Williams
Programme Director

2009-10-20 – prog dir report - lnw

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-August 09/10

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

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	976	976	976	0	0	0	0	0	0	0	4,880		11,710		Gill Gadd	Activity below target owing to reduced hours of operating. ENP and Physiotherapy activity
Actual	865	927	1,008	865	905	0	0	0	0	0	0	0	4,570				SWBH	increasing. Request for provision of number of patients attending Parsonage Street
Variance													**-310**	**-6**				requested from Sandwell PCT to understand if this is a factor in the underperformance.
URGENT CARE - HoB																		
Targets (Attendances):																		
City	2,500	2,500	2,500	2,500	2,500	0	0	0	0	0	0	0	12,500		30,000		Mark Curran	Activity just below target.
Actual	2,424	2,433	2,113	3,176	2,233	0	0	0	0	0	0	0	12,379				HOB PCT	
Variance													**-121**	**-1**				HoB tPCT have given SWBH notice to cease financial support to UCC GPs from 1st April 2010.
Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0		13,000			Project closure requested - to be decided through Final Project Review process early
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					November.
Variance													**0**	**n/a**				
	Note: July actual includes activity from additional GP in response to swine flu																	
REHAB BEDS - SHELDON																		
Targets:																		
Community - D43 (OBDs)	647	647	646	646	647	0	0	0	0	0	0	0	3,233		7,760		Angela Young	Project exceeding targets overall.
Actual	638	783	631	643	643	0	0	0	0	0	0	0	3,338				HOB PCT	
Variance													**105**	**3**				
Care Centres (OBDs)	571	571	571	570	571	0	0	0	0	0	0	0	2,854		6,850			
Actual	595	657	592	662	606	0	0	0	0	0	0	0	**3,112**					
Variance													**258**	**9**				
Comm. Alternatives Sub-Acute D47 (?)	0	0	0	0	0	0	0	0	0	0	0	0	0		2625*			
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
Comm. Alternatives Rehabilitation (Patient Package)	292	292	292	291	291	0	0	0	0	0	0	0	1,458		3,500			
Actual	836	977	1,045	1,114	856	0	0	0	0	0	0	0	**4,828**					
Variance													**3,370**	**231**				
	Note: Target for Community Alternatives Sub-Acute D47 is HoBPCT only - Sandwell target to be agreed.																	
REHAB BEDS - ROWLEY																		
Targets:																		
Community Step Up - ET Ward (OBDs)	317	317	317	316	316	0	0	0	0	0	0	0	1,583		3,800		Chris Gibbs	Significant overperformance for step-down element of the project but underperforming
Actual	48	231	246	285	300	0	0	0	0	0	0	0	1,110				(interim)	for step-up activity. No data provided for August from the STAR service - interim Project Lead
Variance													**-473**	**-30**			SPCT	acting to obtain this.
Community Step Down - Mc Ward (OBDs)	642	642	642	641	641	0	0	0	0	0	0	0	3,208		7,700			
Actual	1,526	1,663	1,611	1,627	1,588	0	0	0	0	0	0	0	8,015					
Variance													**4,807**	**150**				
STAR (Av Admits)	83	83	84	83	0	0	0	0	0	0	0	0	333		1,000			
Actual	60	77	75	91	n/a	0	0	0	0	0	0	0	303					
Variance													**-30**	**-9**				
MUSCULOSKELETAL (includes Orthopaedic beds & outpatients, Rheumatology outpatients & Pain Management																		
Targets:																		
HoB Orthopaedics Triage (NCL OPs)	545	545	545	545	543	0	0	0	0	0	0	0	2,723		6,535		Paul Hazle	Orthopaedic triage activity is exceeding target, as is Community Rheumatology.
Actual	641	556	902	884	739	0	0	0	0	0	0	0	3,722				SWBH	Reasons for Community Orthopaedics being significantly below target being explored with
Variance													**999**	**37**				the Project Lead. HoB community Pain Management Clinic start date postponed
Sandwell Orthopaedics Triage (NCL OPs)	574	574	574	574	573	0	0	0	0	0	0	0	2,869		6,885			indefinitely, contributing to activity for this element of the project being below target.
Actual	585	520	623	669	490	0	0	0	0	0	0	0	2,887					
Variance													**18**	**1**				Some of the actual data reported for previous months has changed - Project Lead asked for
Community Rheumatology (CL OPs)	381	381	381	381	378	0	0	0	0	0	0	0	1,902		4,564			explanation as issue persists.
Actual	387	397	453	496	404	0	0	0	0	0	0	0	2,137					
Variance													**235**	**12**				Project lead actively chasing primary care rheumatology activity.
Primary Care Rheumatology (CL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		140			
Actual	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
Community Orthopaedics (CL OPs)	74	74	74	74	74	0	0	0	0	0	0	0	370		889			
Actual	50	4	43	47	72	0	0	0	0	0	0	0	216					
Variance													**-154**	**-42**				
Community Pain Management (CL OPs)	59	59	59	59	59	0	0	0	0	0	0	0	295		702			
Actual	11	13	15	20	20	0	0	0	0	0	0	0	79					
Variance													**-216**	**-73**				
	Note; Community Pain Management actual activity only includes Lyng activity																	

	MONTH (2008/09)														2008/09			

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-August 09/10

PROJECT	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	Yearend Target	Status	PROJECT LEAD	Comments
OPHTHALMOLOGY																		
Target (CL OPs)	1,273	1,273	1,273	1,272	0	0	0	0	0	0	0	0	5,091		15,274		Vacant	No report submitted, Project Lead vacant. Request to member of support SWBH Project Lead to provide the August activity but on leave.
Actual	1,162	973	1,000	886	n/a	0	0	0	0	0	0	0	4,021				SPCT	
Variance													**-1,070**	**-21**				
DERMATOLOGY																		
Targets:																		
Community (CL OPs)	267	267	267	265	266	0	0	0	0	0	0	0	1,332		3,198		Kayode	Project exceeding target overall. No venue for Rowley identified. Consultant vacancies have resulted in the suspension of clinics at Tipton, Lyng and Soho. SWBH acting to fill Consultant posts.
Actual	219	250	246	268	245	0	0	0	0	0	0	0	1,228				Odetayo	
Variance													**-104**	**-8**			HOB PCT	
Community - GPwSI (OPs)	134	134	134	132	134	0	0	0	0	0	0	0	668		1,602			
Actual	178	187	260	275	188	0	0	0	0	0	0	0	1,088					
Variance													**421**	**63**				
	Note: Community Consultant Led Outpatients August actual figure is estimated as data not available																	
RESPIRATORY																		
Targets:																		
Community - Nurse-led (OPs)	80	80	90	100	100	0	0	0	0	0	0	0	450		1,034		Sally Sandel	Significant overperformance against target.
Actual	295	281	153	139	153	0	0	0	0	0	0	0	1,021				SPCT	
Variance													**571**	**127**				
Primary Care - GP/Nurse/GPwSI (OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		432			
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
	Note: Primary Care service planned to commence in October																	
ENT																		
Target (CL Outpatients)	822	822	822	821	821	0	0	0	0	0	0	0	4,108		9,860		Jane Clark	Actual activity exceeding target .
Actual	852	883	978	991	739	0	0	0	0	0	0	0	4,443				SWBH	
Variance													**335**	**8**				
CARDIOLOGY																		
Targets:																		
Community (CL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		782			No report submitted. No interim lead identified. Actual activity requested from support project leads but incomplete.
Actual - Rowley & Neptune	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0				Vacant	
Variance													**0**	**n/a**			SPCT	
Community (NCL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		1,867			
Actual	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
GYNAECOLOGY																		
Target (CL OPs)	88	88	88	88	88	0	0	0	0	0	0	0	440		1,053		Therese	Actual activity exceeding target.
Actual	89	100	88	91	79	0	0	0	0	0	0	0	447				McMahon	
Variance													**7**	**2**			HOB PCT	
DIABETES																		
Targets:																		
Community (CL OPs)	553	553	553	553	553	0	0	0	0	0	0	0	2,765		6,635		Olivia Amartey	Activity below target. Project Lead has explained that 08/09 was checked subsequent to the agreement of 09/10 targets and some clinics were found to have been double counted, and in consequence the project is working to a 09/10 target of 5835 for CL outpatients. Target issue to be taken to the final project review scheduled for early November.
Actual	379	463	631	605	436	0	0	0	0	0	0	0	2,514				HOB PCT	
Variance													**-251**	**-9**				
Primary Care (NCL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		361			
Actual	n/a	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	RCRH Acute Hospital Development: Project Director's Report
SPONSORING DIRECTOR:	Graham Seager, Director of Estates/New Hospital Project
AUTHOR:	Andrea Bigmore, New Hospital Project Manager
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The Project Director's report includes reference to:

- The Arts Strategy
- The patient experience in the new hospital

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to deliver New Hospital Project 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:

Usual monthly report

Sandwell and West Birmingham Hospitals NHS Trust

right care right here

RIGHT CARE, RIGHT HERE PROGRAMME
ACUTE HOSPITAL DEVELOPMENT

Report to:	**Trust Board**
Report of:	**Andrea Bigmore / Graham Seager**
Subject:	**Acute Hospital Development Progress Report**
Date:	**17th November 2009**

1. Public Art Strategy

A Public Art Strategy has been approved by the Project Board. This document has been developed with the help of the Arts Steering Group through a series of workshops.

The Strategy provides a brief for Private Finance Initiative (PFI) bidders to consider how they will build arts into the design solution. The fabric of the building will include artistic expression as well as support the display of artwork. There is now considerable evidence that art in hospitals improves patient and staff well being, PFI bidders will need to demonstrate that they have taken this into consideration in their designs.

The strategy also outlines an evidence based approach to how the Trust will deliver a vibrant Art Programme on opening of the new hospital and beyond. The Art Programme will be initiated during the final year of construction to prepare for commissioning of the building and will continue beyond opening to ensure full benefits are realised.

Engagement of patients, staff and local communities will be central to the loan, commissioning and creation of art pieces.

An Arts Co-ordinator will be appointed to facilitate this process under the guidance of a Joint Arts Committee. It is assumed that the Trust will be able to secure external funding for this appointment and the Art Programme. A strategy for fund raising is proposed in the document. Close working with Birmingham City and Sandwell Metropolitan Councils and other partners with knowledge and expertise will be essential if funding is to be obtained.

A pilot project has been proposed for the Birmingham Treatment Centre and Sandwell Hospital. This project would give the Trust an opportunity to test and evaluate the approach prior to the move to the new hospital. A paper will be presented to the January Trust Board to outline plans for this project.

2. Patient Experience

As outlined above in the section on the Public Art Strategy, good design can make a huge difference to the patient experience. Development of a new hospital provides a great opportunity to set new standards to ensure that patients will feel comfortable and supported in the new environment.

The project team is undertaking a full review of the standards for privacy and dignity in the new hospital. Some examples of things for consideration are outlined below:

- Privacy for patients being interviewed
- Supportive environments for the breaking of bad news
- Ensuring that carers can accompany patients to appointments
- Supporting vulnerable adults
- Privacy for patients needing to undress for tests or procedures

A robust set of standards to ensure the best possible patient experience will be set from the outset. The standards will be presented in a whole hospital policy that the Private Finance Initiative partner will need to respond in the design.

Best practice assessments will be applied to the scheme at each stage to ensure that the standards are delivered when the new hospital opens.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance – Month 7
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The report is provided to update the Board on financial performance for the seven months to 31st October 2009.

In-month surplus is £251k against a target surplus of £222k; £29k above plan.

Year to date surplus is £1,559k against a plan of £1,690k, £131k below plan.

In-month WTEs are 5 below plan, excluding the effect of agency staff.

Cash balance is approximately £2m greater than the revised plan at 31st October.

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 amendments to the capital programme.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Financial Management Board and Trust Management Board on 17 November 2009; Finance and Performance Management Committee on 19 November 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2009

EXECUTIVE SUMMARY

• In the period 1st April 2009 to 31st October 2009, the Trust has generated an overall I&E surplus of £1,559,000 which is £131,000 lower than the planned position. During the month of October, the Trust produced a net surplus of £251,000 exceeding the planned budget surplus by £29,000. This result continues the trend for the last quarter of meeting or slightly exceeding the planned surplus for the month.

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

• At month end, WTE's (whole time equivalents) excluding the impact of agency staff were 8 below plan and total pay expenditure for the month £246,000 above plan. This includes £391,000 of agency expenditure during October which is a slight fall compared with September levels.

• The month-end cash balance is approximately £2m above the revised cash profile.

• Divisional performance in month has been very mixed and, at 31st October four divisions remain in significant year to date deficit positions: Medicine A, Medicine B, Surgery A and Facilities.

Financial Performance Indicators

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	29	-131	> Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	35	-88	> Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	-246	-1,739	< Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	-504	-1,421	< Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	8	76	< Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	2,092	2,092	> = Plan	> = 95% of plan	< 95% of plan
CIP Actual v Plan £000	-70	-207	> 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	1,690	1,559
Capital Resource Limit	4,775	3,367
External Financing Limit	---	12,621
Return on Assets Employed	3.50%	3.50%

2009/2010 Summary Income & Expenditure Performance at October 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	Forecast Outturn £000's
Income from Activities	330,449	27,744	28,515	771	193,185	196,140	2,955	336,124
Other Income	37,382	3,188	3,202	14	21,629	21,746	117	37,499
Operating Expenses	(338,714)	(28,474)	(29,224)	(750)	(197,464)	(200,624)	(3,160)	(344,468)
EBITDA	29,117	2,458	2,493	35	17,350	17,262	(88)	29,155
Interest Receivable	150	13	7	(6)	88	45	(43)	72
Depreciation & Amortisation	(16,444)	(1,370)	(1,370)	0	(9,592)	(9,592)	0	(16,444)
PDC Dividend	(8,374)	(698)	(698)	0	(4,885)	(4,885)	0	(8,374)
Interest Payable	(2,180)	(181)	(181)	0	(1,271)	(1,271)	0	(2,140)
Net Surplus/(Deficit)	**2,269**	**222**	**251**	**29**	**1,690**	**1,559**	**(131)**	**2,269**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2009

Divisional Performance

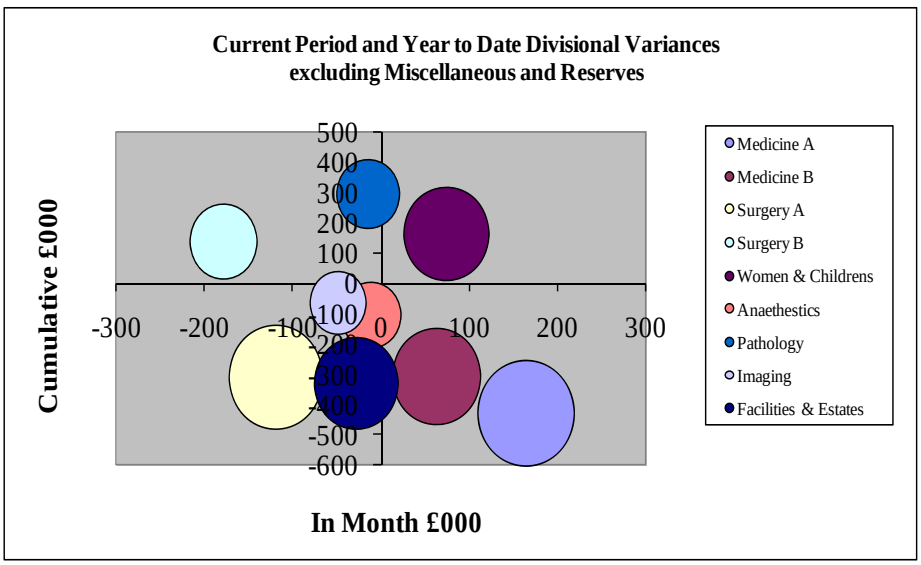
• As has been experienced over the last few months, the overall position of the Trust has improved slightly and the shortfall against the year to date I&E target is now reduced to £131k. This improvement in performance continues to be wholly driven by additional income, primarily from patient related SLAs.

•Pay costs remain significantly above plan now reaching £1,739k for the year to date with a further worsening in month of £246k. WTE numbers, excluding the impact of agency staff, have now fallen below planned levels although this is driven by increases in the plan rather than reductions in actual wte's in post. After taking into account agency staff, actual wte's are approximately 125 above plan. The non pay position also continues to be higher than plan, in part reflecting activity related pressures as patient treatment numbers exceed contracted levels.

•In month, Surgery A and Surgery B have generated significant deficits while both medical divisions are in surplus. To a significant extent, this performance reflects shortfalls in activity and income performance relative to ongoing high levels of expenditure (including, for example, additional waiting list sessions) and is, in part at least, driven by the changes made to reflect movements in case mix and the balance between long and short stay patients. On the cost side, many operational divisions continue to experience significant pressures on both pay and non pay although in many cases these are balanced by over achievement of income.

•The performance for the Trust overall is assisted by favourable budget positions within corporate divisions with a year to date performance of £431,000 better than plan and £89,000 in month.

• In month, £235k of cost pressure reserve funding has been utilised in support of the Trust's overall performance, primarily to recognise the issues outlined above with regard to casemix and length of stay issues plus additional 'flu' related expenditures including vaccinations for staff.

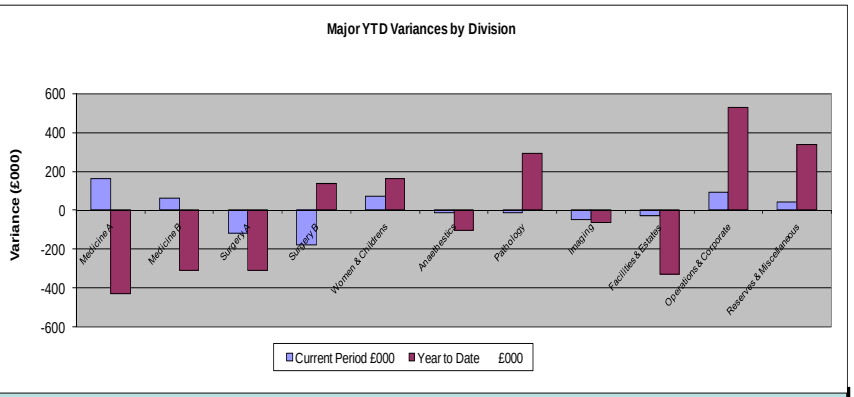


The tables adjacent and overleaf show a mixed position across divisions. The performance, in particular of Surgery A and Surgery B worsened in month while Medicine A and Medicine B improved. However, Medicine A, Medicine B, Surgery A and Facilities all continue to report sizeable year to date net deficit positions.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

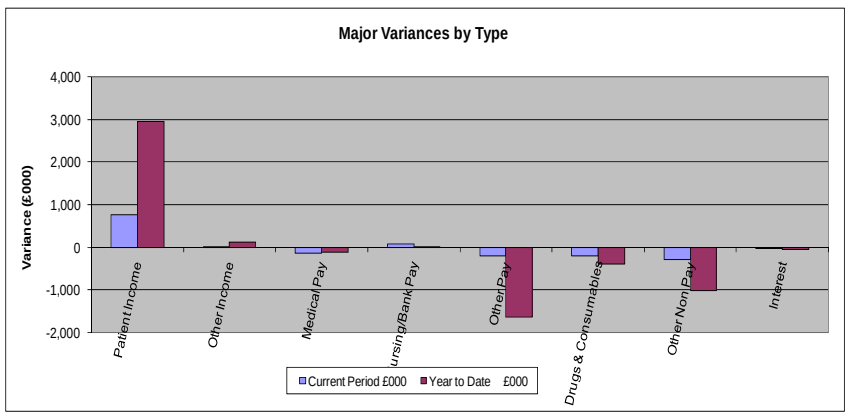
Financial Performance Report – October 2009

Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine A	164	-431
Medicine B	62	-307
Surgery A	-119	-310
Surgery B	-179	137
Women & Childrens	74	165
Anaethestics	-12	-105
Pathology	-15	292
Imaging	-49	-65
Facilities & Estates	-28	-331
Operations & Corporate	95	531
Reserves & Miscellaneous	40	339



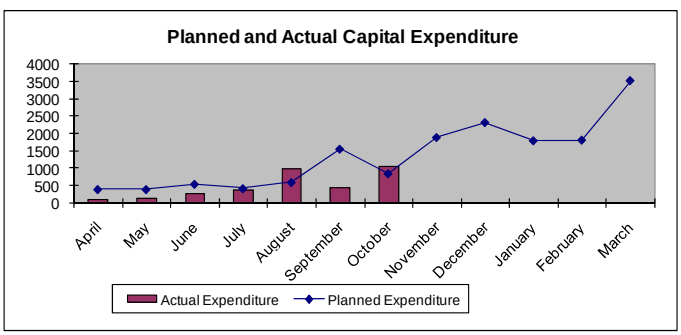
The tables below illustrate that overall income continues to perform better than plan for the month and year to date, primarily driven by higher levels of patient related SLA (service level agreement) activity. Despite this positive overall SLA income position, issues do exist regarding casemix and the relationship between short stay and long stay admissions, especially where the former results in a reduced reimbursement level for the divisions affected. Given the materiality of these in-year shifts in activity, limited adjustments have been made to divisional positions to reflect this. Overall pay expenditure remains significantly above plan and expenditure on bank and agency remains high, although, at least for agency, lower than previous months. In month, non pay expenditure is again in excess of plan, particularly in respect of medical equipment and consumables, reflecting the additional activity undertaken.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	771	2,955
Other Income	14	117
Medical Pay	-129	-118
Nursing/Bank Pay	86	9
Other Pay	-203	-1,630
Drugs & Consumables	-210	-396
Other Non Pay	-294	-1,025
Interest	-6	-43



Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Expenditure of £1,153,000 was incurred in October mainly relating to the Urgent Care Centre, energy conservation measures, D16 refurbishment and medical equipment. This brings total capital expenditure for the year to date up to £3,367,000.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2009

Capital Expenditure Continued

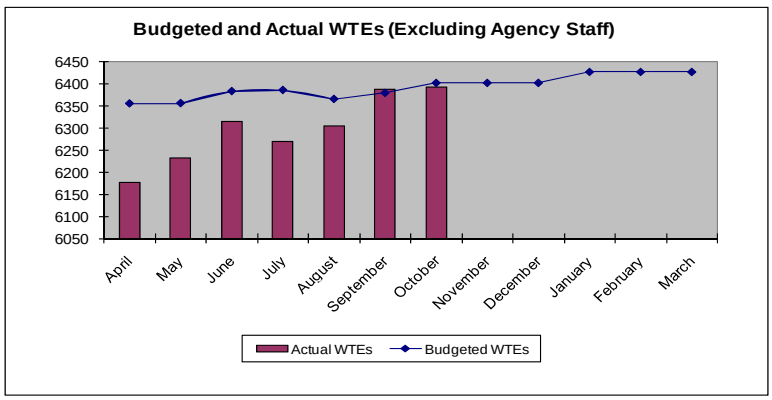
- The following changes are proposed to the capital programme:
  - •Addition of a replacement backup generator for City maternity £200k
  - •Rephasing of plans for replacement of the CT scanner increasing expenditure in 09/10 from £800k to £1,300k with an equal reduction in the following year.

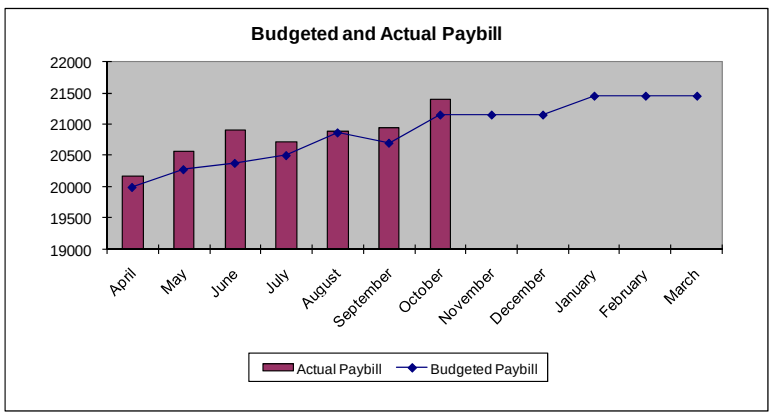
Paybill & Workforce

• Overall workforce numbers (wtes), excluding the effect of agency staff, are 8 below plan for October, which is a small improvement on the position for September although this is largely accounted for by an increase in budgeted establishment as schemes agreed as part of the financial plan come on stream. The number of actual wte's in post has increased by approximately 5. Taking an estimate of the wte effect of agency staff, wte numbers are effectively 125 above plan.

•Paybill (including agency staff) is £246,000 above budgeted levels for the month and £1,739,000 for the year to date. This represents a continuing worsening of performance against planned levels and represents a key risk that must be managed in terms of delivering the yearend forecast surplus.

•In month expenditure on agency staff was £391,000, a reduction of £51,000 against expenditure in September.





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.

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – October 2009

Analysis of Total Pay Costs by Staff Group						
	Year to Date to October					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	42,488	42,474		1,260	43,734	-1,246
Management	8,043	7,463		0	7,463	580
Administration & Estates	16,252	15,814		685	16,499	-247
Healthcare Assistants & Support Staff	7,067	7,045	1,131	771	8,947	-1,880
Nursing and Midwifery	50,563	46,872	2,495	441	49,808	755
Scientific, Therapeutic & Technical	19,399	18,980		128	19,108	291
Other Pay	22	14			14	8
Total Pay Costs	143,834	138,662	3,626	3,285	145,573	-1,739

Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the IFRS based audited accounts for 2008/2009.

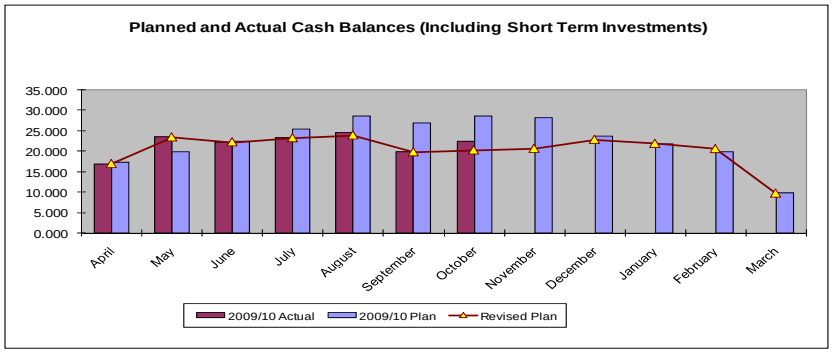
•Cash balances at 31st October are approximately £2m higher than the revised plan, the major variation from plan being the receipt of £1m from HoB tPCT in respect of RCRH project costs. The Trust is still planning to hold the same year end cash balance as included in its original financial plan for the year.

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at March 2009 £000	Balance as at October 2009 £000	Forecast at March 2010 £000
Non Current Assets	Intangible Assets	547	470	522
	Tangible Assets	277,912	271,687	257,801
	Investments	0	0	0
	Receivables	1,158	1,150	1,200
Current Assets	Inventories	3,295	3,260	3,300
	Receivables and Accrued Income	19,138	20,828	18,500
	Investments	0	0	0
	Cash	8,752	22,371	9,751
Current Liabilities	Payables and Accrued Expenditure	(28,516)	(40,655)	(31,751)
	Loans	0	0	0
	Borrowings	(1,885)	(1,880)	(1,880)
	Provisions	(5,440)	(2,111)	(2,200)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	0	0	0
	Borrowings	(33,627)	(32,227)	(31,127)
	Provisions	(2,193)	(2,193)	(1,943)
		239,141	240,700	222,173
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	161,047
	Revaluation Reserve	60,699	60,699	40,966
	Donated Asset Reserve	2,531	2,531	2,391
	Government Grant Reserve	1,985	1,985	1,805
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	4,637	6,196	6,906
		239,141	240,700	222,173

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – October 2009



Cash Flow

• The table below shows cash receipts and payments for October 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 October 2009

ACTUAL/FORECAST	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	Aug-10 £000s	Sep-10 £000s	Oct-10 £000s
Receipts													
SLAs: Sandwell PCT	**13,013**	13,040	13,040	13,040	13,040	13,040	13,236	13,236	13,236	13,236	13,236	13,236	13,236
HoB PCT	**7,236**	7,198	7,198	7,198	7,198	7,198	7,306	7,306	7,306	7,306	7,306	7,306	7,306
South Birmingham PCT	**1,286**	1,264	1,264	1,264	1,264	1,264	1,282	1,282	1,282	1,282	1,282	1,282	1,282
BEN PCT	**1,733**	1,732	1,732	1,732	1,732	1,732	1,757	1,757	1,757	1,757	1,757	1,757	1,757
Pan Birmingham LSCG	**1,213**	1,213	1,213	1,213	1,213	1,213	1,231	1,231	1,231	1,231	1,231	1,231	1,231
Other PCTs	**2,289**	2,496	2,496	2,496	2,496	2,496	2,534	2,534	2,534	2,534	2,534	2,534	2,534
Over Performance Payments	**311**	0	750	0	0	0	1,000						
Education & Training	**1,474**	1,501	1,501	1,501	1,501	1,501	1,523	1,523	1,523	1,523	1,523	1,523	1,523
Loans	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Interest	**7**	6	6	6	7	6	11	8	8	8	8	8	8
Other Receipts	**4,783**	2,412	2,412	2,412	2,412	2,412	2,090	2,090	2,090	2,090	2,090	2,090	2,090
Total Receipts	**33,345**	30,860	31,610	30,861	30,861	30,861	31,971	30,968	30,968	30,968	30,968	30,968	30,968
Payments													
Payroll	**12,392**	12,350	12,350	12,520	12,520	12,520	12,673	12,673	12,673	12,673	12,673	12,673	12,673
Tax, NI and Pensions	**8,322**	8,456	8,456	8,571	8,571	8,571	8,677	8,677	8,677	8,677	8,677	8,677	8,677
Non Pay - NHS	**2,146**	2,465	2,157	2,465	2,465	3,096	2,490	2,490	2,490	2,490	2,490	2,490	2,490
Non Pay - Trade	**6,288**	6,035	5,281	6,035	6,035	7,579	5,940	5,940	5,940	6,250	6,200	6,200	6,200
Non Pay - Capital	**1,202**	771	771	1,850	2,158	4,932	500	500	500	501	501	501	501
PDC Dividend	**0**	0	0	0	0	4,629	0	0	0	0	0	4,200	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	**355**	325	325	325	325	325	335	335	335	335	335	335	335
Other Payments	**62**	70	70	70	70	70	355	355	356	357	358	359	360
Total Payments	**30,767**	30,472	29,409	31,835	32,144	41,722	30,969	30,969	30,970	31,282	31,233	35,434	31,235
Cash Brought Forward	**19,793**	22,371	22,760	24,961	23,987	22,704	11,843	12,844	12,843	12,840	12,525	12,260	7,793
Net Receipts/(Payments)	**2,578**	389	2,201	(975)	(1,283)	(10,861)	1,001	(2)	(3)	(315)	(266)	(4,467)	(268)
Cash Carried Forward	**22,371**	22,760	24,961	23,987	22,704	11,843	12,844	12,843	12,840	12,525	12,260	7,793	7,526

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 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 processing rules generated via the CBSA. The Trust has challenged the interpretation of activity performance levels by the CBSA and PCT and is working collaboratively in resolving these.

Year to Date Key Performance Against SLA

PERFORMANCE UP TO SEPTEMBER	Activity			Finance		
	Planned	Actual	Variance	Planned £000	Actual £000	Variance £000
Accident & Emergency	117,263	116,970	-293	8,597	8,780	183
Admitted Patient Care - Elective	30,524	32,329	1,805	27,643	29,038	1,395
Admitted Patient Care - Non Elective	28,739	30,423	1,684	45,544	44,341	-1,203
Excess Bed Days	17,903	18,247	344	3,706	3,688	-18
Other	72	72	0	38,363	38,823	460
Out-Patients First Attendance	79,365	80,816	1,451	13,334	13,415	82
Out-Patients Follow Up	187,720	200,946	13,226	16,289	17,685	1,396
Out-Patients With Procedure	3,734	11,152	7,418	777	2,463	1,686
Unbundled Activity	7,442	28,443	21,001	5,564	5,661	97
Total	**472,761**	**519,398**	**46,637**	**159,817**	**163,894**	**4,077**

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

SLA Performance by Commissioner

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

Year to Date SLA Performance by Commissioner

PERFORMANCE UP TO SEPTEMBER	Finance		
	Planned £000	Actual £000	Variance £000
SANDWELL PCT	77,132	77,727	595
HEART OF BIRMINGHAM TEACHING PCT	42,849	43,466	617
BIRMINGHAM EAST & NORTH PCT	10,303	10,327	24
SOUTH BIRMINGHAM PCT	7,527	8,348	821
PAN BIRMINGHAM LSCG	7,232	8,149	917
WALSALL PCT	3,199	3,159	(40)
WEST MIDLANDS SCT	2,628	2,658	31
DUDLEY PCT	2,244	2,523	278
WORCESTERSHIRE PCT	1,338	1,530	191
SOLIHULL CARE TRUST	1,167	1,271	104
OTHERS	4,197	4,737	540
TOTAL	**159,817**	**163,894**	**4,077**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2009

SLA Performance by Specialty

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

Year to Date SLA Performance: Variances From Plan

PERFORMANCE UP TO SEPTEMBER	Finance		
	Planned £000	Actual £000	Variance £000
Cardiology	5,065	6,570	1,505
Gastroenterology	2,266	3,719	1,452
Urology	3,447	4,295	848
Respiratory Medicine	1,272	1,994	722
Elderly	9,734	10,419	685
Clinical Haematology	1,997	2,654	658
Ophthalmology	11,486	12,045	559
Other	11,532	12,007	475
ENT	2,542	3,002	460
Direct Access	2,561	2,995	434
Neurology	996	1,371	375
Plastic Surgery	1,644	1,925	280
Maternity	12,254	12,522	268
Vascular Surgery	1,179	1,446	267
Oral Surgery	495	753	257
Rehabilitation	0	251	251
Gynaecological Oncology	1,161	1,373	212
Paediatrics	4,985	5,192	206
Oncology	6,550	6,737	187
Dermatology	2,334	2,499	165
Trauma & Orthopaedics	12,717	12,107	(610)
A&E	10,323	9,679	(644)
General Surgery	10,144	9,490	(654)
General Medicine	18,683	13,591	(5,092)
Others	24,447	25,260	812
TOTAL	**159,817**	**163,894**	**4,077**

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	8.6%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	99.5%	4
Return on Assets	Surplus before dividends over average assets employed	2.9%	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	3.5	1
Overall Rating			**2.2**

Risk Ratings

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

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

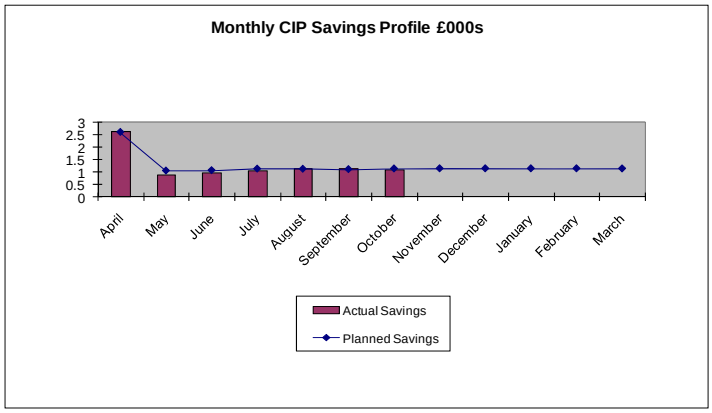
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2009

Cost improvement Programme

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

•As at October, there is a shortfall against planned levels of £206k or 2.2% which is a slight absolute worsening against the position reported for September.



External Focus and Forward Look

•Based on performance up to September, Sandwell and West Birmingham Hospitals continues to forecast fairly significant over performance against its Service Level Agreements with PCTs. 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.

•Both Sandwell and Heart of Birmingham PCTs are reporting significant over performance both for Sandwell and West Birmingham Hospitals and for a number of other providers. Although this over performance is causing financial pressures for the PCTs, they are expecting to achieve overall financial plans at the year end.

•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. The review of Right Care, Right Here assumptions is currently being undertaken and this along with the LDP negotiations for 2010/2011 will be key to ensuring the financial stability of the whole local health economy.

• 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 – October 2009

Conclusions

•For the year to 31st October 2009, the Trust has generated an overall income and expenditure surplus of £1,559,000 which is £131,000 below plan. For the current month, the actual surplus of £251,000 was £29,000 above plan.

•Capital expenditure in October was significantly higher than in previous months, predominantly related to larger building schemes, although actual spend still remains well below the expected profile for the year.

•At 31st October, cash balances are approximately £2m higher than the revised cash plan.

• Surgery A and Surgery B have generated significant in month deficits. Surgery A, along with Anaesthetics and Critical Care, Medicine A, Medicine B and Facilities have year to date deficits. This is balanced by better than planned performance in other divisions and, in particular, in corporate services.

•Expenditure against pay budgets continues to worsen in month with a further deterioration of £246k. Excluding agency staff, actual numbers of whole time equivalents (wtes) in post has increased by 5 in month although the variance against budgeted wtes has decreased. Taking into account an estimated effect on wtes of agency staff, wte numbers are 125 or 2% greater than planned. It remains imperative that staff costs, and particularly the use of agency staff, are realigned to budgeted levels.

•Review of the performance of all divisions has recently been completed as part of the normal divisional review process and actions have been agreed with key divisions to ensure that acceptable financial outturns are delivered. Controls on pay and staffing remain in place and will need to be strengthened and applied with increasing rigour if the current trend of increasing wte numbers is to be reversed, particularly in the light of the financial situation facing the whole of the NHS over the next few years.

Recommendations

The Finance & Performance Management Committee 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 proposed changes to the capital programme.

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management
DATE OF MEETING:	26 November 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 – October 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 and Trust Management Board on 17 November 2009 and Finance and Performance Management Committee on 19 November 2009.

EXECUTIVE SUMMARY

<table>
<tr><th>Note</th><th>Comments</th></tr>
<tr><td>a</td><td>The Cancer 2-week target was met in 92.8% of cases during the month of September. This level of performance, below the national threshold of 93.0% was exclusively influenced by patients not attending or deferring appointments, all of which were offered initially within the 2-week period. Performance for the year to date is 93.2%. Performance against the other Cancer targets well-exceeded the minimum applicable thresholds.</td></tr>
<tr><td>b</td><td>Cancelled Operations increased slightly during October to 0.6% across the Trust. The proportion of cancellations year to date is 0.7%, this compares with 1.0% for the corresponding period last year.</td></tr>
<tr><td>c</td><td>Overall Delayed Transfers of Care increased on both sites to 3.6% overall. Of these 60% on the day of census were attributable to Social Care delays.</td></tr>
<tr><td>d</td><td>Stroke Care - the proportion of patients spending at least 90% of their hospital stay on a Stroke Unit reduced during the month of September to 58.18% (56.3% year to date).</td></tr>
<tr><td>e</td><td>Accident & Emergency 4-hour waits - performance during the month of October was 99.0%, with year to date performance now 99.04%.</td></tr>
<tr><td>f</td><td>Cases of C Diff increased during the month to 14 (10 in September), with a fairly even distribution across sites. There was 1 case of MRSA Bacteraemia reported during October, at Sandwell. The Trust continues to meet National and Local performance trajectories.</td></tr>
<tr><td>g</td><td>Referral to Treatment Time targets for Admitted Care and Non-Admitted Care were both met during the month of October.</td></tr>
<tr><td rowspan="6">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 rate on both sites reduced during the month. The rate for the year to date is 23.1%, within the trajectory for the period.</td></tr>
<tr><td>Brain Imaging - During the month of October the proportion of patients admitted as an emergency following a stroke who received a brain scan within 24 hours of admission increased to 88.0%, increasing the year to date performance to 77.2%.</td></tr>
<tr><td>Hip Fracture - Performance during October was 100%, with the year to date performance further increasing to 89.7%.</td></tr>
<tr><td>Smoking Cessation Referrals - The number of referrals made to PCT smoking cessation services of patients specifically prior to listing for Elective Surgery, which is the specific definition of this target, has been confirmed to be 249 for the year to date. Of these 167 were referred in the most recent month, October.</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>Detailed analysis of Financial Performance is contained within a separate paper to this meeting.</td></tr>
<tr><td>j</td><td>Activity (trust-wide) to date is compared with the contracted activity plan for 2009 / 2010 - Month and Year to Date.
<table>
<tr><th></th><th colspan="4">Month</th><th colspan="4">Year to Date</th></tr>
<tr><th></th><th>Actual</th><th>Plan</th><th>Variance</th><th>%</th><th>Actual</th><th>Plan</th><th>Variance</th><th>%</th></tr>
<tr><td>IP Elective</td><td>1200</td><td>1207</td><td>-7</td><td>-0.6</td><td>8073</td><td>7579</td><td>494</td><td>6.5</td></tr>
<tr><td>Day case</td><td>4616</td><td>4581</td><td>35</td><td>0.8</td><td>30454</td><td>28769</td><td>1685</td><td>5.9</td></tr>
<tr><td>IPE plus DC</td><td>5816</td><td>5788</td><td>28</td><td>0.5</td><td>38527</td><td>36348</td><td>2179</td><td>6.0</td></tr>
<tr><td>IP Non-Elective</td><td>5669</td><td>6057</td><td>-388</td><td>-6.4</td><td>39276</td><td>39820</td><td>-544</td><td>-1.4</td></tr>
<tr><td>OP New</td><td>14904</td><td>14673</td><td>231</td><td>1.6</td><td>96108</td><td>94618</td><td>1490</td><td>1.6</td></tr>
<tr><td>OP Review</td><td>37203</td><td>34364</td><td>2839</td><td>8.3</td><td>243684</td><td>228940</td><td>14744</td><td>6.4</td></tr>
</table>
Activity to date is compared with 2008 / 09 for the corresponding period
<table>
<tr><th></th><th>2008 / 09</th><th>2009 / 10</th><th>Variance</th><th>%</th></tr>
<tr><td>IP Elective</td><td>7847</td><td>8073</td><td>226</td><td>2.9</td></tr>
<tr><td>Day case</td><td>29858</td><td>30454</td><td>596</td><td>2.0</td></tr>
<tr><td>IPE plus DC</td><td>37705</td><td>38527</td><td>822</td><td>2.2</td></tr>
<tr><td>IP Non-Elective</td><td>39921</td><td>39276</td><td>-645</td><td>-1.6</td></tr>
<tr><td>OP New</td><td>88852</td><td>96108</td><td>7256</td><td>8.2</td></tr>
<tr><td>OP Review</td><td>218643</td><td>243684</td><td>25041</td><td>11.5</td></tr>
</table></td></tr>
<tr><td>k</td><td>Bank and Agency - The Nurse Bank Fill Rate continues to remain at 86%+, with 4915 shifts being covered during the month of October. Overall use of Nurse Bank & Agency staff, and the associated cost remains within the trajectory set for the period. A reduction in the use of non-Nurse & Medical Agency Staff has reduced the overall spend on agency staff in month to 1.83% of total pay spend.</td></tr>
<tr><td>l</td><td>Overall Sickness Absence increased to 5.00% during the month of October, with both long-term and short-term absence increasing. Year to date overall sickness absence is 4.04%, remaining within the Trust target of 4.25%.</td></tr>
<tr><td>m</td><td>PDR compliance overall for the 7 months year to date is on track, with 3125 staff reported as receiving a PDR during this period.</td></tr>
</table>

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS			June	July	August	September			October			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	-5	364	177	→		257	→		251	1599	1690	2269		0%	0 - 1%	>1%	3399	6547	2535
RK	Cancer	2 weeks	%	93.3	93.0	93.7	→		92.8	→			93.2	=>93	=>93		No variation		Any variation	100	97.1	98.6
		31 Days	%	99.4	100	99.4	→		100	→			99.8	=>96	=>96	a	No variation		Any variation	99.9	99.9	100
		62 Days	%	88.1	86.0	87.9	→		94.0	→			89.9	=>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	%	1.1	1.0	0.6	0.2	0.7	0.5	0.2	0.9	0.6	0.7	<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	%	2.6	2.5	2.1	1.5	3.6	2.6	2.9	4.3	3.6	2.7	<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)	%	93	79	83	75	89	85				78	80	80		>80	75-80	<75	n/a	63.0	70.5
		Rapid Access Chest Pain	%	100	100	100	100	100	100				99.7	=>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	80	80		>80	75-80	<75	57	80	0
DO'D	Stroke Care	>90% stay on Stroke Unit	%	61.11	55.36	67.3	→		58.18	→			56.3	67.5	70	d	+>70	65 - 70	<65	n/a	n/a	36.5
RK	A/E 4 Hour Waits		%	99.2	99.1	99.2	99.4	98.1	98.6	99.4	98.7	99.0	99.04	=>98	=>98	e	=>98		<98	98.20	98.28	98.16
RK	GUM 48 Hours	Patients seen within 48 hours	%	89.6	89.6	91.2	→		88.2	→		87.0	88.3	=>90	=>90		=>90	80-89	<80	n/a	n/a	81.0
		Patients offered appt within 48 hrs	%	99.1	100	100	→		100	→		99.5	99.7	=>98	=>98		=>98	95-98	<95	35.8	80.7	98.3
R0	Infection Control	C. Diff - EXTERNAL (DH) TARGET	No.	7	14	15	4	6	10	6	8	14	85	158	264	f	No variation		Any variation	n/a	355	163
		C. Diff - INTERNAL (LHE) TARGET	No.	7	14	15	4	6	10	6	8	14	85	131	220		No variation		Any variation	n/a	355	163
		MRSA - EXTERNAL (DH) TARGET	No.	2	1	0	0	1	1	1	0	1	8	21	33		No variation		Any variation	61	43	15
		MRSA - INTERNAL (LHE) TARGET	No.	2	1	0	0	1	1	1	0	1	8	14	23		No variation		Any variation	61	43	15
RK	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	94	95	95	→		95	→			94	90	90		>/=90	89.0-89.9	<89	90.0	89.0	87.0
RO	Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	99.5	→	→	→		99.3	→			99.4	=>99.0	=>99.0		=>99		<98	99.9	99.5	99.9
		Breast Feeding Status Data Complete	%	99.1	→	→	→		98.8	→			99.0	=>99.0	=>99.0		=>99		<98	98.3	99.8	97.8
		Maternal Smoking Rates	%	13.0	→	→	→		11.5	→			12.2	<12.0	<12.0		<12.0	12-14	>14.0	13.2	13.1	12.6
		Breast Feeding Initiation Rates	%	62.9	→	→	→		62.0	→			62.4	>57.0	>57.0		>57.0	55-57	<55.0	52.5	55.0	54.2
RK	Patient Access	Inpatients >26 weeks	%	0	0	0	→		0	→		0	0.000	0	0		<0.03		>0.03	1	0	0
		Outpatients >13 weeks	%	0	0	0	→		0	→		0	0.001	0	0		<0.03		>0.03	4	0	5
RK	RTT Milestones	Admitted Care (RTT <18 weeks)	%	97.2	97.7	96.5	→		97.2	→		97.6	97.6	=>90.0	=>90.0	g	=>90.0		<90.0	52.0	90.6	98.6
		Admitted Care - Data Completeness	%	101.7	101.1	102.0	→		109.5	→		108.4	108.4	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	100.4
		Non-Admitted Care (RTT <18 weeks)	%	98.6	97.9	98.0	→		98.0	→		97.7	97.7	=>95.0	=>95.0		=>95.0		=<95.0	n/a	95.5	98.8
		Non-Admitted Care - Data Completeness	%	101.0	109.6	105.0	→		109.7	→		108.3	108.3	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	98.1
		Audiology Direct Access Waits (<18 wks)	%	100	100	100	→		100	→		100	100	=>95	=>95		=>95		<95	n/a	n/a	99.0
		Audiology Data Completeness	%	91.0	84.0	91.0	→		97.0	→		108.0	108.0	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	96.0
		Diagnostic Waits greater than 6 weeks	No.	23	21	14	→		0	→			0	0	0		0		>0	996	25	26
DO'D	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	89.1 March '09	82.0 April '09	85.5 May '09	→		80.5 Jun '09	→		83.4 Jul. '09	86.4	Rate only	Rate only					101.1	100.2	99.0
		Peer (SHA) HSMR	HSMR	88.7	88.4	89.2	→		89.1	→		90.7	93.9	Rate only	Rate only					110.7	106.1	96.5
RK	CQUIN	OP Source of Referral Information	%	1.77	2.02	1.13	→		2.02	→		1.21	1.45	6.5	5.0	h	No variation		Any variation	n/a	n/a	10.0
		Caesarean Section Rate	%	23.9	20.5	21.8	26.6	28.3	27.6	23.4	23.5	23.4	23.1	26.3	26.0		=<26.0		>26.0	n/a	27.7	27.0
		Brain Imaging for Em. Stroke Admissions	%	82.5	66.7	70.2	→		84.6	→		88.0	77.2	72.0	72.0		=>72.0		<72.0	n/a	n/a	72.0
		Hip Fracture Op's <48 hours of admission	%	92.9	91.3	96.2	→		89.5	→		100	89.7	83.0	87.0		No Variation	0 - 2% Variation	>2% Variation	63.6	70.1	77.8
		Smoking Cessation Referrals	No.		17	37	→		28	→		167	249	583	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)	%	10.9	11.2	11.7	12.8	10.7	11.6				11.5	No. Only	No. Only					10.1	n/a	11.6
		(Within 14 days of discharge)	%	8.1	8.1	8.5	9.3	8.0	8.6				8.4	No. Only	No. Only					n/a	n/a	7.3
R0	Infection Control	Savings Lives Compliance	%	99	99	99	→		99	→		100	100	>95	>95		< YTD target		> YTD target	n/a	n/a	99.0
		Phlebitis Rate	%	0.43	0.54	0.49	→		n/a	→			0.49	<5	<5		< YTD target		> YTD target	n/a	1.77	
		Phlebitis Compliance	%	84.9	86.1	83.7	→		n/a	→			83.7	>95	>95		>95%	75-95%	<75%	n/a	78	
		MRSA Screening (Elective)	No.	2007	1782	1871	→		2242	→		2305	13721	No. Only	No. Only		0 - 10%	10 - 15%	>15%	n/a	n/a	6495
		MRSA Screening (Non-Elective)	No.	678	595	332	→		2209	→		2133	7548	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	0	1	0	1	1	1	1	2	9	28	48		=<2	3 - 4	>4	n/a	n/a	
		Admissions to Neonatal ICU	%	6.7	5.2	5.3	5.8	9.9	8.2	4.3	6.3	5.5	6.2	=<10	=<10		=<10	10.0-12.0	>12.0	n/a	9.6	
		Adjusted Perinatal Mortality Rate	/1000	17.1	8.6	9.4	4.7	0.0	2.0	n/a	n/a	n/a	2.0	<8.0	<8.0		<8	8.1 - 10.0	>10	n/a	n/a	
	FINANCE & FINANCIAL EFFICIENCY																					
RW	Gross Margin		£000s	2206	2565	2382	→		2462	→		2493	17262	17350	29805	i	0%	0 - 1%	>1%	26429	33250	26436
	CIP		£000s	949	1060	1105	→		1126	→		1079	9035	9242	15075		0 - 2.5%	2.5 - 7.5%	>7.5%	19679	14027	11084
	In Year Monthly Run Rate		%	-102	1.11	4.12	→		12.23	→		13.06	-7.75	0	0		NO or a +	0 - 5% variation	>5% variation	329	45	1.4
RK	Income / WTE		£s	4908	4998	4917	→		4892	→		4960	4943	5127	5127		No variation	0 - 5% variation	>5% variation	5460	4924	5014
	Income / Open Bed		£s	32662	32615	32904	→		32353	→		32496	32424	31184	31184		No variation	0 - 5% variation	>5% variation	24774	29065	30498
	Income per Spell	Total Income	£s	2719	2649	3082	→		2853	→		2762	2800	2762	2762		No Variation	0 - 4% Variation	>4% Variation	2636	2740	2701
		Clinical Income	£s	2448	2389	2760	→		2560	→		2483	2621	2454	2454		No Variation	0 - 4% Variation	>4% Variation	2317	2449	2400
		Non-Clinical Income	£s	272	260	322	→		293	→		279	279	308	308		No Variation	0 - 4% Variation	>4% Variation	318	291	301
RK	Cost per Spell	Total Cost	£s	2720	2618	3065	→		2829	→		2740	2780	2742	2742		No Variation	0 - 4% Variation	>4% Variation	n/a	2643	2682
		Total Pay Cost	£s	1834	1751	2077	→		1912	→		1862	1871	1825	1825		No Variation	0 - 4% Variation	>4% Variation	1772	1737	1785
		Medical Pay Cost	£s	515	506	609	→		562	→		570	546	544	544		No Variation	0 - 4% Variation	>4% Variation	543	517	532
		Nursing Pay Cost (including Bank)	£s	648	605	711	→		658	→		638	649	639	639		No Variation	0 - 4% Variation	>4% Variation	609	615	625
		Non-Pay Cost	£s	886	867	988	→		917	→		877	909	917	917		No Variation	0 - 4% Variation	>4% Variation	n/a	906	897
		Mean Drug Cost / IP Spell	£s	107	114	122	→		121	→		123	116	123	123		No Variation	0 - 4% Variation	>4% Variation	n/a	95	120
		Mean Drug Cost / Occupied Bed Day	£s	44	42	48	→		51	→		52	48	48	48		No Variation	0 - 4% Variation	>4% Variation	n/a	35	47
	PATIENT EXPERIENCE																					
KD	Complaints	Number Received	No.	228	→		→			→			228	No. Only	No. Only					673	697	789
		Response within initial negotiated date	%	75.9	→		→			→			75.9	85	85		80%+	70 - 79%	<70%	77.4	81.2	81.1
	Thank You Letters		No.	411	→		→			→			411	No. Only	No. Only					6026	3491	2912
RK	Elective Access Contact Centre	Number of Calls Received	No.	13516	12366	11117	→		12667	→			72895	No. Only	No. Only					n/a	n/a	190434
		Average Length of Queue	mins	0.50	1.03	1.00	→		1.54	→			1.54	0.5	0.5		No variation	0 - 10% variation	>10% variation	n/a	n/a	0.44
		Maximum Length of Queue	mins	22.5	17.5	12.5	→		7.4	→			7.4	6.0	6.0		No variation	0 - 10% variation	>10% variation	n/a	n/a	17.4
RK	Telephone Exchange	Number of Calls Received	No.	121140	93372	77550	→		81809	→		86302	687742	No. Only	No. Only					n/a	1826476	1559688
		Calls Answered	%	75.2	87.3	88.8	→		88.4	→		90.7	82.8	No. Only	No. Only					n/a	81.0	82.3
		Answered within 15 seconds	%	43.0	48.8	46.7	→		44.6	→		51.9	51.9	No. Only	No. Only					n/a	n/a	39.1
		Answered within 30 seconds	%	55.9	64.5	63.0	→		60.9	→		68.5	68.5	No. Only	No. Only					n/a	n/a	55.5
		Average Ring Time	Secs	22.6	24.9	26.9	→		28.0	→		23.1	23.1	No. Only	No. Only					n/a	n/a	28.8
		Longest Ring Time	Secs	917	741	719	→		877	→		774	774	No. Only	No. Only					n/a	n/a	695
	STRATEGY																					
RK	Referrals	Total By Site	No.	17146	17093	14708	→		16574	→			96893	89213	178070		No Variation	0 - 2% Variation	>2% Variation	138580	151755	178070
		Total GP Referrals	No.	11471	11157	9609	→		11040	→			63834	60309	120138		No Variation	0 - 2% Variation	>2% Variation	98476	95857	120138
		Total Other Referrals	No.	5675	5936	5099	→		5534	→			33059	28904	57932		No Variation	0 - 2% Variation	>2% Variation	40104	55898	57932
		By PCT - Heart of B'ham	No.	4547	4642	4108	→		4430	→			26278	24680	49859		No Variation	0 - 2% Variation	>2% Variation	40394	41628	49859
		By PCT - Sandwell	No.	8751	8565	7210	→		8412	→			48745	44065	87779		No Variation	0 - 2% Variation	>2% Variation	72580	77592	87779
		By PCT - Other	No.	3848	3886	3390	→		3732	→			21870	20468	40453		No Variation	0 - 2% Variation	>2% Variation	25606	32535	40453
		Conversion (all referrals) to New OP Att'd	%	83.6	84.3	84.4	→		87.6	→			83.7	No. Only	No. Only					91.5	87.0	85.9

Exec Lead	ACTIVITY			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	Spells	Elective IP	No.	1204	1185	1078	395	829	1224	430	770	1200	5073	7579	13077	j	No Variation	0 - 2% Variation	>2% Variation	13887	SWBTB (11/09) 232 (a) 13395	13106
		Elective DC	No.	4451	4715	3839	2032	2370	4402	2213	2403	4616	30464	28769	49636		No Variation	0 - 2% Variation	>2% Variation	45831	46304	50873
		Total Elective	No.	5655	5900	4917	2427	3199	5626	2643	3173	5816	38527	36348	62713		No Variation	0 - 2% Variation	>2% Variation	59718	59699	63979
		Non-Elective - Short Stay	No.	1406	1499	1452	681	746	1427	678	743	1421	10977	7989	13745		No Variation	0 - 2% Variation	>2% Variation	12414	11575	12770
		Non-Elective - Other	No.	4338	4433	3685	1648	2255	3903	1816	2432	4248	28301	31831	54971		No Variation	0 - 2% Variation	>2% Variation	52662	55163	56226
		Total Non-Elective	No.	5744	5932	5137	2329	3001	5330	2494	3175	5669	39278	39820	68716		No Variation	0 - 2% Variation	>2% Variation	65076	66738	68996
	Outpatients	New	No.	14333	14405	12407	4805	9712	14517	5286	9618	14904	96108	94618	159666		No Variation	0 - 2% Variation	>2% Variation	127449	131941	152923
		Review	No.	35633	35583	31282	13010	23386	36396	13604	23599	37203	243684	228940	385680		No Variation	0 - 2% Variation	>2% Variation	370970	361113	374867
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	17984	16319	15415	6843	8390	15233	7056	9028	16084	115844	117978	197122		No Variation	0 - 2% Variation	>2% Variation	200561	195093	191141
	A/E Attendances	Type II (BMEC)	No.	2923	2854	2955	→	3079	3079	→	2971	2971	21093	18403	30749		No Variation	0 - 2% Variation	>2% Variation	31373	29803	30800
	PATIENT ACCESS & EFFICIENCY																					
RK	Length of Stay	Average Length of Stay	Days	4.5	4.3	4.4	5.1	4.3	4.7				4.5	5.0	5.0		No Variation	0 - 5% Variation	>5% Variation	5.7	5.0	5.0
		All Patients with LOS > 14 days	No.	257	322	292	144	137	281	151	147	298	298	No. Only	No. Only					n/a	345	312
		All Patients with LOS > 28 days	No.	145	154	157	66	76	142	69	78	147	147	No. Only	No. Only					190	174	152
		Min. Stay Rate (Electives (IP/DC) <2 days)	%	92.2	92.44	91.59	94.2	89.3	91.39	94.4	90.1	92.0	92.1	92.0	92.0		No Variation	0 - 5% Variation	>5% Variation	88.3	90.5	91.6
	Admissions	Day of Surgery (IP Elective Surgery)	%	86.1	86.0	86.3	87.5	82.7	84.3	87.8	82.5	84.5	84.2	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	63.2	76.5	79.4
		Day of Surgery (IP Non-Elective Surgery)	%	69.8	63.78	69.68	66.72	66.23	66.44	59.0	66.49	63.0	68.1	No. Only	No. Only					n/a	68.3	70.2
		With no Procedure (Elective Surgery)	%	10.2	10.1	10.5	11.2	11.0	11.1				10.2	No. Only	No. Only					10.6	n/a	10.6
		Per Bed (Elective)	No.	5.27	6.47	5.08	4.52	5.58	5.07	6.18	7.41	6.81	5.67	5.90	5.90		No Variation	0 - 5% Variation	>5% Variation	4.66	4.87	5.33
	Discharges	Pt's Social Care Delay	No.	10	16	11	4	13	17	7	8	15	15	<18	<18	c	No Variation	0 - 10% Variation	>10% Variation			
		Pt.'s NHS & NHS plus S.C. Delay	No.	8	3	5	1	10	11	3	6	9	9	<10	<10		No Variation	0 - 10% Variation	>10% Variation			
	Beds	Occupied Bed Days	No.	26305	26501	25595	11426	14472	25898	12369	15023	27392	188884	198171	342000		No Variation	0 - 5% Variation	>5% Variation	378060	348676	342793
		Occupancy Rate	%	85.71	85.2	84.3	84.2	87.8	86.1	86.6	86.4	86.5	86.4	86.5 - 89.5	86.5-89.5		86.5 - 89.5	85.3-86.4 or 89.6-90.6	<85.3 or >90.6	88.6	90.8	90.3
		Open at month end (exc Obstetrics)	No.	949	961	942	469	497	966	476	500	976	976	975	975		No Variation	0 - 2% Variation	>2% Variation	1039	1007	975
	Day Case Rates	All Procedures	%	76.3	78.5	76.2	82.2	71.6	76.1	82.8	74.2	78.1	77.3	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	76.0	76.9	79.0
		BMEC Procedures	%	80.2	80.74	79.09		77.93	77.93		78.81	78.81	78.5	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	71.5	77.2	79.7
	Non-Admitted Care	New : Review Rate	Ratio	2.49	2.47	2.52	2.67	2.42	2.50	2.54	2.48	2.50	2.54	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	2.91	2.74	2.45
		DNA Rate - New Referrals	%	15.3	14.6	15.3	13.2	13.5	13.4	13.1	14.5	14.0	13.6	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	10.8	10.9	12.0
		DNA Rate - Reviews	%	13.8	13.1	12.6	12.3	12.1	12.2	12.1	11.9	11.9	12.0	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	12.8	13.5	13.5
	Pathology	Cervical Cytology Turnaround	Weeks	4.3	3.3	2.4	→		1.8	→			1.8	<4.0	<4.0		<4.0	4.0-6.0	>6.0	1.7 - 4.0	1.5 - 2.9	2.7
	Ambulance Turnaround	In Excess of 30 minutes	%	17	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	<10.0	<10.0		<10	10 - 12.5	>12.5	n/a	29.1	19.0
		(West Midlands average)	%	19	n/a	n/a	→		n/a	→		n/a	n/a	No. Only	No. Only					n/a	31.1	21.0
		In Excess of 60 minutes	No.	26	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0		0	1 - 5	>5	n/a	n/a	
	THEATRE UTILISATION																					
RK	Sitrep Declared Late **Cancellations** by Specialty	General Surgery	No.	16	13	1	2	1	3	1	2	3	47	35	60	b	0-5% variation	5 - 15% variation	>15% variation	n/a	75	104
		Urology	No.	2	4	1	0	4	4	0	4	4	19	28	48		0-5% variation	5 - 15% variation	>15% variation	n/a	67	102
		Vascular Surgery	No.	1	0	0	0	0	0	0	4	4	5	2	3		0-5% variation	5 - 15% variation	>15% variation	n/a	1	7
		Trauma & Orthopaedics	No.	5	11	7	1	4	5	1	7	8	39	42	72		0-5% variation	5 - 15% variation	>15% variation	n/a	100	75
		ENT	No.	3	2	0	0	1	1	0	3	3	9	7	12		0-5% variation	5 - 15% variation	>15% variation	n/a	19	23
		Ophthalmology	No.	14	12	5	0	7	7	0	10	10	76	63	108		0-5% variation	5 - 15% variation	>15% variation	n/a	139	153
		Oral Surgery	No.	6	0	4	0	1	1	0	0	0	13	5	8		0-5% variation	5 - 15% variation	>15% variation	n/a	10	19
		Cardiology	No.	1	1	1	0	0	0	0	0	0	4	12	21		0-5% variation	5 - 15% variation	>15% variation	n/a	28	31
		Gynaecology	No.	6	4	10	1	2	3	4	0	4	31	32	54		0-5% variation	5 - 15% variation	>15% variation	n/a	69	71
		Plastic Surgery	No.	1	5	0	0	1	1	0	0	0	8	7	12		0-5% variation	5 - 15% variation	>15% variation	n/a	17	21
		Dermatology	No.	1	0	0	0	5	5	0	0	0	16	14	24		0-5% variation	5 - 15% variation	>15% variation	n/a	4	24
		TOTAL	No.	56	52	29	4	26	30	6	30	36	267	247	422		0-5% variation	5 - 15% variation	>15% variation	n/a	529	630

Page 3

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.	6315	6271	6304	→		6388	→		6394	6394	6399	6241		No Variation	0 - 1% Variation	>1% Variation	6000	5875	6042
		Medical and Dental	No.	744	739	770	→		763	→		769	769	780	761		No Variation	0 - 1% Variation	>1% Variation	822	736	755
		M'ment, Admin. & HCAs	No.	2015	2016	2050	→		2054	→		2038	2038	2013	1952		No Variation	0 - 1% Variation	>1% Variation	1806	1765	1852
		Nursing & Midwifery (excluding Bank)	No.	2355	2344	2337	→		2360	→		2396	2396	2599	2547		No Variation	0 - 1% Variation	>1% Variation	2481	2255	2259
		Scientific and Technical	No.	935	949	959	→		958	→		966	966	1006	981		No Variation	0 - 1% Variation	>1% Variation	891	869	913
		Bank Staff	No.	266	223	188	→		253	→		225	225	No. Only	No. Only					n/a	250	260
		Gross Salary Bill	£000s	20906	20724	20887	→		20944	→		21389	145573	143834	243342		No Variation	0 - 1% Variation	>1% Variation	220244	219667	238674
RK	Bank & Agency	Nurse Bank Fill Rate	%	82.8	86.4	87.2	→		86.5	→		86.9	86.4	No. Only	No. Only	k				n/a	87.6	81.8
		Nurse Bank Shifts covered	No.	5136	5261	5420	→		4898	→		4915	36076	36071	61836		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	67330	68707	69675
		Nurse Agency Shifts covered	No.	466	495	262	→		254	→		206	2249	2900	4972		0 - 5% Variation	5 - 10% Variation	>10% Variation	2879	5524	4765
		Nurse Bank AND Agency Shifts covered	No.	5602	5756	5682	→		5152	→		5121	38325	38971	66808		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	70209	74231	74440
		Nurse Bank Costs	£000s	529	530	510	→		522	→		509	3608	3747	6423		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	6883	6980	6844
		Nurse Agency Costs	£000s	24	103	89	→		68	→		97	471	579	992		0 - 5% Variation	5 - 10% Variation	>10% Variation	474	1078	832
KD		Medical Agency Costs	£000s	277	174	238	→		156	→		159	1232	695	1192		0 - 5% Variation	5 - 10% Variation	>10% Variation	693	1296	2026
RK		Other Agency Costs	£000s	331	240	224	→		218	→		135	1584	822	1410		0 - 5% Variation	5 - 10% Variation	>10% Variation	1661	2223	3759
KD		Medical Locum Costs	£000s	174	293	238	→		265	→		275	1701	1312	2250		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	2566	2445	2747
RK/KD		Agency Spend cf. Total Pay Spend	%	3.02	2.49	2.64	→		2.11	→		1.83	2.26	<2.00	<2.00		<2	2 - 2.5	>2.5	1.50	2.15	2.77
CH	Sickness Absence	Long Term	%	2.60	3.16	3.19	→		3.18	→		3.42	2.95	<3.00	<3.00	l	<3.0	3.0-3.35	>3.35	2.50	3.52	3.16
		Short Term	%	1.26	1.51	1.17	→		1.23	→		1.59	1.28	<1.25	<1.25		<1.25	1.25-1.40	>1.40	2.17	1.26	1.22
		Total	%	3.86	4.67	4.36	→		4.41	→		5.00	4.23	<4.25	<4.25		<4.25	4.25-4.75	>4.75	4.67	4.78	4.38
	Recruitment & Retention	Permission to Recruit	wte	91	79	72	→		90	→		100	577	No. Only	No. Only					n/a	1143	1124
		New Starters	wte	56	54	274	→		142	→		n/a	680	No. Only	No. Only					n/a	855	1066
		Leavers	wte	35	53	245	→		94	→		n/a	520	No. Only	No. Only					n/a	1004	999
		Inductions	No.	72	71	104	→		87	→		83	564	No. Only	No. Only					n/a	442	896
	Learning & Development	PDRs (includes Junior Med staff)	No.	459	650	665	→		510	→		275	3125	3115	5341	m	0-5% variation	5 - 15% variation	>15% variation	n/a	1963	4518
		Mandatory Training	%							→		40.1	40.1	100	100		=>80	50 - 79	<50	4313 (No.)	2770 (No.)	4044 (No.)
		Conflict Resolution Training	No.	270	253	171	→		226	→		246	1623	1167	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

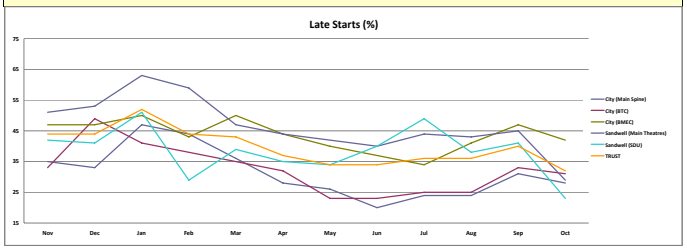
Page 4

SUPPLEMENTARY DATA THEATRE UTILISATION

SWBTB (11/09) 232 (a)

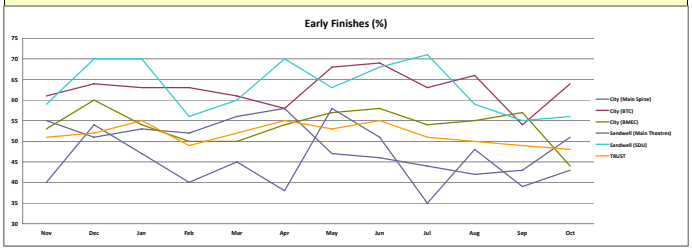
LATE STARTS (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	35	33	47	44	36	28	26	20	24	24	31	28					
City (BTC)	33	49	41	38	35	32	23	23	25	25	33	31					
City (BMEC)	47	47	50	43	50	44	40	37	34	41	47	42					
Sandwell (Main Theatres)	51	53	63	59	47	44	42	40	44	43	45	29					
Sandwell (SDU)	42	41	51	29	39	35	34	40	49	38	41	23					
TRUST	44	44	52	44	43	37	34	34	36	36	40	32					

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



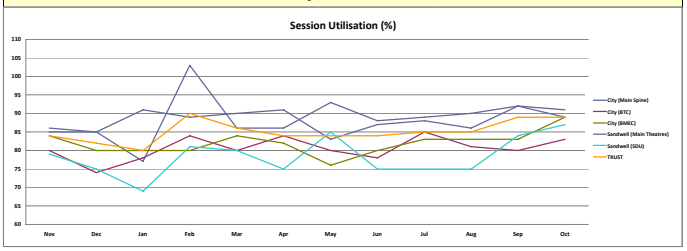
EARLY FINISHES (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	55	51	53	52	56	58	47	46	44	42	43	51					
City (BTC)	61	64	63	63	61	58	68	69	63	66	54	64					
City (BMEC)	53	60	54	50	50	54	57	58	54	55	57	44					
Sandwell (Main Theatres)	40	54	47	40	45	38	58	51	35	48	39	43					
Sandwell (SDU)	59	70	70	56	60	70	63	68	71	59	55	56					
TRUST	51	52	55	49	52	55	53	55	51	50	49	48					

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



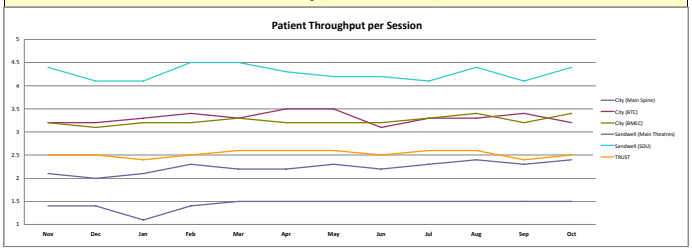
SESSION UTILISATION (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	86	85	77	103	86	86	93	88	89	90	92	91					
City (BTC)	80	74	78	84	80	84	80	78	85	81	80	83					
City (BMEC)	84	80	80	80	84	82	76	80	83	83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

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



THROUGHPUT / SESSION	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	1.4	1.4	1.1	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5					
City (BTC)	3.2	3.2	3.3	3.4	3.3	3.5	3.5	3.1	3.3	3.3	3.4	3.2					
City (BMEC)	3.2	3.1	3.2	3.2	3.3	3.2	3.2	3.2	3.3	3.4	3.2	3.4					
Sandwell (Main Theatres)	2.1	2.0	2.1	2.3	2.2	2.2	2.3	2.2	2.3	2.4	2.3	2.4					
Sandwell (SDU)	4.4	4.1	4.1	4.5	4.5	4.3	4.2	4.2	4.1	4.4	4.1	4.4					
TRUST	2.5	2.5	2.4	2.5	2.6	2.6	2.6	2.5	2.6	2.6	2.4	2.5					

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



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary performance assessed against the NHS FT Governance Risk Rating (FT Compliance Report)
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management and Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The **NHS Performance Framework Monitoring Report** provides an assessment of the Trust's performance mapped against the indicators which comprise the framework. The areas of underachievement identified in the report are:

- Referral to Treatment Time (Non-Admitted Care) – Gastroenterology was 92.69%. All other specialties exceeded 95.0%, with overall performance at 97.76%.
- Delayed Transfers of Care, which are reported as 3.6% for the month of October, and,
- Stroke (Stay on Stroke Unit) – performance is reported as 58.18% for September.

Foundation Trust Compliance Report – the overall performance score for October remains 0.4 and the overall Governance Risk Rating remains GREEN.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Finance and Performance Management Committee on 19 November 2009

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2009/10

Operational Standards and Targets

Indicator	Weight	Thresholds		2009 / 2010								
		Achieve	Fail	Q1	Score	Weight x Score	Q2	Score	Weight x Score	October	Score	Weight x Score
A/E Waits less than 4-hours	1.00	98.00%	97.00%	99.39%	3	3.00	98.90%	3	3.00	99.00%	3	3.00
Cancelled Operations - 28 day breaches	1.00	5.0%	15.0%	0	3	3.00	0	3	3.00	0	3	3.00
MRSA Bacteraemia	1.00	0	>1.0SD	5	3	3.00	2	3	3.00	1	3	3.00
Clostridium Difficile	1.00	0%	>1.0SD	32	3	3.00	39	3	3.00	14	3	3.00
18-weeks RTT (Admitted)	1.00	90.0%	85.0%	98.0	3	3.00	>90.0%	3	3.00	97.6%	3	3.00
18-weeks RTT (Non-Admitted)	1.00	95.0%	90.0%	98.5	3	3.00	>95.0%	3	3.00	97.7%	3	3.00
• Achievement in all specialties (inc. DAA Audiology, exc. Orthopaedics)	0.50	95.0%	90.0%	>95.0%	3	1.50	>95.0%	3	1.50	>95.0%**	2	1.00
• Achievement in Orthopaedics	0.50	95.0%	90.0%	>95.0%	3	1.50	>95.0%	3	1.50	97.4%	3	1.50
Cancer - 2 week GP Referral to First Outpatient Appointment	1.00	93.0%	90.0%	93.1%	3	3.00	93.3%	3	3.00	>93.0%*	3	3.00
Cancer - 31 day second or subsequent treatment (surgery and drug)	0.50	98.0%	94.0%	100%	3	1.50	99.1%	3	1.50	>98.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers	0.50	96.0%	94.0%	99.8%	3	1.50	99.8%	3	1.50	>96.0%*	3	1.50
Cancer - 62 day referral to treatment from screening	0.33	90.0%	80.0%	99.8%	3	0.99	100%	3	0.99	>90.0%*	3	0.99
Cancer - 62 day referral to treatment from hospital specialist	0.33	90.0%	80.0%	66.70%	0	0.00	98.6%	3	0.99	>90.0%*	3	0.99
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%	90.6%	3	0.99	89.3%	3	0.99	>85.0%*	3	0.99
3-month revascularisation breaches (as % admissions)	1.00	0.1%	0.2%	0.0%	3	3.00	0.0%	3	3.00	0.0%	3	3.00
2-week Rapid Access Chest Pain	1.00	98.0%	95.0%	99.50%	3	3.00	100%	3	3.00	100%*	3	3.00
48-hours GU Medicine Access	1.00	98.0%	95.0%	99.60%	3	3.00	100.00%	3	3.00	99.50%	3	3.00
Delayed Transfers of Care	1.00	3.5%	5.0%	2.60%	3	3.00	2.40%	3	3.00	3.60%	2	2.00
Stroke (Stay on Stroke Unit)	1.00	80%	50.0%	53.50%	2	2.00	59.60%	2	2.00	>50.00%*	2	2.00
Outpatient Waits >13 weeks (% of First OP Attendances)	0.50	0.03%	0.5%	0.002%	3	1.50	0.000%	3	1.50	>0.000%	3	1.50
Inpatient Waits >26 weeks (% of Elective Admissions)	0.50	0.03%	0.5%	0.000%	3	1.50	0.000%	3	1.50	>0.000%	3	1.50
										*projected		
Sum	**16.00**					**45.98**			**46.97**	** Except Gastroenterology		**45.47**
Average Score						**2.87**			**2.94**			**2.84**

Scoring:	
Fail	0
Underachieve	2
Achieve	3

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

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

Financial Indicators				SCORING			2009 / 2010										
Criteria	Metric	Weight (%)		3	2	1	July	Score	Weight x Score	August	Score	Weight x Score	September	Score	Weight x Score	October	Score	Weight x Score
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	0	3	0.15	0	3	0.15	0	3	0.15	0	3	0.15
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	-0.05%	3	0.6	-0.05%	3	0.6	-0.04%	3	0.6	-0.04%	3	0.6
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	7.83%	3	0.15	7.79%	3	0.15	7.81%	3	0.15	7.80%	3	0.15
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	0.00%	3	0.6	0.00%	3	0.6	0.00%	3	0.6	0.00%	3	0.6
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	7.77%	3	0.15	7.74%	3	0.15	7.71%	3	0.15	7.69%	3	0.15
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45
Underlying Financial Position	Underlying Position (%)	10	5	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	0.61%	3	0.15	0.61%	3	0.15	0.61%	3	0.15	0.61%	3	0.15
	EBITDA Margin (%)		5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	7.78%	3	0.15	7.75%	3	0.15	7.72%	3	0.15	7.69%	3	0.15
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	70.00%	2	0.05	74.00%	2	0.05	70.00%	2	0.05	68.00%	2	0.05
	Better Payment Practice Code Volume (%)		2.5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	73.00%	2	0.05	67.00%	2	0.05	70.00%	2	0.05	57.00%	1	0.025
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	1.23	3	0.15	1.21	3	0.15	1.28	3	0.15	1.05	3	0.15
	Debtor Days		5	Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	17.75	3	0.15	18.88	3	0.15	18.71	3	0.15	20.35	3	0.15
	Creditor Days		5	Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	38.83	2	0.1	41.43	2	0.1	34.85	2	0.1	42.53	2	0.1
						Weighted Overall Score			2.9			2.9			2.9			2.9

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Sustainable Development Management Plan
SPONSORING DIRECTOR:	Graham Seager, Director of Estates/New Hospital Project
AUTHOR:	Rob Banks, Head of Estates
DATE OF MEETING:	26 November 2009

SUMMARY OF KEY POINTS:

The purpose of this paper is to update the Trust Board on the progress to date with the sustainability agenda following the previous sustainability presentation to the Board in June 2009.

ACTIONS:

- Listening into Action Sustainability Event held 22nd October 2009
- Sustainability Development Group establishment
- Sustainability Development Group action plan produced and attached for receipt and discussion.

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

Approval	Receipt and Noting	Discussion
	X	**X**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to consider the Sustainable Development Management Plan, including the establishment of Sustainability Development Group and the draft action plan developed after LiA event.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Trust reaching government set targets of cutting CO_2 emissions.
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	Standard 2.3.4 – Trust can demonstrate commitment to sustainability

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

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

PREVIOUS CONSIDERATION:

Sustainable Development Management Plan has been approved by Sustainability Development Group.

SWBTB (11/09) 213 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SUSTAINABLE DEVELOPMENT MANAGEMENT PLAN

NOVEMBER 2009

TABLE OF CONTENTS

1.0 BACKGROUND

As the largest single organisation in the UK, the NHS is responsible for major consumption of resources emitting around 18 million tonnes of CO_2 every year.

The NHS is directly responsible for the health of the nation and, as such, it can provide a clear example for others to follow by working in partnership within the communities it serves and by providing clear leadership. This principle has led to the development of the NHS Carbon Strategy: Saving Carbon, Improving Lives, launched in January 2009 by the Sustainable Development Unit (SDU).

The strategy sets out key commitments and timeframes around carbon reduction for NHS organisations. Meeting the Climate Change Act requirement of a 26% reduction of carbon emission by 2020 and 80% by 2050 will be a huge challenge. The major impact of this legislation for the NHS will be the requirement to join an emissions trading scheme, the Carbon Reduction Commitment (CRC) Energy Efficiency Scheme.

The NHS Carbon Reduction Strategy establishes that the NHS should have a target of reducing its 2007 carbon footprint by 10% by 2015. This will require the current level of growth of emissions not only to be curbed, but the trend to be reversed and absolute emissions reduced. Interim NHS targets will need to be met and, if necessary, exceed the government's targets.

2.0 INTRODUCTION

There is now clear evidence of how our individual and joint actions can impact on the environment, and how we can positively influence this if we make the right choices in what we do. The NHS is the largest public sector organisation and, as such, has a major part to play in reducing the effect of carbon emissions resulting from our daily activities and leading on approaches that promote long-term health and well-being.

This Sustainable Development Management Plan has been drawn up as a guide to the Trust's ambition to provide high quality healthcare today and into the future in a way that minimises negative effects and, aims overtime to in reducing our carbon footprint.

Our commitment is to ensure that we encourage and enable our staff to provide healthcare services in the most sustainable way as possible, and involve patients, visitors, external organisations and the wider public in helping us to meet the challenge.

3.0 SCOPE

The principles of the Sustainable Development Management Plan take the following into account:

a) Complying with all relevant legislation.

b) Including climate change in the organisation's risk register, including financial risk and also in Board Assurance Frameworks.

c) Confirming the designated Board lead for sustainability, allocating additional lead responsibilities and establishing a sustainable development group to oversee and coordinate the implementation of the plan.

d) Developing and implementing reduction plans to address the major components of NHS carbon emissions including direct energy consumption, procurement, transport (including business, commuting and patient travel) and waste. For example a Board approved active travel plan as part of the Sustainable Development Management Plan.

e) Working in partnership with identified stakeholders under Local Strategic Partnerships to ensure that collaboration aids the integration of this agenda, both within the organisation and also in a wider setting.

f) Pursuing an active communications initiative to engage all staff, visitors and patients who visit/use Trust facilities.

g) Review progress using the Good Corporate Citizenship Assessment Model and key actions of the NHS Carbon Reduction Strategy.

4.0 ORGANISATIONAL ROLES AND RESPONSIBILITES

Overall responsibility for the plan sits with Chief Executive.

The Director of Estates is the Board-level executive with responsibility for sustainable development.

The Head of Estates is responsible for co-ordinating sustainable development across the Trust.

Successful implementation of the plan requires Trustwide support. The Sustainable Development Group, established in November 2009, will oversee the operational side of implementing this agenda (see Appendixes 1 and 2 for Terms of Reference and Aims and Objectives of this group).

The Director of Estates or in his absence Head of Estates chair the Sustainable Development Group reporting to the Trust Board.

Membership of the Sustainable Development Group consists of a variety of key departmental/divisional representatives, other staff members and external agency representatives (see Appendix 1 and 1a). Other attendees will be asked to join the group from time to time as specific projects are identified or when specific technical/professional input is required.

5.0 PARTNERSHIP

In delivering sustainable development, it is vital to work closely with partners, especially other NHS organisations and local authorities to develop a community-wide health economy approach to sustainability and carbon reduction. Links have already been established as follows:

a) Sandwell Metropolitan Borough Council

b) Heart of Birmingham Primary Care Trust

c) Birmingham City Council

d) Sandwell Primary Care Trust

e) The Carbon Trust

f) NHS Sustainability Development Unit

g) Campaign for Greener Healthcare

h) Energy Saving Trust

i) Birmingham Environmental Partnership

The wealth of resources this network provides will support the development of projects designed to deliver the Trust's sustainability agenda.

6.0 CARBON IMPACT FROM HEALTHCARE

6.1 NHS (ENGLAND) IMPACT

The NHS has a carbon footprint of 18 million tonnes CO_2 per year. This is composed of energy (22%), travel (18%) and procurement (60%). Despite an increase in efficiency, the NHS has increased its carbon footprint by 40% since 1990. This means that meeting the Climate Change Act targets of 26% reduction by 2020 and 80% reduction by 2050 will be a huge challenge. This strategy establishes that the NHS should have a target of reducing its 2007 carbon footprint by 10% by 2015. This will require the current level of growth of emissions to not only be curbed, but the trend to be reversed and absolute emissions reduced. Interim NHS targets will be needed to meet the government targets.

Figure 1 highlights the NHS England projected emissions to 2020 with the NHS and governmental targets.

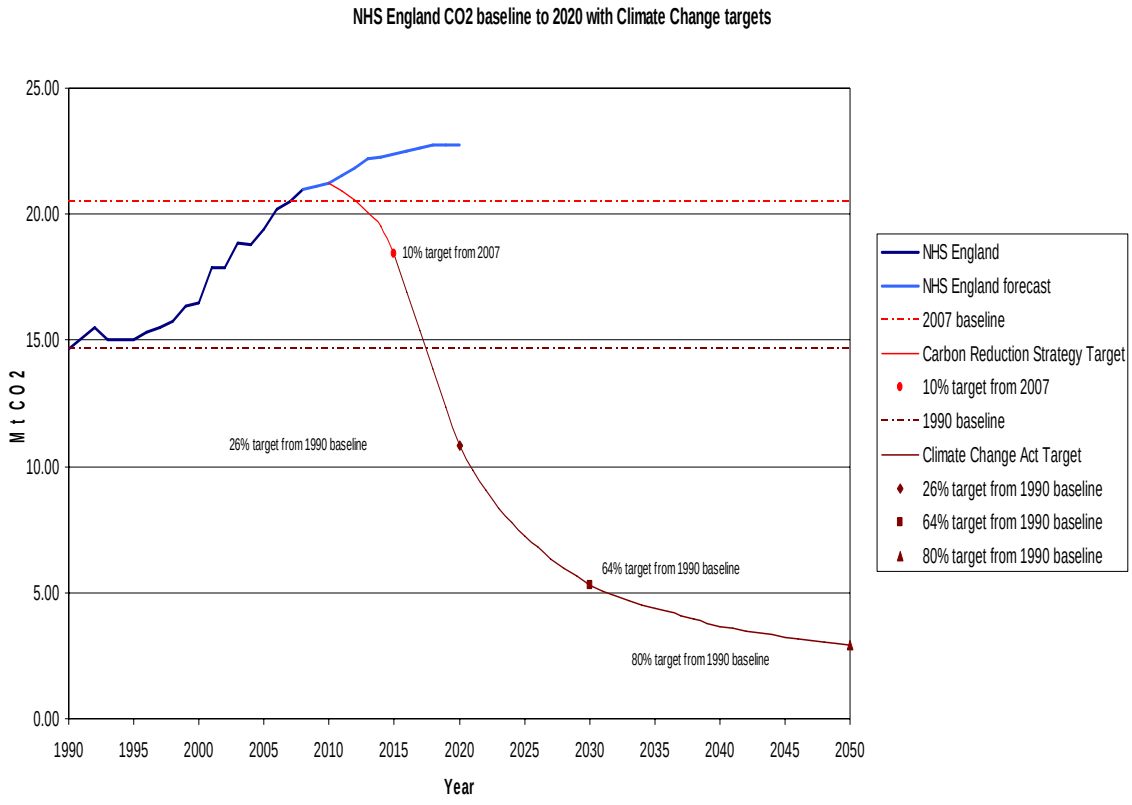


Figure 1

As can be seen from the figure 1 above if the NHS carbon emissions continue at the current rate not only will the government targets be unachievable but also emissions will steadily increase year on year.

6.2 SWBH CARBON IMPACT

SWBH are committed to reducing its emissions through the development of a sound Carbon/Sustainability Management Plan. The breakdown of carbon footprint across the three main strands of energy, travel and procurement for the NHS is as shown in Figure 2 below.

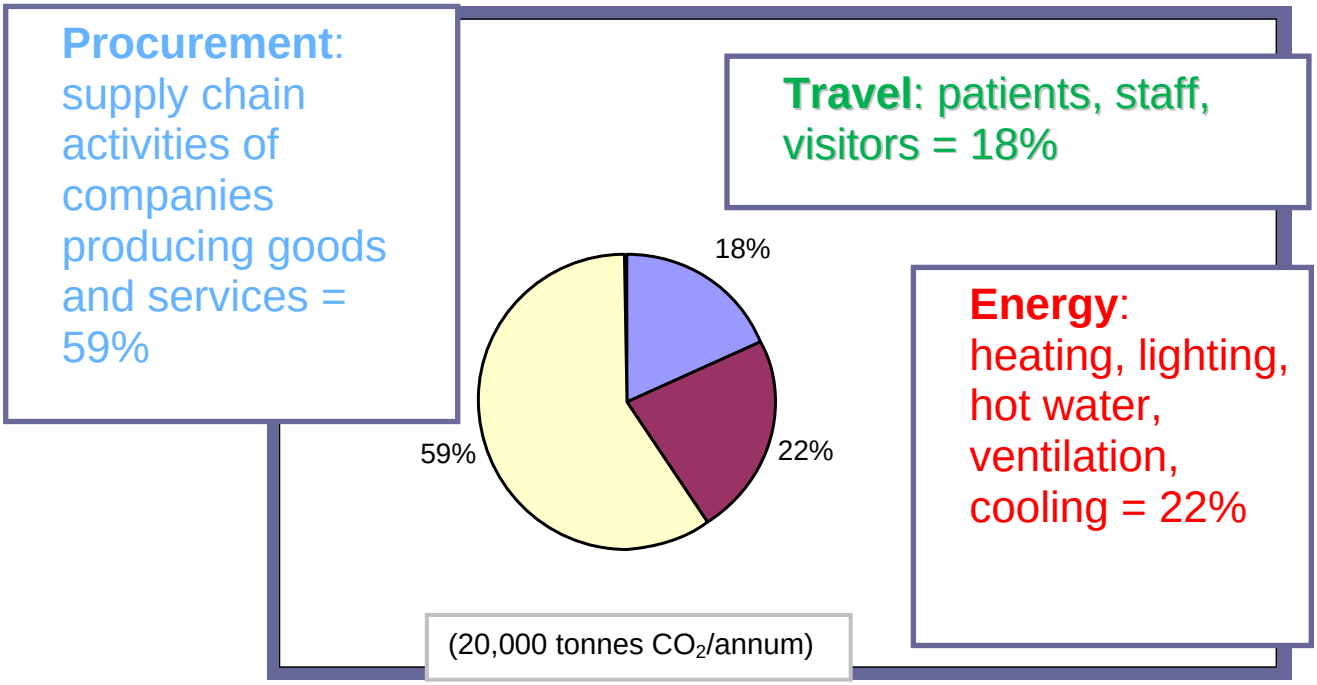


Figure 2

Based on the 2008/09 energy consumption the SWBH carbon footprint for this element alone is circa 20,000 tonne CO_2 per annum. Using the NHS CO_2 footprint breakdown as shown above SWBH overall carbon footprint would be as shown in table 1 below.

ENERGY at 22%	20,000 TONNES CO_2
TRANSPORT at 18%	16,500 TONNES CO_2
PROCUREMENT at 59%	54,500 TONNES CO_2
TOTAL FOOTPRINT	91,000 TONNES CO_2

Table 1 SWBH Carbon Footprint

7.0 GOOD CORPORTATE CITIZENSHIP

The Good Corporate Citizenship (GCC) Assessment Model is an online resource designed to help NHS organisations assess and improve their contribution to sustainable development. Good Corporate Citizenship is the term used by the NHS to describe how NHS organisations can embrace sustainable development and tackle health inequalities through their day-to-day activities. This means using the organisation's corporate powers and resources in ways that benefit rather than damage the social, economic and environmental conditions in which we live.

How the NHS behaves – as an employer, a purchaser of goods and services, a manager of transport, energy, waste and water, a land holder and commissioner of building work and as an influential neighbour in many communities – can make a big difference to people's health and to the well being of society, the economy and the environment. By operating as good corporate citizens, the Trust benefit from a healthier local population, improved staff morale and faster patient recovery rates. It may also result in financial savings.

The GCC Assessment Model contains information on sustainability divided into six areas: transport, procurement, facilities management, employment and skills, community engagement and new buildings.

7.1 Sustainable transport –
is about encouraging walking, cycling and the use of public transport and making sure that pollution and CO2 emissions are minimised.

7.2 Sustainable procurement –
means purchasing goods and services in a way that maximises positive benefits and minimises negative impacts on society, the economy and the environment throughout the full life cycle of the product.

7.3 Sustainable facilities management –
is about minimising impacts on the environment and supporting the local community and economy. This often results in saving money that can be used to deliver better healthcare.

7.4 Employment and Skills –
The Improving Woking Lives standard goes a long way towards ensuring that NHS organisations operate as good corporate citizens. Sound, sustainable HR practices help improve the mental and physical health of employees. Providing career development opportunities, managing appropriate work life balance, offering childcare facilities and a pleasant work environment, and promoting employees' health all contribute.

7.5 Community engagement –
contributes to a healthy community, social cohesion, regeneration and tackling health inequalities. Regular and accessible engagement with the public through the involvement of local organisations, public/patient partnerships and other stakeholders in the decision making and delivery helps to ensure that services are patient focussed.

7.6 Sustainable buildings –
are those that are designed to reduce waste, energy and resources, thereby saving money, reducing negative environmental impacts and benefiting health. The built environment is an important factor in patient care and good design is essential to help ensure that patients, staff and visitors are afforded appropriate facilities.

Each area of the self-assessment test contains a range of question to help assessment of the contribution to sustainability. Initial completion of the assessment provides a benchmark against which progress can be measured and allowing comparison with other organisations. An initial GCC assessment was undertaken on 20th March 2008, a summary of the assessment is shown in Appendix 2. A further assessment will be undertaken in the near future as part of the Sustainable Development Management Action Plan.

8.0 THE PLAN

With its 150,000m^2 estate spread across Sandwell, City and Rowley Regis hospital sites, over 6000 staff and 500,000 patients, the Trust has significant environmental impact. The Trust is committed to continuously minimising this impact by:

- Complying with all relevant legislation:
- Including climate change on the organisation's risk register, including financial risk and also in Board Assurance Frameworks.
- Developing and implementing reduction plans to address the major components of NHS carbon emissions including direct energy consumption, procurement, transport (including business, commuting and patient travel), food and waste.
- Working in partnership with identified stakeholders under local strategic partnerships to ensure that collaboration aids the integration of this agenda both within the organisation and also in a wider stetting.
- Pursuing an active communications initiative to engage all staff, visitors and patients who visit the Trust's facilities.
- Reviewing progress using the GCC Assessment Model and key actions of the NHS Carbon Reduction Strategy.

In order to run our Trust more efficiently and ecologically friendly a LiA Sustainability Event was organised on 22 October 2009 by the Estates Department. A list of ideas and suggestions raised at the event has been collated and from that list 'Quick Wins' have been identified that can be implemented with minimal or zero investment: All other suggestions captured have been included in the drafted action plan as shown in Appendix 3. Sustainability has been featured in the the Trust's Hot Topics communications and so it is anticipated further suggestions will be received, thus the action plan requires further development by the Sustainability Development Group to identify short, medium and long term actions and responsible persons to lead the implementation of the actions.

Further progress reports will be presented to the Trust Board at quarterly intervals.

9.0 REFERENCES

Saving Carbon, Improving Lives (NHS Carbon Reduction Strategy for England), 2009
NHS Sustainable Development Unit (SDU) Resource Pack

APPENDIX 1

SUSTAINABILITY DEVELOPMENT GROUP

TERMS OF REFERENCE

1. CONSTITUTION

The Sustainability Steering Group will produce the Sustainable Development Management Plan and co ordinate its implementation reporting directly to the Trust Board on progress with this.

2. MEMBERSHIP

A Board Level Director, Mr. G. Seager, Director of Estates/New Hospital Project Director, or Mr. R. Banks, Head of Estates will chair the Sustainability Steering Group.

Other Members:

Sally Fox – LiA Facilitator
Jessamy Kinghorn – Head of Communications
Leroy Prince – Operational Purchasing Manager
Brian Hebron – Head of Pharmaceutical Services
Jilly Croasdale – Head of Radiopharmacy
Rob Ashley – General Manager – Pathology
Steve Lawley - Compliance Manager, Estates
Diane Alford – Facilities
David Newbould – Anaestheitst
Adam Andrew – Mandatory Training Instructor
Jenny Marshall – Interim Purchasing Manager
Simon Sims – Transport Manager
Paul Russell – Waste Manager
Kate Chodnik – Estates Admin Support

3. QUOROM

The Committee will consist of a minimum of four members in attendance including at least either the Director of Estates, Head of Estates, or nominated deputy and two different department/ division/directorates representatives other than estates department.

4. ATTENDANCE

The Committee may co-opt other members on to the Committee as required and invite other persons to attend occasionally as necessary.

5. FREQUENCY OF MEETINGS

Initially, meetings will be held monthly to be reviewed in twelve months time.

6. REPORTING ARRANGEMENT

The Sustainability Steering Group will produce a quarterly report to the Trust Board.

7. REVIEW DATE

The Review Date for the Terms of Reference will be December 2010.

APPENDIX 1A

SUSTAINABLE DEVELOPMENT GROUP

AIMS AND OBJECTIVES

1. Develop the content of the Sustainable Development Management Plan encompassing all Trust activities which impact on the environment.

2. Ensure implementation of an active travel plan within a wider sustainable development plan – this could also include a flat rate for business mileage, regardless of the transport option.

3. Agree energy saving and carbon reduction targets, in line with what is proposed in the NHS Carbon Reduction Strategy.

4. Develop potential for renewable energy production.

5. Establish opportunities for recycling and reuse of waste – the Trust should also monitor the quantity and cost of all waste and strive to use this data to set targets and to reduce absolute amounts over time.

6. Promote staff engagement at all levels and promote the development of leadership competencies to delivery carbon reduction.

7. Reporting quarterly will raise awareness of individual impacts, achievements and targets within the organisation and externally.

8. Develop implementation of biodiversity, water and chemical management strategies.

9. Systems for efficient use of water should be integrated into building developments at design stage.

10. Produce plans and ideas for increased green space in the hospital grounds, both in the new builds and existing buildings.

11. Encourage use of local suppliers in procurement, whilst integrating sustainability procurement terms into all contacts with suppliers.

12. Work with suppliers on encouraging a culture of life cycle costing and environmental awareness in procurement options.

13. Identify and work effectively in partnership with all relevant stakeholders (in this agenda)

14. Keep up to date with best practice and inform of any progress through quarterly report.

15. The group will receive administration support to capture agreed actions and distribute relevant paperwork.

APPENDIX 2

GCC ASSESSMENT RESULTS

Topic 1: Transport | Topic 2: Procurement | Topic 3: Facilities Management | Topic 4: Employment & Skills | Topic 5: Community Engagement | Topic 6: New Buildings

Scores

topic 1: Transport
Your Score - 15 / 54 of a possible 54
National Average - 9 / 54
View transport resources

topic 2: Procurement
Your Score - 4 / 72 of a possible 72
National Average - 10 / 72
View procurement resources

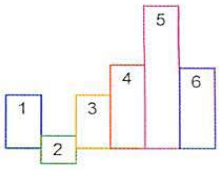
topic 3: Facilities Management
Your Score - 15 / 54 of a possible 54
National Average - 11 / 54
View facilities management resources

topic 4: Employment & Skills
Your Score - 28 / 63 of a possible 63
National Average - 15 / 63
View employment and skills resources

topic 5: Community Engagement
Your Score - 34 / 45 of a possible 45
National Average - 10 / 45
View community engagement resources

topic 6: New Buildings
Your Score - 31 / 72 of a possible 72
National Average - 12 / 72
View new buildings resources

YOUR SCORES (%)



NATIONAL AVERAGE (%)

Your Comments

topic 3: Facilities Management | Good Practice | Future Action

OVERALL COMPARISON

Your Score - 127
National Average - 67

Print Previous Assessment

Return to homepage

APPENDIX 3

Sustainability Development Group

ACTION PLAN

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
1.00	**TRAVEL ARRANGEMENTS (patients, visitors, staff)**					
1.01	Patients travel					
a)	More clinical activity in the community – less patients travel					
b)	Patients – travel details supplied with appointments and suggestions of how to get to the hospital,					
c)	If patient have several appointments at hospital manage time so they only have to come once					
d)	Reduction in patients' visits – more towards RCRH modes of care					
1.02	Staff travel/general travel arrangements					
a)	Travel – single permit for car parking rather than two, transport links improved, car sharing, free bicycle for staff who live near the Trust – car parking only for staff who lives further than 3 miles					
b)	One day a month no vehicles on site					
c)	Regular competitions to promote sustainable travel					
d)	Smarter driving – all Trust's vehicles on bio fuel, smart driving lessons					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
e)	Fully integrated transport systems – bus services, direct onto hospital site, re open local railway station					
f)	Replace shuttle bus with more sustainable vehicle					
g)	Shuttle bus could pick up from central point to get to work					
h)	Review car parking charges for low emission of carbon vehicles					
i)	Green travel plan					
j)	Link up with Toyota who make Hybrids to get some deal on corporate sponsorship for negotiated rates					
k)	Do not pay travel expenses to staff that choose to drive between Sandwell and City, rather than using the shuttle bus.					
2.00	**ENERGY (heating, lighting, hot water, ventilation)**					
a)	Essential to measure all critical areas to ensure progress can be measured and reported against – smart meters, energy monitoring, put in more controls on heaters, energy efficient electrical equipment					
b)	Change all light bulbs to eco friendly					
c)	Double door that shut automatically					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
d)	Heating on/off appropriate time of the year					
e)	Energy performance certificate Energy hotline, sustainability well publicised on website					
f)	Fit low energy measurers to buildings (sensor lighting, sensor laps)					
g)	Servers powering down when not in use, energy efficient computer rooms					
h)	Turning temperature down 2C and cut down external lighting					
i)	Being able to turn off patient line monitors when not in use					
j)	Windows that open easily					
k)	Experimenting with Biomass Fuels, schemes and production plants are now being developed as part of the sustainable fuels initiative, such operations could claim support under the Renewable Obligation and Climate Change Levy.					
l)	Turn off plugs/lights out of hours at plug point					
m)	Heating on and windows open, close doors					
n)	Turn heating off in some areas for the weekend Non touch light switches motion					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
	sensors					
o)	Buy stand by savers for computers					
p)	More reminders to switch off the light – stickers to put up in all areas					
r)	Green gas, electricity, burning recycled waste					
s)	"Switch it off" campaign					
t)	Funds from Salix Finance for refurbishment of buildings					
u)	Make staff cost aware of what is spent on energy – monthly energy spend advised to staff in "Heartbeat"					
v)	Practical implementation – double glazing, modernising buildings to preserve energy, A-rated appliances					
w)	Wherever possible use our own waste to generate fuel, use solar panels for water heating and energy					
x)	Energy smart equipment, ground source heat pumps, solar films					
y)	Competition between wards/departments for the most energy efficient department					
3.00	**GOVERNANCE**					
a)	Sustainability development budget, plans for all prospects					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
b)	Carbon officers for departments (similar to H&S)					
c)	Pilot some ideas before moving to the new hospital to see what works and what not					
d)	Employ energy manager					
e)	Introduce sustainability award					
f)	Introduce budget holder responsibility					
g)	Energy reduction schemes implemented					
h)	Trust needs an environment policy					
i)	Mandatory environmental training as part of the induction					
j)	Study days or workshops for greener Trust					
k)	Choose one champion for each department to monitor energy saving/recycling/making the ward greener and money saving team					
l)	Sanction for breaking the roles should be implemented with regards to greener environment in a workplace					
m)	Introduce rewards for lowering carbon footprint					
n)	Cascade information – set targets for environmental training					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
o)	Local budgeting					
p)	Introduce reporting of sustainability programmes at Trust level – pass on shared experience					
q)	Carbon management programme					
r)	Carbon survey from Carbon Trust					
s)	Responsibility for every employee – targets, aims, objectives					
t)	Steering Group					
u)	Focus groups to reach high energy users					
v)	Include in PDR's					
w)	Liaise with other hospitals, City Council					
x)	Devolution of responsibilities to each department					
y)	Awareness of carbon impact of decisions					
z)	Give financial rewards for green departments					
aa)	Consult with staff non compliance					
bb)	Strategy needed for equipment replacement – to environmentally friendly					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
4.00	**PROCUREMENT**					
a)	Re use of envelopes for internal letters					
b)	Encourage to bring their own food to work					
c)	Use email to communicate information on sustainability					
d)	Holding staff events and suggestion schemes					
e)	Pharmaceutical procurement – educating staff about the life cycle of the product, this could encourage appropriate level of purchase rather than					
f)	Shop around for best eco friendly option					
g)	Nitrous free anaesthesia					
h)	Material reclamation facilities					
i)	Paper, food, waste recycling/anaerobic digestion (offices and other areas)					
j)	Reduced computer print outs					
k)	Reduction and correct segregation of clinical waste					
l)	Stock control audits, internal stock supply, fewer deliveries					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
m)	Have on site shredding facility, use recyclable products					
n)	Repair rather than throw					
o)	Buying of pharmaceuticals from companies which concentrate on lowering their carbon footprint					
p)	Buying medical devices from carbon footprint aware manufacturers					
q)	Don't waste resources by sending questionnaires etc to home addresses, use email, internal mail					
r)	Stop sending staff payslips home					
s)	Issuing electronic payslips where possible would increase efficiency and reduce costs long term.					
t)	The Trust should not send mail to the home addresses of employees where they can use the internal mail.					
u)	I frequently receive mail to my home address from the Trust and where a reply is needed, the Trust also enclosed a prepaid envelope					
v)	Being able to send and receive correspondence electronically to save faxing and physically sending out letters, therefore cutting down on costs of paper, toners, cartridges, etc and even perhaps the phasing out of					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
	case notes, opting for an alternative electronic system					
w)	An electronic letter head to save costs of printing headed paper					
x)	Web base bookings for Nurse bank could potentially save time and money. It may potentially mean that instead of Nurse Bank having two staff on shift to cover each weekend day, this could reduce to one. The interpreter review may show that there is a need for this service over a weekend which could mean a staffing review.					
y)	Have our own Administration bank instead of using temping agency. This has been in the pipeline but never materialised due to financial backing – aren't we spending more money though using temping agencies?					
z)	Reuse old envelopes					
aa)	Use courier runs to take mail out to surgeries					
bb)	Learn how to rotate stock efficiently					
cc)	Recycling bins and systems to be put in place, on site biomass/waste energy					
dd)	Stock rationalisation group to include ethical					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
ee)	Avoid sterilization of unneeded item					
ff)	Measure carbon output – for individual departments					
gg)	Documents to be viewed on line, double sided printing					
hh)	Food – local, seasonal, anaerobic digestion Food – less meat					
ii)	Electronic payslips, e-invoicing, twitter, e-procurement					
jj)	Use of own mugs, caps no plastic ones, stop deliveries of bottled water					
kk)	Share photocopiers					
ll)	Open 2014 hotline					
mm)	Cut down on instructions in pocket drugs					
nn)	Make better use of video conferencing					
oo)	Regular email remainders about environmental issues					
pp)	Could NHS mail be used more reducing resource required for Trust email, archive and Blackberry servers?					
qq)	Installing laser jet printers for secretaries as these are more cost					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
	effective than desk jets in the long run					
rr)	Standardise equipment, such as printers, so cartridges could be bought in bulk, rather than piecemeal.					
ss)	IT to look at printers, every printer is different and requires different ink cartridges. Be aware of how much cartridges cost, some printers may be cheap but the ink is expensive.					
tt)	Are there areas where a large, shared, leased printer/photocopier/scanner is available and staff still have individual printers on desk?					
uu)	Why so many staff have costly colour laser printers? Could Medical Illustration print high quality colour when required?					
vv)	Monitoring the use of the photocopier – assigning a cost code whereby an invoice gets sent to each department instead of the Nursing division or for all of Arden House. Need to maintain a record/ know of who is spending what.					
ww)	There is no need for photocopying reams of notes/reports, Maintain electronic files which could save cost of not also printing out every email for the paper file- double entry and waste of paper/ink					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
xx)	Heartbeat could be printed for each group of staff rather than individuals, or could there be an e-version to save even more money (and trees).					
yy)	Don't duplicate information leaflets i.e. if already given out ante-nately, do not then give them out again post-nately.					
zz)	Unnecessary dispensing of medication. Make sure medication is actually required. Inappropriate prescribing, does the patient need analgesia on discharge. Large amounts of analgesia are dispensed and then returned to Pharmacy unused.					
aaa)	Use patients' medication more efficiently on admission. Improve advertising, via appointment letters encouraging that they always bring in their medication to hospital. This also helps with drug reconciliation and drug history taking, but also means that drugs already dispensed from outside the hospital are utilised correctly and assessed for suitability. Advertise in GP surgeries, out-patient departments and the BTC with posters and leaflets.					
bbb)	Should we review the quantity of drugs supplied for short stay surgery patients. Patients are discharged on up to 28 days supply. Drugs are re-supplied when there is less than 14 days supply remaining. Surgery					

REF	SUBJECT	DISCUSSION	ACTION	CURRENT STATUS	PERSON RESP	DATE
	patients may not require such a large quantity.					
ccc)	Education at all levels – do not use/open thing you do not need					
ddd)	Implement team working at all times with regards to greener environment					
eee)	Self discipline for each and everyone					
fff)	Staff involvement and participation – knowledge and understanding, training, visibility and cooperation					

Members of Sustainability Steering Group

Graham Seager (GS)	Jilly Croasdale (JC)	Brian Hebron (BH)	Adam Andrews (AA)	Rob Ashley (RA)
Rob Banks (RB)	Diane Alford (DA)	Sally Fox (SF)	Steve Lawley (SL)	Jessamy Kinghorn (JK)
David Newbould (DN)	Jenny Marshall (JM)	Leroy Prince (LP)	Simon Sims (SS)	Paul Russell (PR)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance and Performance Management Committee – v0.2

Venue Executive Meeting Room, City Hospital **Date** 22 October 2009; 1430h – 1630h

Members Present		In Attendance	Secretariat
Mr R Trotman	[Chair]	Mr J Adler	Mr S Grainger-Payne
Mrs S Davis		Mr R White	
Miss I Bartram		Mr R Kirby	**Guests**
Mrs G Hunjan		Mr A Stevenson	Mrs J Morton [Item 4.1 only]
Dr S Sahota		Mr T Wharram	Dr J Berg [Item 4.2 only]
Miss P Akhtar		Mr M Harding	Mrs N Reid [Item 4.1 and 4.2 only]
Prof D Alderson			

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
No apologies for absence were received.	
2 Minutes of the previous meeting – 17 September 2009	**SWBFC (9/09) 192**
The minutes of the previous meeting were agreed to be an accurate reflection of discussions held on 17 September 09.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBFC (9/09) 192 (a)**
The updated actions log was noted by the Committee.	
4 Presentation by the Imaging directorate	**SWBFC (10/09) 205** **SWBFC (10/09) 205 (a)**
Mrs Jackie Morton and Mrs Nicola Reid joined the meeting to present an overview of the financial position and activities in connection with the Imaging directorate. Mrs Morton advised that the directorate was currently overspent by £16k, although an action plan is in place to ensure that this position is rectified. In terms of activity, the directorate is over performing against plan at present, resulting in income being £57k higher than plan. Some of the CIP will however offset this position. Mr Trotman asked what unbundling of outpatient activity meant. Mrs Reid advised that the diagnostic part of the imaging tariff had been separated to be associated with an particular outpatient episode. Mr Trotman noted that there was an underperformance on unbundled outpatient activity due to tests that could not be recorded in April, to the value of £236k. Mrs Reid assured the Committee however that a non-recurrent adjustment had been made, so the directorate was not affected by this situation.	

Mrs Morton reported that the Krypton service had underperformed for a significant period, although a surplus is being generated on a marginal basis. As a consequence, the future of the Krypton service is being reviewed. The service is part of a partnership arrangement with the University of Birmingham which has provided a significant capital investment, therefore this needed to be considered within the review of the service.

The Committee was advised that Medical Physics activity, including the Myocardial Perfusion Infusion (MPI) technique, undertaken for other Trusts has increased in year and is currently overperforming against plan.

In terms of pay expenditure, the directorate is underspent by £105k, largely due to a number of consultant vacancies. It was highlighted that costs associated with waiting list initiatives and agency staff costs will reduce in coming months.

Non-pay expenditure was noted to be overspent by £178k. This was reported to be due to a number of factors including a steady increase in MRI scans being undertaken by Lister-in-Health. It is envisaged that this situation will be rectified when the new facility is commissioned at City site. Expenditure associated with payments to Medica Services, for reducing backlog reporting is also contributing to the overspend. This is a short-term option however and will cease once the backlog in plan filming has been completed. Maintenance to support the Walsall arm of the breast screening service was noted to have increased significantly during the year. The situation is currently being addressed with Walsall PCT, with a view to sharing the cost. Khyphoplasty was reported to be a new development and has resulted in significant pressure on the directorate. Mrs Morton explained that the procedure ensures a better quality of life for patients and is less expensive than the alternative, technique verterbraeplasty. Income generated covers the non-pay costs of this procedure at present, however the cost of each kit is £2,500. A business case is due to be prepared and submitted to the Sandwell Clinical Advisory Group. It is clear that if this business case is rejected, that the procedure will have to cease.

The directorate's CIP was discussed and reported to be £563k. All schemes are on target to deliver as planned. A key measure will be to rationalise the administration support in the directorate. Renegotiation of some contracts through HPC will also be undertaken. Consultants and managers will work collaboratively to ensure that service improvements are delivered. Clinical engagement is also planned to review the current skill mix in the area.

Significant capital projects with which the directorate is involved were outlined to be the replacement of a MRI scanner and CT scanner, subject to approval by the appropriate corporate bodies. The potential to set up a mobile PET scanning service, in advance of the new hospital build in also being investigated. In terms of the equipment strategy, there are currently several different models across the Trust and there are issues around maintenance and training. A consultation process has therefore commenced with a view to introducing an integrated service model. This includes in particular, central management of the Trust's ultrasound machines.

Much work is being done to support the reconfiguration of the stroke services pathway, including provision of 24/7 CT scanning and prompt reporting. Work with the cardiology and stroke network is also underway to review the TIA pathway. Mrs Davis remarked that there are indications that all measures are in place to ensure improvement in performance against the stroke target, yet performance continues to remain poor. Mr Kirby advised that it is now clear that the reporting of time to scan has been inaccurate and a revised mechanism will be introduced which should assist. Performance against the time spent on a stroke unit was also highlighted to have improved.

It was noted that the breast screening service is well regarded within the region. There has been a need to expand the service to include women 41-47 years of age. Digital units are due to be introduced into Walsall and City Hospitals from December 2010 in line with the cancer reform strategy. Mrs Morton expressed her gratitude at being recognised for the directorate's adoption of the Listening into Action approach, through the staff awards process. Mr Trotman asked who took the Chair of the Imaging team meetings and asked with what frequency the meetings were held. He was advised that the Chair alternated between Mrs Morton and Dr Frank Leahy, Divisional Director. The meetings are held monthly. Dr Sahota asked what likely competition the division would be faced with in the coming months. Mrs Morton explained that a local Trust is a major competitor for diagnostic services and this would be a challenge in the future, therefore there is a strong focus on providing a high quality service with low waiting times. The low number of complaints received in connection with the directorate suggests that this is being achieved. Mrs Davis asked what the sickness absence rate was for the directorate. She was advised that this was slightly higher than target at 4.27%. This will be addressed through publicity of performance against this target and peer pressure. Mrs Morton and Mrs Reid were thanked for their comprehensive and informative report.	
4.2 Presentation by the Pathology directorate	**SWBFC (10/09) 204**
Dr Jonathan Berg joined the meeting to present an overview of the financial position and activities in connection with the Pathology directorate. He reported that reconfiguration of the services had been successfully achieved and would stand the area in good stead for the delivery of future plans. The current volume of work is a concern and needs to be addressed to ensure that waiting times are as optimal as possible. The Trust has recently won a tender for the provision of services to Birmingham and Solihull Mental Health Trust and specialist services continue to be offered across the country. Dr Berg advised that the unit is currently expressing an interest in a contract concerning Chlamydia screening. In relation to activity, Dr Berg reported that performance against all targets has been exceeded. Year on year, the demand from GPs is increasing. The directorate's CIP was noted to be £710k and all schemes are on track to deliver as planned. The recently introduced blood tracking system supports the CIP. The directorate was reported to be carrying a significant surplus, the majority of which is due to the activity levels, direct access cases and specialist services. Overperformance as a result of GP work has generated £400k for the Trust. One of the most significant pressures on the directorate relates to Vitamin D deficiency tests, where the expense of performing a test outweighs the income received. The PCT responsible for the high number of tests requested has been advised of the situation. Mrs Davis recommended that work should be undertaken with the PCT to ensure that the requests for testing are appropriate and have sufficient clinical justification. Dr Sahota remarked that the high level of such tests is reflective of the high proportion of black and ethnic minority groups within the local population.	

Dr Berg reminded the Committee that Toxicology services had incurred a deficit in past years, however this position has now been offset largely due to the work received from the Birmingham and Solihull Mental Health Trust. Pay expenditure was reported to be underspend due to the current vacancies, particularly those within sample reception. Non-pay expenditure was noted to be overspent by £239k, associated with reagents and consumables. Printing and stationery costs are also high due to the expense of preprinted barcode labels. Professor Alderson expressed surprise at the small amount of income generated from Research and Development activities. Dr Berg explained that Research and Development has historically not involved Pathology. The establishment of 'well woman' and 'well man' clinics were reported to be a potential source of income in the future. It was suggested however that such tests needed to be reviewed for appropriateness and cost benefit. Dr Berg was thanked for his informative report.	
5 Trust Board performance management reports	
5.1 2009/10 month 6 financial position and forecast	**SWBFC (10/09) 194** **SWBFC (10/09) 194 (a)** **SWBFC (10/09) 194 (b)**
Mr Wharram reported that an in-month surplus of £257k against a target surplus of £229k was achieved in-month. In-month FTEs were noted to be 9 below plan, with the cash balance being in line with plan at present. The better performance in-month was reported to be driven by income. The CIP position remains similar to the previous month, although Surgery A division's deficit is reducing. Pay is still an overall concern and the Trust is now carrying more WTEs than planned. When an approximation of agency staff WTEs is added, this increases the WTEs to significantly above plan. Mrs Davis suggested that if there are more staff in post than plan, that agency staff used should be covering sickness and leave. She suggested that a proactive approach should be taken to resolving sickness absence. Mrs Hunjan asked whether the vacancy control had been ineffective given the continued rise in staff numbers. Mr Kirby pointed out that a vacancy freeze had not been implemented and highlighted that the staff figures being reviewed represent a historical position, rather than the current picture. The situation is also exacerbated by an overlap between substantive staff starting in posts currently occupied by agency staff. Once inductions and handover have been completed, it is expected that the position will improve. Mr Trotman highlighted that an increase in pay costs would not be expected in addition to an increase in bank and agency costs. Mr Adler stressed that the situation will be seen to improve once the current data is available. Mr Trotman asked what effect the closure of wards over the summer period had effected on staff numbers. Mr Kirby advised that there had not been a loss of staff despite the ward closures. Mr Kirby outlined the current criteria for recruitment of staff, where new posts are generally rejected unless they are replacing front line staff. There is a high turnover in Facilities in particular. Mr Wharram continued that capital expenditure is currently very slow, however there are a number of changes to the capital programme planned, which may address this situation.	

The cash position is stable. Performance against contract continues to be strong, but is dominated by outpatients with procedure cases. Discussions are underway with PCTs to ensure that there is an awareness that the increased income from outpatient with procedure cases is offset by fewer medical admissions. Mrs Hunjan asked whether the Trust was likely to receive any further funding in respect of pandemic flu planning. She was advised that this was not likely. Mrs Hunjan added that the rate of capital spend is concerning and asked what guidance is being given to divisions regarding expediting expenditure. Mr White advised that divisions are being reminded, however a discussion with the Strategic Health Authority is also planned to ensure that the funds are ringfenced and carried forward into the new financial year if necessary.	
5.2 Progress with divisional recovery plans	**Verbal**
Mr Kirby reported that for the majority of divisions, the actions developed are delivering the required results. The trend of overspending, in particular was noted to have slowed. Much work is continuing to address Medicine A and Medicine B divisions' position. There is an issue regarding the change in the mix of long stay to short stay cases, which has reduced income received. There is some optimism however that the income position will improve towards the end of the financial year. Medicine B is presently using agency staff to cover middle grade rotas at Sandwell Hospital Accident and Emergency Department. A discussion is also being pursued regarding whether central reserves should be used to mitigate the income shortfall incurred.	
5.3 Performance monitoring report	**SWBFC (10/09) 200** **SWBFC (10/09) 200 (a)**
Mr Harding provided an overview of performance against key indicators and targets between April – September 2009. In terms of performance against the stroke pathway, 67.3% of patients were noted to have spent more than 90% of their time on a stroke unit during their stay. It is anticipated that the performance against this target will improve further as the effect of the revised pathways impacts. Regarding smoking cessation during pregnancy, there is a continued improvement in the number of women who stop smoking. Data completeness against this indicator is a concern however, although measures are in place to address this situation. In relation to the referral to treatment targets, performance has been good in month, with all targets having been met. No diagnostic waits were reported to have been in excess of six weeks. Regarding the brain imaging target, the current performance relates to the definition of the indicator initially agreed, however changes have been proposed to count a number of related procedures within the remit of the target. Performance against the smoking cessation referrals target was discussed, where it has been revealed that only approximately 10% of those currently reported relate to patients due to undergo elective surgery. It was agreed that future versions of the performance report will highlight the number of patients to which the indicator actually relates. Sickness absence was noted to have risen slightly to 4.36%, mainly attributable to an increase in short term sickness. PDR submissions have reached 50%, although there are variations between	

divisions, which are being handled through the divisional review process.	
5.4 Foundation Trust compliance report	**SWBFC (10/09) 198** **SWBFC (10/09) 198 (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.	
5.5 NHS performance framework	**SWBFC (10/09) 197** **SWBFC (10/09) 197 (a)**
Mr Harding presented the Trust's performance against the indicators comprising the NHS performance framework. The Committee was pleased to note that the Trust remains classified as a 'performing' organisation, despite the amber rating for stroke services.	
6 Cost improvement programme (2009/10)	
6.1 CIP delivery report	**SWBFC (10/09) 195** **SWBFC (10/09) 195 (a) - SWBFC (10/09) 195 (d)**
Mr Wharram presented the monthly 2009/10 CIP delivery report, which it was noted had been reviewed in detail at the Financial Management Board meeting. The number of schemes underperforming against plan is improving.	
6.2 Quality and Efficiency programme (QuEP) update	**Verbal**
Mr Adler reported that the Financial Management Board (FMB) had considered the initial plans to fulfil the workstreams required to deliver the QuEP. The overall project management of the work is due to be discussed at the November meeting of the FMB. The establishment review workstream will commence shortly as an accrual will need to be made for redundancy costs. It is planned that the current establishment of c 6400 will be reduced to 6000. This is likely to yield £15m in savings. On a separate matter, Mr Adler was asked to determine progress with processing the cost-saving ideas generated at the AGM.	
ACTION: Mr Adler to determine progress with processing the cost-saving ideas generated at the AGM	
7 Financial Planning Framework 2010-11	**SWBFC (10/09) 203** **SWBFC (10/09) 203 (a)**
Mr White advised that Primary Care Trusts have been asked to submit spending plans and growth assumptions to the Strategic Health Authority. The Department of Heath is at present, reluctant to issue indices relating to the future tariff, efficiency requirements within the tariff and changes to the mandatory element of services. As context to the plans, Mr White was asked to send a copy of the financial slides presented at the Consultant Conference in September.	

ACTION: **Mr White to send Non Executives, a copy of the financial slides presented at the Consultant Conference in September**	
8 Possible changes at the Healthcare Purchasing Consortium (HPC)	**SWBFC (10/09) 202** **SWBFC (10/09) 202 (a)**
Mr White reported that there are proposed changes at HPC, including a plan to merge with a larger American-based logistics provider. Although the Trust currently uses the services of HPC, a number of local Trusts do not. As part of the efficiency plans around shared services, the termination of the contract with HPC might be necessary. A formal decision will need to be made to pursue this course of action if it is decided that this is appropriate. The Committee was asked to note that if as a result of this decision, average prices of purchased goods increase by a quarter of 1%, this has the potential to incur c. £100k of additional cost.	
9 Memorandum Trading Accounts	**SWBFC (10/09) 199** **SWBFC (10/09) 199 (a)**
Mr Wharram reported that in response to an Internal Audit recommendation, and guidance issue by the Department of Health in 2006, a set of memorandum accounts for income generating schemes should be prepared. The Trust currently runs three schemes to which this requirement relates: garage services; the mortuary service; and the opticians service. It was agreed that a short report of performance against these schemes should be presented to the Committee on a yearly basis.	
AGREEMENT: **A short report of performance against the Trust's income generation schemes should be presented to the Committee on a yearly basis**	
10 Minutes for noting	
10.1 Minutes of the Strategic Investment Review Group	**SWBSI (10/09) 002**
The Committee noted the minutes of the SIRG meeting held on 8 September 09.	
10.2 Actions and decisions from the Strategic Investment Review Group	**SWBFC (10/09) 201**
The Committee noted the actions and decisions arising from the meeting of SIRG meeting held on 13 October 09.	
10.3 Minutes of the Financial Management Board	**SWBFM (9/09) 090**
The Committee noted the minutes of the FMB meeting held on 15 September 09.	
11 Any other business	**Verbal**
There was none.	
12 Details of next meeting	**Verbal**
The next meeting is to be held on 17 November 2009 at 1400h in the Executive	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Meeting Room at City Hospital.	

Signed .....

Print .....

Date .....