Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Boardroom, Sandwell Hospital **Date** 27 October 2011; 1530h - 1730h

Members			**In Attendance**	
Mrs S Davis	(SD)	[Chair]	Mr G Seager	(GS)
Mr R Trotman	(RT)		Miss K Dhami	(KD)
Dr S Sahota	(SS)		Mrs J Kinghorn	(JK)
Mrs G Hunjan	(GH)		Mrs C Rickards	(CR)
Prof D Alderson	(DA)		Mrs C Powney	(CP) [Sandwell LINks]
Mrs O Dutton	(OD)			
Mr J Adler	(JA)		**Secretariat**	
Mr D O'Donoghue	(DO'D)		Mr S Grainger-Payne	(SGP) [Secretariat]
Mr R White	(RW)			
Miss R Barlow	(RB)			
Miss R Overfield	(RO)			
Mr M Sharon	(MS)			

Item	Title		Lead
1	**Apologies**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Chair's opening comments**	**Verbal**	**Chair**
4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 29 September 2011 as true and accurate records of discussions*	**SWBTB (9/11) 203**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (9/11) 203 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	FOR APPROVAL		
7	**Application for the use of the Trust Seal – Lease and supply agreements for the Krypton generator service**	**SWBTB (10/11) 217** **SWBTB (10/11) 217 (a)**	**RB**

MATTERS FOR INFORMATION/NOTING			
8	**Safety, Quality and Governance**		
8.1	Care Quality Commission (CQC) reports and action plans	SWBTB (10/11) 223 SWBTB (10/11) 223 (a) - SWBTB (10/11) 223 (e)	RO
8.2	Safeguarding update	SWBTB (10/11) 219 SWBTB (10/11) 219 (a)	RO
8.3	Update on complaints handling	Hard copy paper	KD
8.4	Board Assurance Framework – Quarters 1 and 2	SWBTB (10/11) 218 SWBTB (10/11) 218 (a)	SG-P
8.5	Annual Audit Letter	SWBTB (10/11) 207 SWBTB (10/11) 207 (a)	RW
9	**Performance Management**		
9.1	Monthly finance report	SWBTB (10/11) 210 SWBTB (10/11) 210 (a)	RW
9.2	Draft minutes from the Finance and Performance Management Committee meeting held on 20 October 2011	To follow	RT
9.3	Monthly performance monitoring report	SWBTB (10/11) 221 SWBTB (10/11) 221 (a)	RW
9.4	NHS Performance Framework/FT Compliance monitoring report	SWBTB (10/11) 220 SWBTB (10/11) 220 (a)	RW
9.5	Corporate Objectives progress report – Quarter 2	SWBTB (10/11) 209 SWBTB (10/11) 209 (a)	MS
10	**Strategy and Development**		
10.1	'Right Care, Right Here' programme: progress report including update on decommissioning	SWBTB (10/11) 213 SWBTB (10/11) 213 (a)	MS
10.2	Foundation Trust application programme		
▶	Programme Director's report	SWBTB (10/11) 212 SWBTB (10/11) 212 (a)	MS
10.3	Midland Metropolitan Hospital project: Programme Director's report	Verbal	GS
11	**Operational Matters**		
11.1	Sustainability update	SWBTB (10/11) 208 SWBTB (10/11) 208 (a)	GS
11.2	TCS benefits realisation update	SWBTB (10/11) 215 SWBTB (10/11) 215 (a)	RB

12	**Any other business**	**Verbal**	**All**
13	**Details of next meeting** *The next public Trust Board will be held on 24 November 2011 at 1530h in the Anne Gibson Boardroom, City Hospital*	**Verbal**	**Chair**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 29 September 2011

Present	**In Attendance**
Mrs Sue Davis CBE (Chair)	Miss Kam Dhami
Mr Roger Trotman	Mr Graham Seager
Mrs Gianjeet Hunjan	Mrs Jessamy Kinghorn
Dr Sarindar Sahota OBE	Mrs Carol Powney [Sandwell LINks]
Prof Derek Alderson	
Mrs Olwen Dutton	
Mr John Adler	**Secretariat**
Mr Robert White	Mr Simon Grainger-Payne
Mr Donal O'Donoghue	
Miss Rachel Barlow	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
No apologies were received.	
2 Declaration of Interests	**Verbal**
There were no declarations of interest raised.	
3 Chair's Opening Comments	**Verbal**
The Chair had no opening comments.	
4 Minutes of the previous meeting	**SWBTB (8/11) 185**
The minutes of the previous meeting were presented for approval and were	

accepted as a true and accurate reflection of discussions held on 25 August 2011.	
AGREEMENT: The Trust Board approved the minutes of the last meeting	
5 Update on actions arising from previous meetings	**SWBTB (8/11) 185 (a)**
The updated actions list was reviewed and it was noted that there were no outstanding actions requiring discussion or escalation. It had been noted that a request had been received from Sandwell LINks to provide details of the actions underway to address the issues raised as part of the review of discharge. Miss Barlow confirmed that this response was in hand.	
6 Questions from members of the public	**Verbal**
No questions were raised by members of the public present.	
Items for Approval	
7 Single Tender Action – Krypton generator service	**SWBTB (9/11) 190**
Miss Barlow presented a single tender action in respect of two purchases, £150k for the delivery of radioactive krypton generators and £480k for the provision of Rb81 solution. It was reported that there was only one provider available from which to purchase the materials, the Alta Cyclotron Group. Mr Trotman asked whether the Trust benefited financially from the provision of the krypton generator service. He was advised that a benefit of c. £200k was generated from this service.	
AGREEMENT: The Trust Board unanimously supported the proposed single tender arrangement in respect of a krypton generator service	
8 Annual planning process and timetable	**SWBTB (9/11) 202** **SWBTB (9/11) 202 (a) - SWBTB (9/11) 202 (c)**
Mr Sharon presented the proposed annual planning process and timetable for 2012/13, which he advised were amended from previous years to incorporate the input of the specialities. To this end, the Board was advised that the specialities had been asked to develop their own strategies to inform the overall future plan of the Trust. The Board was informed that the timetable for the annual planning process was challenging, however discussions had been held with each division to articulate the rationale behind the process and had received good co-operation to date. In terms of the development of the financial plan, Mr White reported that a six-month work programme had been developed, which would build on the work with Atos, including the high level project level savings and efficiencies identified.	

Internally, the plan was reported to be being developed in the context of the Transformation Plan. Mr Adler advised that the shape of the next year's Local Delivery Plan (LDP) would be developed with the Transformation Plan and the 'Right Care, Right Here' programme efficiencies in mind. The Chair asked whether the Clusters had discussed the LDP plans with GPs. She was advised that this stage had not yet been reached in the process, however the LDP negotiating strategy would be presented the Trust Board in due course. The Trust Board approved the annual process and timetable.	
AGREEMENT: The Trust Board approved the annual process and timetable for 2012/13	
9 Changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation	**SWBTB (9/11) 200** **SWBTB (9/11) 200 (a)** **SWBTB (9/11) 200 (b)**
Mr White advised that the Trust had an obligation to review its Standing Orders, Standing Financial Instructions and Scheme of Delegation on an annual basis and asked the Board to review the proposed changes to the same. It was highlighted that the changes had been previously presented to the Audit Committee which had supported them and had agreed to recommend their acceptance to the Trust Board. Mrs Hunjan highlighted an area of inconsistency on Page 62 of the document, which Mr White agreed to amend. She also drew the Board's attention to the inclusion of a requirement for the Director of Finance to be a qualified accountant. Mr Trotman asked whether the gifts and hospitality policy would cover consultants travelling abroad. He was advised that this was the case. Mrs Hunjan advised that an annual update on the gifts and hospitality register was included within the Audit Committee annual cycle of business. Mrs Dutton suggested that the policy needed to register offers made but declined. Mr Trotman asked whether the requests for orders could be split to avoid the requirement for escalation of the approval for their purchase to the next level. He was advised that the Trust's Supplies team monitored that this did not occur. Mr O'Donoghue noted that the Scheme of Delegation did not specifically reference Clinical Directors for budgetary responsibility. Mr White advised that if this was necessary an in year amendment to the document could be made. It was agreed that within paragraph 17.5.6, it needed to be made clear that it was within the gift of the Board to waive tendering in exceptional circumstances.	

Subject to the amendments proposed, the Trust Board approved the changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.	
ACTION: **Mr White to organise for the amendments suggested to be made to the Standing Orders, Standing Financial Instructions and Scheme of Delegation** **AGREEMENT: Subject to minor amendment, the Trust Board approved the changes proposed to the Standing Orders, Standing Financial Instructions and Scheme of Delegation**	
10 Safety, Quality and Governance	
10.1 Nursing update	**SWBTB (9/11) 201** **SWBTB (9/11) 201 (a) - SWBTB (9/11) 201 (g)**
Miss Overfield presented an update on key nursing activities and performance against nursing quality targets. Dr Sahota remarked that it was encouraging the note an improved performance with reducing the number of inpatient falls, however he observed that completion of fluid balance charts remained poor. Miss Overfield acknowledged that this position was a concern, however she advised that the situation was improving. Mrs Hunjan asked what uptake there had been of the degree programmes aimed at elevating the nursing profession to graduate level. Miss Overfield reported that there was a significant waiting list for staff willing to complete a degree course. The Board was advised that the courses were aimed at Band 6 and 7 staff and they recognised previous clinical experience. It was highlighted that only twenty places were available to the Trust annually. Mrs Hunjan noted that standards on a number of wards had deteriorated according to the ward audits, however these had not been escalated to the list of wards of concern. Miss Overfield advised that although the ward review outcomes were informative, the judgement as to the overall performance of a wards relied on a further set of metrics, including sickness absence levels. Mr Sharon asked whether the Safer Nursing Care Tool could be used to effectively influence shift patterns. He was advised that the Tool was used to determine the acuity of a ward, which could then be used to inform the required nurse staffing, however the e-rostering tool could be used to manage shift patterns.	
10.2 Patient experience update	**SWBTB (9/11) 192** **SWBTB (9/11) 192 (a)**
Miss Overfield presented the latest results from the inpatient staff survey, which she advised covered a period of three months. The Board was advised that a	

much improved level of returns was being received, which would provide more informative judgements on opinions from patients of different ethnic backgrounds and gender. The Chair remarked that there appeared to be a number of areas that needed to be worked through and improved further. Miss Overfield highlighted that any issues raised by the results were being handled through various committees and executive boards. The Chair agreed that the number of returned surveys was pleasing. Mrs Powney asked whether the surveys were undertaken prior to a patient leaving hospital. She was advised that this was the case. Mr Adler observed that the surveys appeared to be more balanced in terms of the returns from across a wider variety of ethnic groups. The Board was advised that the next iteration of the surveys would capture the name of the patient's consultant.	
10.3 Equality and Diversity update	**SWBTB (9/11) 196** **SWBTB (9/11) 196 (a)**
Miss Overfield presented an update on Equality and Diversity activities being undertaken. Mrs Dutton asked whether Equality and Diversity obligations were built into budgets in terms of the operational impact of meeting Equality and Diversity duties. Miss Overfield advised that this was captured to some degree as part of the assessment of the Trust's Cost improvement Programme (CIP) schemes. The Chair observed that there had not been a comprehensive review of the financial impact of the need to comply with Equality and Diversity legislation however. Mr Adler confirmed that the assessment of the CIP schemes specifically had thus far focussed on quality and safety rather than equality and diversity as such. It was suggested therefore that the Transformation Plan templates should include the requirement to assess projects from this perspective.	
ACTION: Miss Barlow to ensure that the Transformation Plan project templates include a requirement to assess the proposals for Equality and Diversity implications	
10.4 Update on Complaints Handling	**Hard copy paper**
Miss Dhami reported that during the fifth 21-day period, the number of live complaints stood at 316, representing a slight reduction on the number at the end of the previous period. In terms of the grade of complaints, the majority were highlighted to be of the less serious grades.	

The number of complaints within the backlog was reported to be 54, including one red complaint that had been reclassified from amber to red. During the reporting period, it was reported that 68 complaints had been received and that 101 responses had been issued against a target of 95. It was reported that an update on complaints had been discussed at the previous meeting of the Quality and Safety Committee, where it had been reported that there were no obvious trends in terms of complaint themes, however the situation was being regularly monitored. The Board was advised that regular updates on complaints handling were being provided to the Care Quality Commission (CQC), which was supportive of the progress on delivery of the action plan to address the complaints backlog. Miss Dhami advised that it continued to be forecast that the backlog of complaints would be removed by December 2011, although it had been hoped that a larger proportion of the backlog would have been addressed at this point. The Chair asked whether there was a sense that complainants were satisfied with the responses received. Miss Dhami reported the during the period six link (follow up to responses) complaints had been received which was an encouraging level and suggested that responses were being well received.	
10.5 Update from the Quality and Safety Committee held on 22 September 2011	**SWBTB (8/11) 172** **SWBTB (8/11) 172 (a)**
Professor Alderson reported that at the recent meeting of the Quality and Safety Committee, three aspects of complaints handling had been discussed, covering those complaints referred for independent review, trends and the progress with the CQC action plan. It was reported that a question about complaints would be added to the Trust board walkabouts questionnaire. The Board was advised that a number of patient safety matters had been discussed, including the death of a child from tuberculosis, where an independent review had concluded that the Trust had acted appropriately but that there were several process issues to be addressed. Likewise, an independent review of the Trust's Haematology service had been conducted which had raised a number of recommendations on which the Trust was acting. A review of the joint breast screening service was reported to have been considered, although this had concluded that there were no apparent patient safety issues related to this service. An update on Patient Related Outcome Measures (PROMs) was reported to have been considered, which suggested that the Trust was an outlier in terms of average health gain following knee replacements. It was highlighted that the issues had been discussed with the relevant directorate, with a view to improving the scores in future.	

A discussion was reported to have been held concerning Never Events, where there was a concerning trend, and it was agreed that the options for raising awareness of these should be considered by the Executive Team. Finally, the Board was informed that an update on progress with addressing NPSA safety alerts had been considered. Mr Adler added that a small cluster of complaints related to ward Lyndon 4 had been noted at the meeting, which Miss Overfield was investigating.	
11 Performance Management	
11.1 Monthly finance report	**SWBTB (9/11) 191** **SWBTB (9/11) 191 (a)**
Mr White reported that during the month a surplus of £35k had been achieved against a target of £51k, with the overall year to date position remaining slightly behind trajectory. The Board was advised that an end of year surplus of £1.8m continued to be forecast as agreed with NHS West Midlands. It was reported that the CIP had been reprofiled in the light of the Medicine & Emergency Care and Surgery, Anaesthetics & Critical Care divisions' positions. Recovery plans for the divisions were noted to have been agreed, together with underspends incurred by the non-clinical areas having been locked in. The Board was advised that an emerging concern related to the position of the Women and Child Health division, where income had been lost due to fewer births that expected and pressure on medical staffing costs had contributed to the adverse variance. Mr White reported that an analysis of the position was being undertaken at the speciality and GP level. The Board was asked to note that capital expenditure was less than planned at present. The loan for the land acquisition was reported to have been approved by the Department of Health. Mrs Davis asked whether the adverse variance reported earlier in the year would trigger closer scrutiny by Monitor should the Trust have acquired Foundation Trust status. Mr White advised that the situation would be expected to be reported to Monitor, however it was unlikely that it would trigger a specific review.	
11.2 Draft minutes from the meeting of the Finance and Performance Management Committee held on 22 September 2011	**Hard copy paper**
Mr Trotman asked the Trust Board to receive and note the draft minutes from the meeting of the Finance and Performance Management Committee held on 22	

September 2011.

The Board was advised that representatives from the Medicine and Emergency Care division had attended the meeting, however prior to their presentation Mr White had updated the Committee on progress with the Surgery, Anaesthetics & Critical Care division's recovery plan, central to which was that the deficit did not grow any further. The Board was advised that it had been noted that there was a degree of underperformance on emergency admissions, which had been mitigated somewhat by the use of some deferred income from the Transitional Financial Framework reserves.

It was noted that the CIP had been reprofiled with non-recurrent slippage shortfall of £478k in the Medicine & Emergency Care division's position and £511k in Surgery, Anaesthetics & Critical Care divisions having been accepted on the basis of the pressure experienced in Months 1 to 4.

The Board was informed that Mr Matthew Dodd, Acting Divisional General Manager for the Medicine & Emergency Care division, had presented detailed CIP schemes, totalling £1,491,124 and was questioned about their deliverability, The Committee was given a realistic but not total reassurance on the deliverability.

Dr Matthew Lewis, Divisional Director for the Medicine & Emergency Care division was asked about clinical engagement with the recovery plan and he had advised that while there was good co-operation from colleagues, there was a lack of understanding of the issues which needed to be addressed. The Committee had been informed that this was being handled through a series of six-weekly meetings, dealing with a range of topics but particularly for clinicians to understand the economic climate and the consequences for the Trust.

The Board was advised that both the Medicine & Emergency Care and Surgery, Anaesthetics & Critical Care divisions would present a further update to the Committee prior to the end of the current financial year.

Other areas of concern for the Committee were reported to relate to the significant adverse variance within the Women and Child Health division's position and an unaccustomed slippage in the position of the Estates area. Reports on these two areas were reported to be being presented at the next meeting.

It was reported that medical staffing costs had been questioned, which were noted to reflect gaps due to training rotas, which the Committee was advised was commonplace across the region.

The Committee was reported to have been pleased at the surplus generated, despite it being less than planned.

Of great interest to the Committee was the report from the Atos consultants, who the Board was reminded were nearing the end of their initial contract. Mr Trotman advised that the consultants were planning to make a presentation to

the Executive Team on 4 October 2011, with options for the development of the Transformation Support Office being underway, which Mr Trotman remarked was of great importance. It was agreed that the Non Executive Directors should join the presentation by the Atos consultants if possible.	
11.3 Monthly performance monitoring report	**SWBTB (9/11) 188** **SWBTB (9/11) 188 (a)**
Mr White reported that there was a concerning trend on Delayed Transfers of Care, although the Board was reassured to learn that the position had improved in September, particularly in relation to Sandwell. Performance against the stroke care target was reported to be 88.6%, which was highlighted to be the highest level for some time. An improvement against the TIA target was reported to be being pursued through a TIA improvement plan. Performance against the Accident and Emergency waiting times target was highlighted to have fallen to below 95%. Mrs Dutton asked how many waits in excess of four hours were necessary for the target to fall below 95%. She was advised that this was c. 20 across both sites per day. The Board was advised that there had been 22 single sex accommodation breaches during the month, although these were attributable to one patient treated within the Medical Assessment Unit. Mr White advised that performance against the CQuIN targets had been reviewed in detail recently.	
11.4 NHS Performance Framework/FT Compliance monitoring report	**SWBTB (9/11) 189** **SWBTB (9/11) 189 (a)**
Mr White presented the NHS Performance Framework update for receiving and noting. Miss Barlow presented the plan to handle the winter pressures on the Trust's capacity. She advised that the plan had been reviewed and developed in the context of the reduction in non-elective activity and the situation with the Delayed Transfers of Care. The Board was advised that 22 reablement beds were due to open at Rowley Regis Hospital, which had been built into the plan and a 10% reduction in capacity compared to the previous year had been assumed. Miss Barlow informed the Board that a winter ward would be opened on each site and staff to operate the wards had been recruited. Mr Adler highlighted that this measure mitigated the risks associated with opening and closing flexible capacity as had been undertaken in previous years. The Chair asked what cost had been attached to the extreme operational pressure experienced in the winter of 2010/11. She was advised that this had not been costed, however an additional	

number of bank shifts had needed to be funded. The Chair cautioned that the impact of school closures needed to be considered, should similar operational pressures be repeated in the forthcoming winter.	
12 Strategy and Development	
12.1 Reconfiguration	
▶ **Clinical Services reconfiguration update**	**SWBTB (9/11) 193** **SWBTB (9/11) 193 (a)**
Mr Sharon reported that steady progress was being made on the reconfiguration of clinical services and that the plans to open the Halcyon birth centre were on track. Options for the reconfiguration of stroke services were also noted to be being developed. The Board was advised that reconfiguration of vascular services was also planned. Mr Sharon advised that communication had been received from the interim Trauma Director, which advised that the Trust may be awarded a designation as a Trauma Unit, subject to completion of a business case and action plan to achieve the required standards. Mr O'Donoghue congratulated Mr Sharon and team for the efforts made to submit the application. The Board was advised that the local Overview and Scrutiny Committees had been attended by members of the Trust to present the approach to proposals for stroke reconfiguration, which had been supported. It was highlighted that there was a possibility that a public consultation exercise for stroke and vascular services reconfigurations may be undertaken in Spring 2012. Mr Adler reported that at a recent meeting of Black Country Cluster Chief Executives, it had been agreed that the same model would be used for the development of stroke services as had been applied for trauma services, with the likelihood being that the same approach would be adopted by the Birmingham and Solihull Cluster.	
▶ **Draft minutes from the Reconfiguration Board meeting held on 8 September 2011**	**Hard copy paper**
Mrs Hunjan asked the Board to receive and note the draft minutes from the Reconfiguration Board meeting held on 8 September 2011. She advised that there was good progress with the preparation of guidelines and flowcharts which could be used by staff as part of reconfiguration planning.	
12.2 'Right Care, Right Here' programme: progress report including an update on decommissioning	**SWBTB (9/11) 194** **SWBTB (9/11) 194 (a)**
Mr Sharon asked the Board to note that the progress against the key activity trajectories was now summarised in a more succinct way. He advised that the care pathway review process was continuing .	

Progress of the decommissioning programme was reviewed, where it was noted that there was currently a shortfall against the target activity savings required. The Board was advised that further work with the PCTs was planned to identify ways to address this gap.	
12.3 Foundation Trust application: progress update	
Programme Director's report	**SWBTB (9/11) 195** **SWBTB (9/11) 195 (a)**
Mr Sharon reported that a revised Tripartite Formal Agreement was due to be submitted shortly, with some milestones having been amended on the basis of advice concerning the likely approval of the Outline Business Case for the new hospital by the Department of Health. The Board was advised that the recent review of Trusts associated with a PFI plan by the McKinsey consultants, had suggested that the scheme was regarded as affordable without any additional activity requirements. This was the best possible outcome from the exercise. Feedback from Deloitte and NHS West Midlands on the Trust's Integrated Business Plan was reported to have been received, which overall suggested that this was an effective document.	
12.4 Midland Metropolitan Hospital project: progress report	**Verbal**
Mr Seager reported that visits to other PFI schemes had been completed, which had provided a good opportunity to understand a number of lessons learned for the experiences. The Board was advised that approval of the Outline Business Case remained awaited. Mr Seager advised that properties affected by the Compulsory Purchase Order had been approached with a view to expediting the vacation of the new hospital site.	
13 Any other business	**Verbal**
There was none.	
14 Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 27 October 2011 and would be held in the Boardroom at Sandwell Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 27 October 2011, Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

29 September 2011, Anne Gibson Boardroom @ City Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Prof D Alderson (DA), Mrs O Dutton (OD), Mr J Adler (JA), Mr R White (RW), Mr Donal O'Donoghue (DO'D), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO)

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

Apologies: None

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 21 October 2011

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.195	Update on complaints handling	Hard copy papers	28-Apr-11	Consider the suggestion made to organise a 'walk through' a complainant's experience and the complaints process	KD	~~31/07/2011~~ ~~22/09/2011~~ 15/12/2011	Process flow of complaints process being developed at as part of the revised Complaints Handling strategy which will be shared the the Trust Board in December 2011	G
SWBTBACT.208	Sustainability update and Sustainability & Environment policy	SWBTB (7/11) 149 SWBTB (7/11) 149 (a) - SWBTB (7/11) 149 (c)	28-Jul-11	Arrange for the anticipated position in respect of the Trust's carbon credit allocation to be presented at a future meeting of the Finance and Performance Management Committee	GS	~~20/10/2011~~ 31/11/2011	Paper received and agreeing when most appropriate to share it with F & PMC	G
SWBTBACT.214	Equality and Diversity update	SWBTB (9/11) 196 SWBTB (9/11) 196 (a)	29-Sep-11	Ensure that the Transformation Plan project templates include a requirement to assess the proposals for Equality and Diversity implications	RB	30/11/11		G
SWBTBACT.213	Changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation	SWBTB (9/11) 200 SWBTB (9/11) 200 (a) SWBTB (9/11) 200 (b)	29-Sep-11	Organise for the amendments suggested to be made to the Standing Orders, Standing Financial Instructions and Scheme of Delegation	RW	27/10/11	Amendments made and added to internet	B

KEY:

R	Outstanding action due for completion more than 6 months ago. Completion has been deferred more than once or there is no firm evidence that it is being progressed towards completion
A	Oustanding action due for completion more than 6 months ago. Completion has been deferred more than once but there is substantive evidence that work is progressing towards completion
Y	Outstanding action raised more than 3 months ago which has been deferred more than once
G	Action that is scheduled for completion in the future and there is evidence that work is progressing as planned towards the date set
B	Action that has been completed since the last meeting

Next Meeting: 27 October 2011, Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

29 September 2011, Anne Gibson Boardroom @ City Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Prof D Alderson (DA), Mrs O Dutton (OD), Mr J Adler (JA), Mr R White (RW), Mr Donal O'Donoghue (DO'D), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO)

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

Apologies: None

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 21 October 2011

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.245	Minutes of the previous meeting	SWBTB (8/11) 185	29/09/2011	The Trust Board approved the minutes of the previous meetings as a true and accurate records of discussions held
SWBTBAGR.246	Single Tender Action – Krypton generator service	SWBTB (9/11) 190	29/09/2011	The Trust Board unanimously supported the proposed single tender arrangement in respect of a krypton generator service
SWBTBAGR.247	Annual planning process and timetable	SWBTB (9/11) 202 SWBTB (9/11) 202 (a) - SWBTB (9/11) 202 (c)	29/09/2011	The Trust Board approved the annual process and timetable for 2012/13
SWBTBAGR.248	Changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation	SWBTB (9/11) 200 SWBTB (9/11) 200 (a) SWBTB (9/11) 200 (b)	29/09/2011	Subject to minor amendment, the Trust Board approved the changes proposed to the Standing Orders, Standing Financial Instructions and Scheme of Delegation

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Renewal of Lease agreement and Supply agreement with the University of Birmingham for continued operation of the krypton generator service
SPONSORING DIRECTOR:	Rachel Barlow, Chief Operating Officer
AUTHOR:	Dr Bill Thomson, Consultant Physicist and Radiation Protection Adviser
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

The continued operation of the krypton generator service (Imaging Division) is dependent on our arrangement with the University of Birmingham Cyclotron Unit (Alta cyclotron Services Ltd) for the supply of stock solution and also on the continued use (through lease) of the laboratory and office space at the cyclotron unit.

The supply agreement and also the lease are due for renewal. The University have offered renewal on continued terms as applied previously.

Renewal of the lease requires the Common Seal of Sandwell and West Birmingham Hospitals NHS trust to be affixed.

The continued operation of the krypton generator service is dependent on the renewal of the supply and lease agreements. The associated income of the krypton generator service is a key revenue stream within the Imaging Division finances.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Imaging Division respectfully requests that the Trust Board gives consideration to authorising that the Supply agreement with University continues. In addition that the Lease agreement for the laboratory and office space at the university cyclotron unit is also signed and the common seal affixed.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Supports the delivery of Safe, High Quality Care
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

Financial	**Y**	
Business and market share	**Y**	
Clinical	**Y**	
Workforce	**Y**	
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience	**Y**	
Communications & Media		
Risks		Risk that the Trust does not succeed in its application

PREVIOUS CONSIDERATION:

The single tender action in respect of the purchases required for the Krypton Generator service was approved at the Trust Board meeting held on 29 September 2011.

Request for Approval of the Continued Lease of Laboratory and Office space at the University Cyclotron Unit and also for approval for renewal of the supply agreement for the Krypton Generator Service

Trust Board - 27 October 2011

Introduction

The Kr81m generator service operates in conjunction with the University of Birmingham Cyclotron Unit. This is the only cyclotron unit in the country capable of producing the radioactive stock solution used for the krypton generator service.

The service has operated since 1981 and there have been several changes over the years. The last major change in operation was made in 2006 when the krypton generator production moved to the University cyclotron site. The division had a lease agreement with the University for the laboratory space and an office. The move of the production laboratory from the City site to the University was agreed by SIRG at the time.

Benefits of Current Arrangement

This move has proved beneficial, and in some aspects crucial, from a number of aspects. The stock solution is highly radioactive and previously had to be transferred into stock vials and transported by road to the City site. This stock then had to be carefully pumped into the loading rig to load the generators. With the current laboratory at the University, the radioactive solution is transferred directly into the generator loading rig, so reducing operator handling procedures.

In addition, this allows generators to be produced within a timescale that allows us to use an overnight courier service for delivery. With the laboratory on the City site and the timescale for loading and transfer of the stock solution, this aspect of transport would not be practical. Reverting to designated supply routes by private courier would be much more expensive.

A final factor is that the University laboratory allows close links with the cyclotron production team. We have also been able to resource their mechanical workshop expertise for servicing aspects of the rig.

Summary

In summary, the continued use of the laboratory at the University cyclotron unit is vital for the continued operation of the krypton laboratory. The krypton generator service is a key revenue stream within the Imaging finances. The lease charges have been accounted for within the krypton budget.

The University lease and our supply agreement needs to be renewed. The University are offering a continued use of the facilities on the same basis as before, and the lease requires The Common Seal of Sandwell and West Birmingham Hospitals NHS Trust to be affixed.

Recommendation

The Imaging Divisions respectfully requests that the Trust Board give consideration to authorising that the Supply agreement with University continues. In addition that the Lease agreement for the laboratory and office space at the university cyclotron unit is also authorised and agreed that the common seal can be affixed.

WH Thomson
17th October 2011

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Report on recent CQC report and progress on action plans
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

The Trust Board are asked to note the contents of this report; the CQC report following their second visit to Sandwell; the revised action plans for Outcomes 1 and 5, the national CQC report into findings from their dignity and nutrition inspections and the additional actions agreed by the Executive Team on 20th October.

Specifically, the Trust Board are asked to note the judgement of the CQC for Sandwell as being:

- Minor for Outcome 5 (nutrition) – an improvement from 'major' in their report published in July.
- Moderate for Outcome 1 (privacy and dignity) – remained the same.

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 contents of the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	1.2 Continue to improve patient experience.
Annual priorities	1.2 Continue to improve patient experience.
NHS LA standards	
CQC Essential Standards Quality and Safety	Regulation 9, Outcome 4 – Care and welfare of people who use services. Regulation 10, Outcome 16 – Assessing and monitoring the quality of service provision. Regulation 17, Outcome 1 – Respecting and involving people who use services.
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:

Initial reports considered at the July 2011 meeting of the Trust Board

Report Title	*Report on recent CQC report and progress on action plans*
Meeting	*Trust Board*
Author	*Rachel Overfield, Chief Nurse*
Date	*27th October 2011*

Introduction

The Trust Board is asked to note the contents of this report; the CQC report following their second visit to Sandwell; the revised action plans for Outcomes 1 and 5, the national CQC report into findings from their dignity and nutrition inspections and the additional actions agreed by the Executive Team on 20th October.

Specifically, the Trust Board is asked to note the judgement of the CQC for Sandwell as being:

- Minor for Outcome 5 (nutrition) – an improvement from 'major' in their report published in July.
- Moderate for Outcome 1 (privacy and dignity) – remained the same.

The national report reflects Sandwell's position from the original visit and names us as being only one of two hospitals to have a 'major' rating.

The trends described in the national report reflect most of the issues on N4 at Sandwell and the early warning signals around other wards highlighted periodically in nursing reports to the Board.

N4 has now been divided into 2 units, Acute Stroke (N1) and Stroke Rehabilitation (N4). Both are working extremely well with very positive reactions from staff and patients. The units will remain in 'special measures' until we are confident that standards are being consistently delivered.

Delivering care standards consistently is the underpinning principle of all the current action plans. In addition to these plans, actions around establishments, ratio reviews, pressure damage, falls etc, which are reported to the Board, compliment and are consistent with our aim to deliver good standards of care consistently. We are confident that systems and processes to enable this are largely in place and that our early warning systems identify when things are going wrong. The challenge now is ensuring that every member of staff does the right thing every time. The actions agreed by the Executives are intended to assist with this.

Among the immediate actions agreed were:

- A revised winter bed plan taking account of latest demand forecasts and staffing availability

- Much stricter controls on the opening of "flexible beds", which can now only be authorised by the Chief Operating Officer, Chief Nurse or Duty Executive Director, and then only in very limited circumstances

- Mock CQC inspections on all wards

- To complement the Extraordinary Hot Topics briefings which have taken place, an October payslip attachment with key messages which all staff need to see

- Removal from Newton 1 ward of non-ward related functions to create more space for ward use

- Funding for a range of items to improve the patient experience, including snack provision on all wards, bed boards, pyjamas and dressing gowns and hoist scales

Medium term agreed actions included:

- A review of the options for freeing up more time for ward management duties

- Clearance of the remaining complaints handling backlog and prioritisation of complaints relating to nursing care

- Introducing a new volunteer service in collaboration with the WRVS

- Introducing a system to bring together different sources of patient feedback (e.g. surveys, complaints, PALS, NHS Choices) and to ensure that this feedback is acted upon

- The creation of a ward dashboard that incorporates all of the data from the Ward Review process and which will feed into the Quality Management Framework Dashboard

Review of compliance

Sandwell and West Birmingham Hospitals NHS Trust Sandwell General Hospital	
Region:	West Midlands
Location address:	Lyndon West Bromwich West Midlands B71 4HJ
Type of service:	Acute services with overnight beds
Date of Publication:	October 2011
Overview of the service:	Sandwell General Hospital is part of Sandwell and West Birmingham Hospitals NHS Trust. It is a busy acute hospital with 470 beds. The Office of National Statistics information shows that Sandwell General Hospital serves a population of around 290,000.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Sandwell General Hospital was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Sandwell General Hospital had made improvements in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 05 - Meeting nutritional needs

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 3 August 2011 and talked to people who use services.

What people told us

Sandwell General Hospital is part of Sandwell and West Birmingham Hospitals NHS Trust (the trust). In March 2011 we carried out a review of Sandwell General Hospital. This review was part of a targeted inspection programme in acute National Health Service (NHS) hospitals to assess how well older people are treated during their hospital stay. In particular we focused on whether they were treated with dignity and respect and whether their nutritional needs were met. Our March 2011 review showed that Sandwell General Hospital was not compliant with the outcome areas we assessed which were:

Outcome 01- Respecting and involving people who use services (we assessed that there were moderate concerns in this area).

Outcome 05- Meeting nutritional needs (we assessed that there were major concerns in this area).

We carried out this review to check whether Sandwell General Hospital had made improvements in respect of these two outcome areas.

We assessed two wards during our inspection; the Emergency Assessment Unit (EAU) and Newton 4 (which provides care to people primarily who have had a stroke). In total we spoke with eleven people. However, out of these eleven, due to individual conditions and communication levels only nine people could answer our questions in detail.

Overall people who were able to talk with us were happy with their care and treatment. People also made positive comments about the food and drink provided. Below are some of the comments they made:

"I am very pleased with everything on EAU. All staff including the doctors keep me informed and they always ask how I am feeling or if there is anything I need". This person further stated "Nothing could be improved on EAU".

"They are very good".

"I am informed of my situation. The staff are very good and they are polite. Overall everything is OK, better than when I was in another hospital ten years ago".

"The food is very good. I am more than happy with it. In fact I was going to fill a comments form in".

On both wards we spent time observing the care provided to people and looking at records, an example being, records of diet and fluid intake. Our observations showed that although improvements have been made since our March 2011 inspection there was still non-compliance particularly regarding how staff protect and/or promote people's dignity. We observed situations that could have been avoided. The outcome for the people involved was that their dignity was not maintained. We also found that further improvements are needed so that people can be assured that their nutritional and hydration needs are met.

Following our inspection the trust informed us that they had taken the decision to close Newton 4 and replace it with two separate units for acute stroke and stroke rehabilitation. The trust told us that the ward would be closed in September 2011 and general medical admissions to the ward would cease immediately.

What we found about the standards we reviewed and how well Sandwell General Hospital was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The trust has implemented systems and processes to improve the way in which people are cared for to promote dignity and improve outcomes for people. Many people told us that they were happy with the care that they receive and the staff on the wards. However, incidents are still occurring which do not give assurance that the care provided always promotes dignity, shows respect for people, or meets their needs.

Outcome 05: Food and drink should meet people's individual dietary needs

Most people were happy with the standard of food and drink offered at Sandwell Hospital. Systems and processes have been implemented to improve the way in which staff assess and monitor people's nutritional risks or well being. However, more improvements are needed to make sure that those people at risk are fully supported by staff to eat and drink. Accurate food and fluid records should be maintained to demonstrate that people are taking adequate food and fluids and that staff are encouraging and enabling them to do so.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are moderate concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
When we visited Sandwell General Hospital in March 2011 we had moderate concerns about this outcome area and we required that improvements were made. At that time people gave us mixed views about their experiences of care and treatment. Some people told us that they had their care needs met and had been treated respectfully. Other people felt that they were not really listened to and staff 'did their own thing' regardless of what they said. We observed care practices that did not ensure people's dignity. For example, we saw a person being taken to the toilet. The staff member only closed the door when they left the toilet room. We saw male patients wearing hospital gowns which did not cover them adequately and one patient had been placed in a bay overnight which was allocated to people of the opposite gender.

In August 2011 we assessed two wards; the Emergency Assessment Unit (EAU) and Newton 4. In total we spoke with eleven people. However, out of these eleven, due to individual conditions and communication levels only nine people could answer our questions in detail. Below are some of the comments people made:

"I am very pleased with everything on EAU. All staff including the doctors keep me informed. They always ask how I am feeling or if there is anything I need". This person further stated "Nothing could be improved on EAU".

"They are very good".

"I am informed of my situation. The staff are very good and they are polite. Overall everything is OK, better than when I was in another hospital ten years ago".

A number of people we spoke with told us that they are kept informed about their situations and are involved in making decisions where possible. A person told us "Staff have explained what will be happening and once it is done we can go home".

Other evidence
In July 2011 following receipt of their final report the trust provided us with an action plan. This action plan told us how and when improvements would be made. We looked at some of the areas where the trust had told us that improvements have been completed.

During this inspection we found that some improvements have been made. For example, the trust has restricted the number of people who can stay on Newton 4. This was done to make sure that there were more resources available to meet people's needs.

When we were on Newton 4 staff told us that relatives are asked at the time of a person's admission to bring in their day clothing or pyjamas. We saw signs displayed in the ward asking relatives to do this. Staff confirmed that Newton 4 now has a stock of hospital pyjamas for people who may be unable to provide their own. We did see one person in EAU wearing a hospital gown which exposed their thigh. This was quickly remedied by staff by placing a blanket over their legs. Staff told us that hospital gowns in EAU are only used initially to enable tests to be carried out, after this people will be supported to change into more appropriate clothing. We did not see anyone on Newton 4 wearing inappropriate clothing that exposed their body. This was an improvement from findings of our March 2011 inspection.

The trust has confirmed that there have not been any 'sleeping breaches' on their wards for two months. This means that people are not placed on mixed gender wards to sleep. We found that EAU has a mixed sex bay. This bay is for people with high dependency needs. We found that the way in which the bay was managed ensured people's dignity. On Newton 4 ward we saw that people of the opposite sex did not have to share the same bay and facilities. This was an improvement from findings of our March 2011 inspection.

On both wards we saw that curtains were pulled around the beds when personal care tasks were being carried out. We also saw that signs were used alerting people that personal care was being carried out and not to enter the curtained area around beds. This action is positive as it promotes privacy and dignity.

We saw that staff were polite and friendly. People told us that they were happy with the staff. One person said "The majority are out of this world. Some cannot do enough for you".

We saw that medical staff gave people time; they listened to what people said to them and then explained the course of action they intended to take. A person told us "The doctors keep me informed".

We did observe a number of situations that could have been avoided.

The action plan provided by the trust in July 2011 stated that the action for 'all ward rounds / handovers to be carried out without breaching patient confidentiality' was complete. After lunch on Newton 4 we observed a staff handover taking place. The handover took place in the main ward area and could be overheard by people in the corridor or in beds nearby. We heard staff discussing intimate details about two people. The trust told us that a new handover system had been introduced to 'enhance staff /patient communications' and to make sure that all staff saw each person at the end and start of their shifts. However, the trust agreed that confidential issues should not be discussed in an open ward area.

The action plan provided by the trust confirmed that a number of areas concerning human rights and diversity had been completed. These areas included 'interpreting services being accessible to staff and clearly understood by staff'. On Newton 4 there was a person whose first language was not English. We asked staff what language the person spoke. The staff member did not know. Afterwards we heard staff discussing this. They were asking each other if they knew what language the person spoke. We saw that the meal co-ordinator took action and asked the person if they would like something to eat then took different options to show them to help them choose. Similarly, as Ramadan was taking place we asked staff what provisions they had made for people. They told us we do not provide anything special. These situations do not give people assurance that their basic diversity needs will be met.

The action plan provided by the trust confirmed that the area 'Observe care to ensure privacy, dignity and respect are maintained' has been completed. Staff told us that the trust has commenced audits which are untaken on an unannounced basis on the wards. These audits are positive in terms of dignity and privacy enhancement and the well being of people on the wards.

We talked to a person on Newton 4 who was distressed because they had been incontinent of faeces. The person told us that they had asked staff an hour and a half before to change them. The person needed to be cleaned. We raised this with the ward manager who found staff to attend to the person. We heard the manager asking staff about this situation. The manager was told that the person had made the request but that staff were doing another task at the time.
We witnessed a similar incident on EAU concerning a person who had been newly admitted. The person was shouting for the toilet. They did not have a call bell so had to resort to shouting. Staff told us that they had been advised by external care professionals that the person does not walk, is not able to go to the toilet, is confused and will ask for the toilet and not go. Fifteen minutes later the person called out again that they needed help as they were wet. We spoke with staff about this and they confirmed that they would not in future rely totally on information given to them by other professionals. They told us that they would also do their own assessment of people's continence needs.

We saw that one person was very agitated and at times aggressive. We observed all staff at different times try and engage with the person to quieten them down. Staff told us that the person had been on a sedative medication but it had made them drowsy so they were only giving the medication now when it was really needed. Staff told us that they had not had any training in dealing with people who might be aggressive or violent.

The trust acknowledges that staff require training in a number of areas. They told us that training programmes have been commenced aimed at senior staff in the first instance. We were given statistics which indicate that staff awareness of for example, safeguarding issues, is increasing.

A person on Newton 4 told us that the ward was short staffed. The person said: "Staffing shortages. Always short, it is not just today either. I feel sorry for the staff". The trust told us that they had increased staffing levels in May 2011 on Newton 4.

Positive initiatives have been taken so that people could make their views known about the services provided or if they had a complaint or concern. An example of this is the comments boxes provided on the wards. The ward manager told us that the boxes are emptied regularly, read and analysed. People we spoke with did know about formal processes they could use or access if they had a complaint or were concerned about anything. One person told us that they had thought about making a comment. Another person told us that they would speak to staff if they were not happy with something. The person said "I also know I can go to that 'PALs' (Patient Advice and Liaison Services) as well".

Our judgement
The trust has implemented systems and processes to improve the way in which people are cared for to promote dignity and improve outcomes for people. Many people told us that they were happy with the care that they receive and the staff on the wards. However, incidents are still occurring which do not give assurance that the care provided always promotes dignity, shows respect for people, or meets their needs.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are minor concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
When we inspected Sandwell General Hospital in March 2011 we had major concerns about this outcome area and we required that improvements were made. At that time some people were happy about their experiences of mealtimes others were not. We found that systems that were in place at that time to support patients who were at risk from malnutrition and dehydration were not being used on all wards. We found that adherence to protected mealtimes was not being practiced. The recording of food and fluid intake was patchy to the extent that they could not be used to determine if patients had eaten and drunk enough to prevent ill health. In August 2011 we assessed two wards; the Emergency Assessment Unit (EAU) and Newton 4. In total we spoke with eleven people. However, out of these eleven, due to individual conditions and communication levels only nine people could answer our questions in detail. Below are some of the comments people made:

"The food is very good. I am more than happy with it. In fact I was going to fill a comments form in".

"Plenty to eat and drink. More than enough for me".

"Food is ok. I don't get a menu but I have not disliked what has been offered. Plenty of water and drinks. I like tea and get it how I like it".

"Given plenty to eat and drink".

Other evidence

The trust sent us an action plan in July 2011 followng receipt of their final report. This action plan told us how and when improvements would be made.

Staff on EAU told us that they are unable to weigh people confined to bed as they do not have equipment to do this. Along with a visual assessment they told us that they have recently started to measure limbs to help them determine an approximate weight.

The trust has undertaken a range of ward based audits in an attempt to make improvements. One audit that the trust is undertaking is to determine if the Malnutrition Universal Screening Tool (MUST) is being undertaken. This tool is used to assess individual risk levels regarding people's nutritional state. Findings from these audits conducted on Newton 4 have shown an improvement from 27% being undertaken in April 2011 to 70% being undertaken in July 2011. More frequent MUST assessments being undertaken will mean that staff will be able to identify at an early stage people who are at risk from malnutrition. They will then be able to implement processes to promote good nutrition and better health.

An improvement that has been made is that wards including Newton 4 now have dedicated 'meal co-ordinators'. The meal co-ordinators are provided with information daily about each person's status regarding their diet and fluid intake needs. The meal co-ordinators offer drinks during the day and distribute the main mid day meals.

We observed the meal co-ordinators at work on Newton 4 and EAU. They were polite, friendly and helpful. They had a good knowledge of individual needs. For example, one person had told us that they had been assessed and due to a swallowing risk could only have a maximum of six teaspoonfuls of food per meal. We heard the ward co-ordinators discussing this. When the meal co-ordinators were giving the drinks out we heard one ask a person if they would like a drink. The person told them that they would have their 'usual'. The meal co-ordinator replied ''Right that's tea with two sugars then''.

The trust have improved processes on wards to make sure that staff and relatives are aware of people who are at risk of malnutrition and/or dehydration. A 'risk list' highlights people who are at risk because of poor diet and fluid intake and is used during shift handovers so that all staff are aware who is at risk. Staff told us that everyone at risk is placed on the red tray and beaker scheme. A red beaker symbol is displayed above the bed of people in this category. This reminds staff who needs encouragement, prompting and more assistance with their diet and fluid intake. We observed the main meal time. We found that there was an improvement from our last inspection. We saw that people who were on the red tray and beaker scheme did have a red tray and a red beaker. In general people did get more assistance and support to eat and drink than we saw during our previous inspection. We observed one person who had to wait ten minutes to be assisted with a hot meal.

On Newton 4 we observed a positive situation where a person although encouraged to eat did not eat much of their main meal. Staff prompted and encouraged this person to eat. They then offered other things to eat instead. The person chose yoghurt, but even with prompting they did not eat much of that either. Staff had done everything they could to encourage and assist them to eat.

On Newton 4 we observed a situation which could have been dealt with better. Staff were attempting to feed someone who was reclined in bed. They did not assist the

person to sit up to eat. We observed that staff assisted the person to eat with their backs to the person, this appeared to upset them and the person flicked the food on the floor. The person was then offered a bowl of custard. The custard was placed on the table at the end of their bed. The staff member asked if they wanted the custard. It was clear that the person had not understood what was being asked. The staff member replied; "That's a no then" and removed the custard. We asked to see what had been written on the food record and saw that it said 'refused'. We checked this persons weight chart which indicated a weight loss from 64 kilogram's on admission 2 July 2011 to 58 kilogram's 23 July 2011. We have been told that this person could be violent towards staff and therefore staff had been anxious when caring for this person. However, this person needed a lot of positive support to eat to prevent further weight loss which they did not get at that meal time.

Overall we found that how staff record the amount of food and fluid people have taken has improved. However, we did see records for two people on Newton 4 where the recording was poor. Both of these people had been assessed as being high risk and placed on the red tray and beaker scheme. For one person there was no care plan for eating and drinking. Care plans or other documentation should be in place to give instruction to staff on how care should be delivered and monitored. The recorded fluid intake for this person from 1 August 2011 to 3 August 2011 (in excess of 30 hours) was only 370 millilitres. The food intake chart for the same person recorded that from lunch time on 25 July 2011 to lunch time 27 July 2011 they did not have any nutrition. Records stated that the person was asleep or drowsy. A fluid chart for another person also showed long durations where there was no record of fluid intake.

The trust is aware that further improvement is needed with food and fluid intake recording. In-house audits have been undertaken regarding the completion of food diaries and fluid intake charts. In April 2011 audits found that the completion rate was 51% for food diaries and 74% for fluid intake charts. In July 2011 these had improved to 85% and 90%.

An initiative the trust has taken to encourage oral fluid intake is to offer people bottled water rather than tap water to drink. Staff told us that people seemed to like the bottled water better. On both wards we saw that people had these water bottles beside them. Staff told us that they not been issued with any guidance on how this bottled water should be recorded on fluid intake records. We saw and were told different versions of how staff record fluids taken. This could lead to inaccurate amounts being recorded, which is important when people need their intake monitored closely due to for example, the risk of dehydration. Staff on EAU said that they would address this straight away.

We saw that extra snacks were offered to people on Newton 4 in between lunch and tea time. The ward co-coordinators asked people if they would like a drink and a snack. They offered a choice of cake or fruit or both. People really enjoyed the snack time. Additional snacks offered between meals are a positive initiative as this will help to maintain or increase the weight of those people who are at risk of malnutrition.

Meal and drink times observed on EAU were positive. We saw that people were sat upright so that they were able to eat. We heard staff giving people choices. Staff gave assistance to people to eat and drink where needed. Throughout the day we heard staff offering people drinks and giving people encouragement to drink.

On both wards we saw that the protected meal time policy was adhered to. During lunch time staff, for example, doctors and physiotherapists who were not needed, left the ward. Staff remaining on the ward dedicated this time to ensuring people had a meal and to give assistance to eat where it was needed. The wards were quiet and there were no unnecessary interruptions. This was an improvement on findings from our previous inspection.

Our judgement
Most people were happy with the standard of food and drink offered at Sandwell Hospital. Systems and processes have been implemented to improve the way in which staff assess and monitor people's nutritional risks or well being. However, more improvements are needed to make sure that those people at risk are fully supported by staff to eat and drink. Accurate food and fluid records should be maintained to demonstrate that people are taking adequate food and fluids and that staff are encouraging and enabling them to do so.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The trust has implemented systems and processes to improve the way in which people are cared for to promote dignity and improve outcomes for people. Many people told us that they were happy with the care that they receive and the staff on the wards. However, incidents are still occurring which do not give assurance that the care provided always promotes dignity, shows respect for people, or meets their needs.	
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: Most people were happy with the standard of food and drink offered at Sandwell Hospital. Systems and processes have been implemented to improve the way in which staff assess and monitor people's nutritional risks or well being. However, more improvements are needed to make sure that those people at risk are fully supported by staff to eat and drink. Accurate food and fluid records should be maintained to demonstrate that people are taking adequate food and fluids and that staff are encouraging and	

	enabling them to do so.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA

SWBTB (10/11) 223 (c)

Care Quality Commission

Dignity and nutrition
inspection programme

National overview

October 2011

Contents

Overview, by Dame Jo Williams

Dame Jo Williams

In December 2010, the Secretary of State for Health asked CQC to look at standards of dignity and nutrition in NHS hospitals. A series of highly concerning reports from bodies like the Patients Association and Age UK had drawn attention, yet again, to the poor care experienced by some older people in hospitals. The Parliamentary and Health Service Ombudsman's report in February 2011 added to the debate by highlighting shocking cases of poor care.

In response to the Secretary of State's request, CQC planned and delivered a series of 100 unannounced inspections of acute NHS hospitals in England between March and June 2011, looking at standards of dignity and nutrition on wards caring for elderly people. Each individual hospital report has already been published and this national report summarises what we found.

This was our first themed programme of inspections using our new 'outcome-based' model of regulation. This means we spent the majority of our time observing how care was delivered on wards, talking to patients and their families, and interviewing staff.

The programme was a genuinely collaborative effort, working with practising nurses and 'experts by experience' (people with direct experience of care services) in our inspection teams. An external advisory group offered us strong challenges throughout the process and helped make sure the inspection reports have had an impact. They added a lot to this piece of work and we have learned a great deal about how we can improve the way we regulate as a result of their input.

I was heartened by the amount of good and excellent care we saw. Many of the hospitals we visited showed a genuine commitment to delivering person-centred care, with registered nurses, doctors, other care professionals and heath care staff pulling together to treat the people they cared for with compassion and respect.

As Chair of CQC, I was pleased to see that three-quarters of trusts told us they had made changes to the way they looked at dignity and nutrition as a result of this inspection programme. An impressive 78% agreed our judgements were fair, despite many of the judgments being negative – and only six per cent disagreed.

There is, however, a great deal in the reports to give cause for alarm. Around half of the hospitals we visited gave our inspection teams cause for concern. Twenty hospitals were not delivering care that met the standards the law says people should expect.

This means that one in five of our inspections – and we looked at only two wards per hospital, on just one day of the year – picked up care that posed risks to people's health and wellbeing. Two hospitals (Sandwell General, and the Alexandra Hospital in Worcestershire) were offering care that put people at unacceptable risk of harm.

The 100 inspection reports and some of the analysis in this national summary cast light on the problems we found. I won't go into these in any detail – they have been well-rehearsed in the reports already published – but it strikes me that there are three key themes that underpin the poor care we saw.

In the first place, leaders in hospitals must create a culture in which good care can flourish. Boards of governors, chief executives, senior managers, health professionals and those who manage teams of nurses and healthcare assistants must create an environment in which care staff understand the importance of dignity and good nutrition, and are supported to deliver this.

All too often, we saw variation within hospitals – where one ward got it right, another in the same building was getting it badly wrong. We saw cases where there was clearly some fault in the hospital's culture that allowed unacceptable care to become the norm, where it should have been an exception. The responsibility for these failings lies with management and leadership.

In the second place, staff attitudes to people (and, by implication, the training and management that nurture these attitudes) are critical. Time and time again, we found cases where patients were treated by staff in a way that stripped them of their dignity and respect. People were spoken over, and not spoken to; people were left without call bells, ignored for hours on end, or not given assistance to do the basics of life – to eat, drink, or go to the toilet.

Those who are responsible for the training and development of staff, particularly in nursing, need to look long and hard at why 'care' often seems to be broken down into tasks to be completed – focusing on the unit of work, rather than the person who needs to be looked after. Task-focused care is not person-centred care. It is not good enough and it is not what people want and expect. Kindness and compassion costs nothing.

Responsibility for this task-based culture has to be shared among those who hold care to account, and we as the regulator have to make sure we don't encourage it. Holding doctors and nurses to account for every box they have or haven't checked sends the wrong message. Care professionals need to strike the right balance between keeping records that ensure people get the care they need in a safe way – how much they have eaten and had to drink, what medications they have taken and when – against a system that puts paperwork over people.

Thirdly, resources have a part to play. Many people told us about the wonderful nurses in their hospital, and then said how hard pressed they were to deliver care. Having plenty of staff does not guarantee good care (we saw unacceptable care on well-staffed wards, and excellent care on understaffed ones) but not having enough is a sure path to poor care. The best nurses and doctors can find

themselves delivering care that falls below essential standards because they are overstretched.

Staff must have the right support if they are to deliver truly compassionate care that is clinically effective. In the current economic climate this is easy to say and far harder to deliver, but as the regulator our role is to cast an independent eye over care and reflect on what we see. There are levels of under-resourcing that make poor care more likely, and those who run our hospitals must play their part in ensuring that budgets are used wisely to support front line care staff.

We entrust our loved ones to the care of the NHS – our parents, brothers and sisters, family members, and friends – and hope that they will be treated as we would treat them.

Many people benefit from truly wonderful care from nurses, doctors and other people in multidisciplinary teams who are a credit to the NHS.

Sadly, a significant number of people are nowhere near so fortunate. The findings of this report suggest that many hospitals are struggling or failing to meet the basic needs of older people.

With this in mind, it is concerning that many of these conclusions are not startling or new. We have had these debates before; there is no mystery around how best to care for older people, and no dearth of toolkits or action plans to help hospitals do what they should. Members of our advisory group for this project – the Royal College of Nursing, BAPEN, Kissing it Better and others – have excellent resources available. The question for leaders in the NHS and policy makers is why so many hospitals still fail to do it.

This report must result in action. CQC will play its part by holding hospitals to account for poor care when we find it. Our survey of trusts suggests many are already responding. Our inspection teams are actively following up where we had concerns to check whether planned improvements have been made. But the system as a whole – those who are responsible for making sure care meets essential standards, and those who commission that care – must respond if we are not to find ourselves here, yet again, a few years down the line.

Dame Jo Williams

Chair, Care Quality Commission

Summary

In December 2010, the Secretary of State for Health Andrew Lansley MP asked CQC to carry out an inspection programme to look at dignity and nutrition in NHS hospitals.

We carried out unannounced inspections at 100 NHS acute hospitals in England between March and June 2011, using teams made up of CQC inspectors, a practising and experienced nurse, and an 'expert by experience' – someone with experience of caring or receiving care, trained and supported by Age UK.

The programme was supported by an 'external advisory group' made up of organisations representing patients, care providers, professionals and campaign groups. Full details are in section five.

We chose the hospitals using our own risk data, information from members of the programme advisory group, and some hospitals named in the Parliamentary and Health Service Ombudsman's *'Care and compassion?'* report (February 2011), as well as several random selections.

We checked two 'outcomes' during each inspection: Outcome 1, which is 'respecting and involving people who use services,' and Outcome 5, 'meeting nutritional needs'. Appendix A has details of how we check standards and more information about these outcomes is available on our website: www.cqc.org.uk.

Of the 100 hospitals inspected, we found overall that:

- 45 hospitals met both standards (they were 'fully compliant').
- 35 met both standards but needed to improve in one or both (they were 'fully compliant, with improvements suggested').
- 20 hospitals did not meet one or both standards (they were 'non-compliant, with improvements required').

We had forecast that 10-20 % of hospitals could be non-compliant (20% were), and that a further 30-40% would show evidence of concerns (35% did), based on findings from our first set of inspections. Overall, 55% of hospitals were either non-compliant or gave cause for concern, against a forecast of 40-60%.

In some cases, we found that care was poor on one ward of a hospital, rather than across both of the wards we looked at. In those cases, our policy was to base our overall decision on the poorest performance found (taking into consideration the proportionality and reasonableness of the decision).

Outcome 1: Respecting and involving people who use services

Of the 100 checks we made against Outcome 1:

- 60 hospitals were fully compliant.
- 28 were compliant but needed to make improvements.
- 12 were not compliant and had to take action to become compliant.
- None were a cause of major concern.

Where we did find problems, key themes were that:

- Patients' privacy and dignity were not respected – for example curtains were not properly closed when personal care was given to people in bed.
- Call bells were put out of patients' reach, or they were not responded to in a reasonable time.
- Staff spoke to patients in a condescending or dismissive way.
- Both staff and patients told us that there were not always enough staff with the right training on duty to spend enough time giving care.

Outcome 5: Meeting nutritional needs

Of the 100 checks we made against Outcome 5:

- 51 hospitals were fully compliant.
- 32 were compliant but needed to make improvements.
- 15 were not compliant and had to take action to become compliant.
- Two were a cause of major concern and had to take urgent action.

Where we did find problems, key themes were that:

- Patients were not given the help they needed to eat, meaning they struggled to eat or were physically unable to eat meals.
- Patients were interrupted during meals and had to leave their food unfinished.
- The needs of patients were not always assessed properly, which meant they didn't always get the care they needed – for example, specialist diets.
- Records of food and drink were not kept accurately, so progress was not monitored.
- Many patients were not able to clean their hands before meals.

Publication and follow-up

We published our inspection reports on all 100 hospitals on our website, along with details of what action hospitals needed to take where they were either delivering poor care, or were at risk of delivering poor care if they did not make improvements.

It took just over six months from the Secretary of State's initial request to conclude the inspection programme. Follow-up actions are now in place and we have already carried out follow-up inspections at some hospitals.

Hospitals where we had major or moderate concerns

We assessed the following hospitals as a 'major' or 'moderate' concern. All other hospitals that we visited as part of the programme are included reporting Appendix B, along with details of which hospitals were not compliant with which outcomes.

Major concern

- Alexandra Hospital, Worcestershire Acute Hospitals NHS Trust
- Sandwell General Hospital, Sandwell and West Birmingham Hospitals NHS Trust

Moderate concern

- Barnsley Hospital, Barnsley Hospital NHS Foundation Trust
- Bedford Hospital, Bedford Hospital NHS Trust
- Colchester General Hospital, Colchester Hospital University NHS Foundation Trust
- Conquest Hospital, East Sussex Hospitals NHS Trust
- Darent Valley Hospital, Dartford and Gravesham NHS Trust
- Eastbourne General Hospital, East Sussex Hospitals NHS Trust
- Great Western Hospital, Great Western Hospitals NHS Foundation Trust
- Ipswich Hospital, Ipswich Hospital NHS Trust
- James Paget Hospital, James Paget University Hospitals NHS Foundation Trust
- John Radcliffe Hospital, Oxford Radcliffe Hospitals NHS Trust
- Norfolk and Norwich University Hospital, Norfolk and Norwich University Hospitals NHS Foundation Trust
- Ormskirk and District General Hospital, Southport and Ormskirk Hospital NHS Trust
- Royal Preston Hospital, Lancashire Teaching Hospitals NHS Foundation Trust
- Royal Free Hampstead Hospital, Royal Free Hampstead NHS Trust
- South Tyneside District Hospital, South Tyneside NHS Foundation Trust

- Stepping Hill Hospital, Stockport NHS Foundation Trust
- University Hospitals Bristol site, University Hospitals Bristol NHS Foundation Trust
- Whiston Hospital, St Helen's and Knowsley NHS Trust

How we carried out the inspections

A CQC inspector led each inspection, often assisted by a second CQC inspector. They were supported by a practising nurse and an Age UK 'expert by experience'. More than 100 CQC inspectors, 50 nurses and 40 experts by experience were trained and took part in the inspections.

In the inspections, we used observation tools, spent time on hospital wards (including observing a meal time) and talked to patients, relatives, carers and a variety of staff. We checked two 'outcomes' in each inspection (see appendix A for an explanation of outcome-based regulation).

We carried out each inspection on a single day (from Monday to Friday) and covered two wards where older people were cared for in each hospital. All inspections were unannounced. We typically arrived at a hospital at 9am and stayed until 4pm, making sure that we observed one meal – usually lunch time – in its entirety. This focus on lunchtime meant we were able to make better comparisons between hospitals.

During the inspections, our emphasis was on observing the quality of care given to older people. This included whether patients were helped to eat and drink if they needed it, and whether they were treated with respect.

We used existing CQC methods and systems as well as specially adapted interview and observation tools to gain a greater understanding of ward activities relating to the two outcomes.

We recorded our observations of the general environment and provision of care, including the process of giving meals to patients. We also checked patients' records to look at how or whether care planning took account of their wishes, preferences and choices, and how these were documented and monitored.

Our findings and key areas of concern

We identified several repeated areas of concern against Outcomes 1 and 5 in the hospitals where we saw non-compliance. In this section, we explain how common these problems were in relation to each outcome in turn, and gives some examples from our published reports. We also set out some basic analysis of what we saw, and highlight areas of consistent practice in those hospitals that did meet the essential standards of quality and safety. Reports for every hospital are available on our website: www.cqc.org.uk.

Appendix A explains in more detail what we mean when we talk about compliance and non-compliance, and minor, moderate and major concerns.

Outcome 1: Respecting and involving people who use services

Sixty hospitals were fully compliant with this standard. Another 28 were compliant but we issued them with 'improvement actions' to make sure they remained compliant. That left 12 hospitals that didn't meet the standard, all of which we identified as moderate concerns. None of the 100 hospitals was rated as a major concern under Outcome 1.

The key themes we saw in non-compliant hospitals were:

- Patients' privacy and dignity were not respected – for example curtains were not properly closed when personal care was given to people in bed.
- Call bells were put out of patients' reach, or they were not responded to in a reasonable time.
- Staff spoke to patients in a condescending or dismissive way.
- Both staff and patients told us that there were not always enough staff with the right training on duty to spend enough time giving care.

Findings by theme

Did staff behave in a way that respected patients' dignity?

Three-quarters of the 12 hospitals that were failing to meet CQC's standard had serious problems in this area in at least one of the wards visited.

> *"The patient constantly called out for help and rattled the bedrail as staff passed by… We noted that 25 minutes passed before this patient received attention. When we spoke with the patient we observed that their fingernails were ragged and dirty."*

> *"People were not taken to a toilet away from their bed space, commodes were used for much of the time and the process could be heard throughout*

the bed areas. Commodes were also taken to patients' bed space at meal times."

Were call bells within reach, audible and responded to properly?

Nine of the 12 hospitals had failings here in at least one of the wards inspected.

"On both wards visited we saw call bell devices left in their holders, on the floor, hanging off the bed, or generally not accessible to the person. One person told us that to attract a nurse's attention he hit his water jug on the bedside table or shouted."

Did patients have their privacy respected?

Seven of the 12 hospitals that failed to meet Outcome 1 had problems in this area in at least one ward.

"We saw a staff member taking a female patient to the toilet. The patient's clothing was above their knees and exposed their underwear. The staff member assisted them to the toilet in full view of other patients on the ward, only closing the door when they left the toilet room."

Were staff appropriately trained?

Half of the 12 hospitals were found to be failing in this outcome area (it was not assessed at one of the 12). Failings were found to be consistent throughout all wards visited at each hospital.

"None of the staff we spoke to were able to recall having specific training in how to ensure people's privacy and dignity was supported."

"Staff told us they had very little training on dysphasia, rehabilitation, privacy, dignity or dementia."

Were patients involved in decisions about their care, including being asked their views and preferences?

Five of the 12 hospitals had failings here, although there was variation within these five and only one hospital had consistent failings in all wards visited.

"One patient said she had received very little communication, whilst another said that the doctors tended to talk about you and not to you."

"We spoke to patients who knew that staff had some information about them, but who had not been involved in the planning of their care. People said that they had not been asked about religion or their needs or preferences. There was little evidence of patients having contributed to their records, for example, by having a care plan which included their views."

Were there enough staff on the ward?

We assessed this standard at half of the 12 trusts that fell below the bar, and of those we looked at five were failing in this area.

> *"When we spoke to one member of staff about how they managed to meet the needs of people on the ward, they said that they did not have enough time to care for patients. They said that when they are rushed they cannot always meet people's needs and some things have to be delayed as a result."*

> *"All the ward staff we spoke to on the stroke unit said they felt the unit was understaffed and the current levels were not appropriate to meet the needs of the patients."*

Comment and analysis on Outcome 1

Poor practice

For the three areas where we found the most common failings – dignity, use of call bells and privacy – there was a large degree of variation in practice.

In terms of dignity and privacy, not one of the hospitals found to be failing was failing consistently on both the wards we visited. In all cases where we did see failings, there were also instances of care being delivered that met the essential standards. For call bells, for example, four of the nine failing hospitals had consistent problems across both wards – but for the other five we saw significant variations in practice.

This suggests that hospitals that were failing to meet this standard had failed to set expectations across and within wards, or had failed to hold staff to account consistently for performance.

There were widespread inconsistencies in practice around call bells, with patients reporting a real variety in responses within wards and hospitals. This is a simple issue that matters a lot to patients, based on the comments and feedback we heard.

In addition to looking at non-compliance, we also identified common minor concerns in hospitals that were meeting the essential standards. These were cases where hospitals were delivering care that meets the standards the law says people should expect, but where our inspection teams saw some matters that were of concern.

Staffing levels were another concern mentioned in hospitals that were meeting this standard, but where we still recommended improvements. The key theme was around the lack of time staff had to spend with patients to attend to their individual care needs. Reference was often made to certain times of day or night when staffing was inadequate.

We had a small number of concerns about providing information to patients and their families. The most common comment was that people had received little or no information about what to expect from care delivered in the wards they were on.

Good practice

We saw common themes in terms of good practice in hospitals that were meeting CQC's standard for dignity (60 of the 100 hospitals met this standard).

We found a high degree of consistency in terms of staff behaving in a way that respected patients' dignity, with patients often describing staff as positive, sensitive and respectful.

Many examples of good practice around privacy were also cited (with reports of seeing good practice across both wards a recurring factor). The most common positive evidence included staff taking care to protect patients' privacy by closing curtains when care was being delivered, and using an appropriate speaking volume when discussing people's care.

Of the 60 hospitals that met Outcome 1, we found strong consistency in involving patients in decisions about their care (although we noted that full documentation of care plans was often lacking in places where the quality of care patients experienced was good). We saw a similar high level of good practice around explaining treatment options.

This suggests that staff (and management) in hospitals that met this standard understood the importance of privacy, and took the time to both involve patients in their care and explain what it meant for them.

Across all 100 hospitals, the availability of single sex facilities was consistently good, with single sex accommodation and facilities available in all 87 locations where we made a specific assessment of it. While overall wards were generally mixed, patients were usually accommodated in single sex bays or side rooms, with single sex bathroom facilities available.

A second area of widespread good practice was people feeling that their care needs were being met – we found only two of 90 locations failing here. This was based largely on patients' feedback, rather than detailed analysis of care plans and individual packages of care needs.

Outcome 5: Meeting nutritional needs

We found that 17 of the 100 hospitals were failing to deliver care that met this essential standard. Two of these were of major concern, with the other 15 subjects of moderate concern.

The key themes we saw in hospitals that did not meet the standard were:

- Patients were not given the help they needed to eat, meaning they struggled to eat or were physically unable to eat meals.
- Patients were interrupted during meals and had to leave their food unfinished.
- The needs of patients were not always assessed properly, which meant they didn't always get the care they needed – for example, specialist diets.
- Records of food and drink were not kept accurately, so progress was not monitored.
- Many patients were not able to clean their hands before meals.

Findings by theme

Were records of food and drink intake accurate?

We checked this at 13 of the 17 hospitals and found 12 of these had significant failings. The majority of cases had problems in both wards.

> *"We found staff recorded what had been offered to a person; not what they had actually eaten."*

Were patients offered the chance to clean their hands?

This was checked at 15 of this group of hospitals and 13 were found to have failings. Problems were across both wards in 10 of these cases.

> *"Nobody was routinely offered hand washing before or after their meals and hand gel was not within easy reach."*

Were procedures for identifying patients at risk followed and was appropriate action taken?

We checked this at 16 of the 17 hospitals that were failing to meet this outcome, and 13 were found to have problems. We found problems on both wards in five of these 13.

> *"When we asked about the red tray system there was a mixed response. Some senior nursing staff told us that the red tray system was in use but the junior nursing staff on the ward did not know what the red tray system was. They told us that they had never used it."*

Did staff have time to support patients?

This was checked at 15 of the 17 hospitals and 11 were found to have failings here. In six of these cases, the wards either appeared understaffed or staff told our inspectors that they were.

> *"Staff were trying to help patients sit up and serve lunch, whilst a medication round was being carried out at the same time."*

"On the second ward although we did observe staff supporting patients to eat and this was done in a caring way, there were not enough staff to support all the patients who needed assistance. Staff told us that this was not an unusual situation. One said: 'Sometimes I am the only staff member to feed on the ward. How can I feed all these people? Sometimes by the time I get to the last bay either the food is cold, or it has been taken away.'"

Were patients who needed support given it?

All 17 hospitals that were failing against this outcome were assessed against this area and 13 were found to have significant problems. In all but two cases, this was not consistent across both wards.

"One person's meal was delivered and a member of staff promptly helped them to eat it. However, another person in the same bay had their meal delivered at the same time. The person did not have any assistance and the food was left on their table for over half an hour before they were assisted to eat."

Was support provided adequately?

We checked this in 17 hospitals and found 12 to have significant failings. There was some overlap between this and the question above. In most cases, there were inconsistencies either within the same ward or between wards.

"Two members of staff who were assisting people with their meal at the time were having a conversation between themselves."

Comment and analysis on Outcome 5

Consistency and inconsistency across wards were a significant factor in this area.

Poor practice

In terms of offering people the chance to clean their hands, failings were usually seen across both wards. But in almost every other area we looked at, problems were not present across both wards, or even varied widely within wards. This suggests that there was a widespread lack of consistent practice around this outcome area in hospitals that were failing to meet CQC's standard.

Key factors that we saw included people not being given the support they needed to eat or being interrupted during meals. We also saw that people's needs were not always assessed properly and that records were not accurately kept. In some cases, staff talked across patients rather than to them.

Several factors may have contributed to what we saw, both in terms of resources and organisational culture.

A lack of time to deliver care (due to short staffing, persistent high demand or excessive bureaucracy) can prevent staff from making sure that people's needs are assessed and they are given the right support to eat.

Poor practice may also result if there is a culture in a hospital that does not place an emphasis on treating people with dignity and respect. This might explain why needs assessments do not seem to be a priority in some hospitals, and the habit of talking across (rather than to) patients by staff.

Good practice

In those hospitals that we judged were meeting the standard, we saw common good practice with making sure appropriate support was provided to patients. In those cases, patients were helped to sit comfortably to eat their meal, staff cut up food where necessary and sat with patients while they ate, and mealtimes were unrushed with staff reassuring and encouraging people.

The availability of meals for people who had missed set mealtimes was consistently strong in hospitals that met Outcome 5, and snacks and drinks were available outside of mealtimes.

In those hospitals that met this standard, we saw good practice around identifying patients at risk, with a significant number using coloured (usually red) trays or jugs to identify people at risk.

The highest level of compliance we saw across all hospitals was in terms of food quality. We checked this at 77 hospitals of the 100, and 73 were found to be meeting this standard. In 66 cases, food was reported to be good across the board, with seven cases where opinion was mixed but acceptable.

The choice of food was also widely reported to be good, with two-thirds of all hospitals offering a choice of food as standard practice. In places where this was not so good, common themes included people not always getting the meal they had chosen if they were the last to be served, people not being able to change their mind, and a lack of pureed or alternative types of food being available.

It should be noted that this assessment of food quality is based on patient feedback – not on any detailed assessment of how appropriate it was for the person given their care needs.

We also saw good availability of dietitians and other specialists across most sites (either on-site, or off-site but accessible), with only a handful of cases where patients did not have timely access to specialists.

CQC follow up actions so far

We published inspection reports on each of the 100 hospital inspections between May and July. We shared these reports with the hospitals in advance of publication, and each inspector gave immediate feedback to the hospital on the day of its inspection.

There were 56 hospitals where improvement or compliance actions were included in the CQC inspection report.

We dealt with each case in the context of the hospital, so there were no standard actions put in place. Details of the actions that individual hospitals had to take are set out in the reports published on our website. We will update these actions regularly as and when we carry out follow-up inspections, so they are not recorded here.

We contacted strategic health authorities, primary care trusts, local media and MPs about every case where we saw non-compliance.

We have so far carried out targeted follow-up visits to eight of 12 trusts that had compliance actions on Outcome 1 (respecting and involving people). In addition we visited two locations in one trust where follow-up was needed as part of a separate review, and this included Outcome 1. We have followed up with six of 17 trusts that had compliance actions on Outcome 5 (nutrition).

In September 2011, we served a warning notice on James Paget University Hospitals NHS Foundation Trust as a result of its failure to protect patients from the risks of inadequate nutrition and hydration. This was a follow-up to our April dignity and nutrition inspection, and the first warning notice to result from the programme.

Following the April inspection, the trust had provided an action plan outlining what improvements it would make. However, when our inspectors returned to the trust on 1 September to carry out a second unannounced inspection, they saw incidences of patients not being given appropriate support to eat and drink, and that people in need of intravenous fluids did not have infusions. The trust could face prosecution or suspension of services for failure to become compliant.

Decisions on when and how to follow up on improvement and compliance actions is based on the levels of risk (in terms of potential impacts on patients) associated with our judgments. Further follow-up action is planned at every hospital where improvement or compliance actions were put in place.

Feedback on our inspection methods and joint working

A CQC inspector led each inspection, often assisted by a second CQC inspector. They were supported by a practising nurse and an Age UK 'expert by experience'. More than 100 CQC inspectors, 50 nurses and 40 experts by experience were trained and took part in the inspections.

In this section, we look at the feedback we had from hospitals during the programme and at the way we worked with experts by experience, practising nurses and our external advisory group.

How hospitals responded to our inspections

We sent out a short survey to the 96 trusts (four trusts had inspections at two hospitals) that were inspected as part of this programme. Of these, 74 responded.

The results from those who replied were positive:

- Nine out of 10 agreed that the process was clearly explained and questions were dealt with effectively during the visit.
- More than 70% agreed or strongly agreed that feedback on the day was helpful, and that the mixed team (CQC inspector, nurse and expert by experience) improved the quality of the inspection.
- In terms of our judgments, 78% agreed or strongly agreed that our decisions were a fair reflection of performance, with only 6% of those who responded disagreeing.
- Three-quarters of trusts agreed they had made changes to the way they approach dignity and nutrition as a result of the inspection programme. Six per cent disagreed.

1. The inspector clearly explained the process when they arrived and was able to answer your questions about the visit

88% agreed, 2% disagreed

	Number	%
Strongly agree	**34**	**46**
Agree	31	42
Neither agree nor disagree	7	9
Disagree	1	1
Strongly disagree	1	1

2. The feedback given on the day of the inspection was helpful

73% agreed, 15% disagreed

	Number	%
Strongly agree	19	26
Agree	**35**	**47**
Neither agree nor disagree	9	12
Disagree	9	12
Strongly disagree	2	3

3. The skill mix of the inspection team (CQC inspector, practising nurse, expert by experience) improved the quality of the inspection team in terms of the scrutiny of care

71% agreed, 8% disagreed

	Number	%
Strongly agree	12	16
Agree	**41**	**55**
Neither agree nor disagree	15	20
Disagree	6	8
Strongly disagree	0	0

4. Overall, the inspection outcomes were a fair judgement of the trust's performance in relation to Outcome 1 and Outcome 5

78% agreed, 6% disagreed

	Number	%
Strongly agree	23	31
Agree	**35**	**47**
Neither agree nor disagree	11	15
Disagree	4	5
Strongly disagree	1	1

5. Our trust made changes to the way it approached dignity and nutrition as a result of the inspection programme

74% agreed, 6% disagreed

	Number	%
Strongly agree	17	23
Agree	**38**	**51**
Neither agree nor disagree	14	19
Disagree	4	5
Strongly disagree	1	1

Using nurses on our inspection teams – what we learned

Our inspectors said that the majority of nurses had an excellent or good impact on the inspection process. Nurses themselves gave us positive feedback from taking part and some remarked that it 'demystified' the CQC inspection process. Others said they incorporated learning from our programme into their everyday practice reviews in their own hospitals.

We faced several challenges in setting up nurse participation. We had initially thought we could use recently retired nurses or those on career breaks – but we needed to ensure that every one who took part had had up-to-date appraisals, CRB checks and current inclusion on the Nursing and Midwifery Council's register. This limited us to those nurses in current practice.

We had to manage conflicts of interest. It was essential that nurses were not asked to report on their own trusts, which meant we needed to plan carefully to make sure there was no suggestion that the nurses' independence was compromised. The tight timescales for the programme, and the need to be reasonable in terms of the distances people travelled, made this a challenge.

Another challenge – and rather a welcome one, in some respects – was demand, which in some areas meant we had 10 times more applicants than we required.

Finally, we had to manage cost. Recruiting, training and deploying the nurses (and experts by experience, see below) was a resource-intensive process. While we appreciated that carrying out inspections at evenings or on weekends might have given us different data, we had to bear in mind the overall cost of the programme and this was a factor in our decisions.

Using 'experts by experience' on our inspection teams – what we learned

CQC works with 'experts by experience'– people of all ages, with experience of giving or receiving care, and from diverse cultural backgrounds – to improve the way it regulates.
Experts by experience take part in an inspection and talk to the people who use the care service. Sometimes they hold telephone interviews for people who use home care agencies, one-to-one meetings with people in supported living and groups sessions over lunch for people in care homes. If they are visiting a service, they will also look at the environment; see how everyone gets on together and what the atmosphere feels like.
For this inspection programme, we engaged experts from the existing contractual arrangements we had with Age UK. Few had experience of hospital visits, having predominantly visited care homes. Several experts took part in more than one inspection.

Age UK's programme manager played a valuable role, coordinating briefing sessions, helping with the inspection programme and updating experts on progress.

Age UK carried out an evaluation of their contribution. Some highlights are:

- Age UK's experts by experience have been positive about the approach taken by CQC in conducting the dignity and nutrition inspections. They all appreciate that CQC has actively involved people that use services in this important inspection programme.
- Experts have fed back overwhelmingly that patients were happy to talk to them and many were very keen to tell their stories. A number mentioned how professional they felt their teams were and that they were impressed by their inspector's knowledge and skills.
- Experts recommend doing further work that takes into account the needs of people with dementia.
- It would help to involve a small group of experts in the development of the tools earlier in the process for future inspections.

Anecdotally, we were told that the mixed teams were a real benefit to CQC because of the range of perspectives that they brought to the inspection process and because they could engage with patients and staff in a different way. A nurse and expert by experience attended a meeting of our advisory group and we heard that staff in hospitals tended to be more open about the challenges they faced with 'fellow nurses'; likewise, patients were more open with 'experts by experience' because they could empathise with them and were not seen as 'part of the establishment'. The CQC inspector brought a welcome independent balance to the team, and was able to speak to both patients and staff to help triangulate feedback.

We are developing this approach further through a range of initiatives to make more use of specialist expertise and to work more closely with people who use services in our inspections.

Working with our external advisory group

The dignity and nutrition inspection programme was CQC's first project to use a new approach to working with stakeholders, by setting up a 'task and finish' advisory group to help us improve the way we delivered the work. The group met six times during the duration of the programme and met for the last time in September to comment on the draft of this report.

Due to the expectation that CQC would deliver this programme in a short space of time, the group had limited influence over the original design of the programme and inspections. They were, however, able to help shape its progress. Other current advisory groups have been set up at an earlier stage to make sure that stakeholders are able to have more influence over overall shape and methodology.

The following organisations were part of CQC's external advisory group for the programme. This summary report should not be taken as a representation of their views, although they all played a vital part in shaping it.

- Age UK
- Action on Elder Abuse
- BAPEN (British Association for Parenteral and Enteral Nutrition)
- Dignity in Care Network, supported by the Department of Health
- Equality and Human Rights Commission
- Kissing it Better
- LINks representatives – Anita Higham (Oxfordshire) and Ivy Elsey (East Sussex)
- National Patient Safety Agency
- Nursing and Midwifery Council
- NHS Confederation
- Patients Association
- Royal College of Nursing
- Royal College of Physicians
- Social Care Institute for Excellence

The group was chaired by CQC. The approach throughout was for CQC to be as transparent as possible with group members – for example, early results of all inspections were shared with the group in confidence to allow them to prepare a response. Every group member respected this arrangement throughout.

The group's views on how CQC carried out the programme were extremely valuable. We made changes to the way we targeted hospital sites and wards, approached the inspections, wrote our compliance reports and gave feedback as a result of their input.

Several of their suggestions about our core model feature in a consultation (launched in September 2011) to make improvements to the way we regulate.

Appendix A: How CQC checks if care is safe

Hospitals must meet 'essential standards of quality and safety'

CQC's role is to check whether care meets standards that the government says people should expect. These standards are based on the Health and Social Care Act 2008 and secondary legislation.

We do this by registering 'care providers' (hospitals, care homes, dentists, and so on), which allows them to provide certain types of care in accordance with the law. The provider (a hospital, for the purposes of this report) accepts responsibility for making sure that the care they deliver meets the 'essential standards of quality and safety' that the law says people should expect.

We then check whether these standards are being met, usually through unannounced inspections. We do this by listening to what people say about care and looking at what data tells us to identify possible risks. If we see signs of risk, we check to see what lies behind them. We make most of these checks through unannounced inspections. Many of our inspections happen as a result of information we receive from members of the public, or care staff.

If we find that a hospital is not meeting the standards we expect, we take action to make them put it right. We seek improvements against clear timescales or take enforcement action. If the care provider does not do what we ask and we believe people are at unacceptable risk of poor care, there are a range of actions we can take, including cancelling their registration as a last resort. This means they are no longer allowed to offer care.

The law does not require CQC to make judgements about whether care is good, bad or excellent. We look to see whether care meets the standards the law says it must (care is 'compliant' with standards) or not (care is 'non-compliant' and therefore breaking the law).

CQC does not make recommendations about improvements, or offer a commentary on the causes of poor care beyond stating what our inspectors have seen and found. When we find non-compliant care, a hospital has to take steps to make sure they become compliant. But we do not tell them how to do this, and do not make suggestions about how hospitals can deliver care that is better than compliant.

It is not CQC's job to guarantee that hospitals are providing safe care. It is the responsibility of the hospital and the people who work there to make sure they are not breaking the law.

Are hospitals meeting the standards people should expect?

When a hospital meets the standards the law says people should expect, we say the hospital is 'compliant'. When a hospital is failing to meet those standards, it is 'not compliant'. There are a number of decisions we can make as a result of our inspections and in this review we used four:

Compliant – this means the hospital is meeting the standards and no action is needed to improve.

Compliant, minor concern – this means the hospital is meeting the standards we expect but needs to take action to make sure they keep meeting the standard. In this case, we set the hospital an 'improvement action' to try to prevent them falling below the bar. We will check later to see if they have done this.

Non-compliant, moderate concern – this means the hospital is not meeting the standards we expect and although people are generally safe there some are unacceptable risks to their health and wellbeing. In this case, CQC puts a 'compliance action' in place for the hospital. They must carry out the action we tell them by a set date or face further action.

Non-compliant, major concern – this means the hospital is not meeting the standards we expect, and people are not protected from unsafe or inappropriate care. In this case, we also use a 'compliance action' but may use one of our most serious powers – which can include suspending or even closing services – to protect people from harm.

When a hospital is non-compliant, it does not mean everyone who uses that hospital will experience poor care. It means there is an increased risk of people receiving poor care. Given the size and complex nature of the care delivered in hospitals, you will always find examples of good care in non-compliant hospitals, and occasional poor care in compliant hospitals. CQC's judgements try to capture the overall quality of care at hospital-wide level. We try to tackle problems that make the risk of poor care in any given case more likely.

Appendix B: Hospitals inspected in this programme

Numbers 1 and 5 in brackets refer to the outcomes where hospitals were not compliant (1 is 'respecting and involving people who use services', and 5 is 'meeting nutritional needs').

Hospitals where we had a major concern

- Alexandra Hospital, Worcestershire Acute Hospitals NHS Trust (major concern 5, moderate 1)
- Sandwell General Hospital, Sandwell and West Birmingham Hospitals NHS Trust (major concern 5, moderate 1)

Hospitals where we had a moderate concern

- Barnsley Hospital, Barnsley Hospital NHS Foundation Trust (5)
- Bedford Hospital, Bedford Hospital NHS Trust (5)
- Colchester General Hospital, Colchester Hospital University NHS Foundation Trust (1 and 5)
- Conquest Hospital, East Sussex Hospitals NHS Trust (1 and 5)
- Darent Valley Hospital, Dartford and Gravesham NHS Trust (1 and 5)
- Eastbourne General Hospital, East Sussex Hospitals NHS Trust (1 and 5)
- Great Western Hospital, Great Western Hospitals NHS Foundation Trust (1)
- Ipswich Hospital, Ipswich Hospital NHS Trust (1 and 5)
- James Paget Hospital, James Paget University Hospitals NHS Foundation Trust (1 and 5)
- John Radcliffe Hospital, Oxford Radcliffe Hospitals NHS Trust (5)
- Norfolk and Norwich University Hospital, Norfolk and Norwich University Hospitals NHS Foundation Trust (5)
- Ormskirk and District General Hospital, Southport and Ormskirk Hospital NHS Trust (1)
- Royal Preston Hospital, Lancashire Teaching Hospitals NHS Foundation Trust (5)
- Royal Free Hampstead Hospital, Royal Free Hampstead NHS Trust (1 and 5)
- South Tyneside District Hospital, South Tyneside NHS Foundation Trust (1)
- Stepping Hill Hospital, Stockport NHS Foundation Trust (5)
- University Hospitals Bristol site, University Hospitals Bristol NHS Foundation Trust (5)
- Whiston Hospital, St Helen's and Knowsley NHS Trust (5)

Hospitals where we had minor or no concerns

- Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust

- Aintree Hospital, Aintree University Hospitals NHS Foundation Trust
- Airedale General Hospital, Airedale NHS Foundation Trust
- Bradford Royal Infirmary, Bradford Teaching Hospitals NHS Foundation Trust
- Cannock Hospital, Mid Staffordshire NHS Foundation Trust
- Chapel Allerton Hospital, Leeds Teaching Hospitals NHS Trust
- Clatterbridge Centre for Oncology, Clatterbridge Centre for Oncology NHS Foundation Trust
- Clatterbridge Hospital, Wirral University Teaching Hospital NHS Foundation Trust
- Countess of Chester Hospital, Countess of Chester Hospital NHS Foundation Trust
- Croydon University Hospital, Croydon University Hospitals NHS Trust
- Cumberland Infirmary, North Cumbria University Hospitals NHS Trust
- Derriford Hospital, Plymouth Hospitals NHS Trust
- Doncaster Hospital, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Dorset County Hospital, Dorset County Hospital NHS Foundation Trust
- Ealing Hospital, Ealing Hospital NHS Trust
- East Surrey Hospital, Surrey and Sussex Healthcare NHS Trust
- George Eliot Hospital, George Eliot Hospital NHS Trust
- Good Hope Hospital, Heart Of England Foundation Trust
- Grantham and District Hospital, United Lincolnshire Hospitals NHS Trust
- Halton Hospital, Warrington And Halton NHS Trust
- Hereford County Hospital, Hereford Hospitals NHS Trust
- Homerton University Hospital, Homerton University Hospital NHS Foundation Trust
- Huddersfield Royal Infirmary, Calderdale and Huddersfield NHS Foundation Trust
- Kettering General Hospital, Kettering General Hospital NHS Foundation Trust
- King George Hospital, Barking, Havering and Redbridge University Hospitals NHS Trust
- Kingston Hospital, Kingston Hospital NHS Trust
- Leighton Hospital, Mid Cheshire Hospitals NHS Foundation Trust
- London Road Community Hospital, Derby Hospitals NHS Foundation Trust
- Manor Hospital, Walsall Hospitals NHS Trust
- Musgrove Park Hospital, Taunton and Somerset NHS Foundation Trust
- Newark Hospital, Sherwood Forest Hospitals NHS Foundation Trust
- New Cross Hospital, Royal Wolverhampton Hospitals NHS Trust
- Northern General Hospital, Sheffield Teaching Hospitals NHS Foundation Trust
- North Hampshire NHS Trust Treatment Centre, Basingstoke and North Hampshire NHS Foundation Trust
- North Manchester General Hospital, Pennine Acute Hospitals NHS Trust
- North Middlesex Hospital, North Middlesex University Hospital NHS Trust
- Northwick Park Hospital, North West London Hospitals NHS Trust
- Nuffield Orthopaedic Centre, Nuffield Orthopaedic Centre NHS Trust

- Ormskirk and District General Hospital, Southport and Ormskirk Hospital NHS Trust
- Peterborough City Hospital, Peterborough and Stamford Hospitals NHS Foundation Trust
- Princess Alexandra Hospital, Princess Alexandra NHS Trust
- Princess Royal University Hospital, South London Healthcare NHS Trust
- Queen Alexandra Hospital, Portsmouth Hospitals NHS Trust
- Queen Elizabeth the Queen Mother Hospital, Margate, East Kent Hospitals University NHS Foundation Trust
- Queen Elizabeth II Hospital, East and North Hertfordshire NHS Trust
- Queen's Hospital, Burton Hospitals NHS Foundation Trust
- Queen Victoria Hospital, Queen Victoria Hospital NHS Foundation Trust
- Royal Blackburn Hospital, East Lancashire Hospital NHS Trust
- Royal Bolton Hospital, Royal Bolton Hospitals NHS Trust
- Royal Bournemouth General Hospital, Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Royal Devon and Exeter Hospital, Royal Devon and Exeter NHS Foundation Trust
- Royal Liverpool University Hospital, Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Royal Orthopaedic Hospital, Royal Orthopaedic Hospital NHS Foundation Trust
- Royal Shrewsbury Hospital, Shrewsbury and Telford Hospital NHS Trust
- Royal Surrey County Hospital, Royal Surrey County NHS Foundation Trust
- Salford Hospital, Salford Royal NHS Foundation Trust
- Scunthorpe General Hospital, North Lincolnshire and Goole NHS Foundation Trust
- Southlands Hospital, Western Sussex Hospitals NHS Trust
- Southmead Hospital, North Bristol NHS Trust
- St George's Hospital, St George's Healthcare NHS Trust
- St Mary's Hospital, Imperial College Healthcare NHS Trust
- Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust
- St Thomas' Hospital, Guy's and St Thomas' NHS Foundation Trust
- Torbay Hospital, South Devon NHS Trust
- Trafford General Hospital, Trafford Healthcare NHS Trust
- University College Hospital and Elizabeth Garrett Anderson Wing, University College London Hospitals NHS Foundation Trust
- University Hospital Coventry and Warwickshire, University Hospital Coventry and Warwickshire NHS Trust
- University Hospital Lewisham, Lewisham Healthcare NHS Trust
- University Hospital of Liverpool, North Tees and Hartlepool NHS Foundation Trust
- University Hospitals Bristol main site, University Hospitals Birmingham Foundation Trust
- Warwick Hospital, South Warwickshire NHS Foundation Trust
- West Cumberland Hospital, North Cumbria University Hospitals NHS Trust
- Wexham Park Hospital, Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- Walkergate Hospital, Newcastle Upon Tyne Hospitals NHS Foundation Trust

- West Middlesex University Hospital, West Middlesex University Hospital NHS Trust
- Whipps Cross University Hospital, Whipps Cross University Hospital NHS Trust
- The Whittington Hospital, Whittington Hospital NHS Trust
- Wythenshawe Hospital, University Hospital of South Manchester NHS Foundation Trust
- York Hospitals NHS Trust HQ, York Hospitals NHS Foundation Trust

How to contact us

Phone us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at:
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Please contact us if you would like a summary of this document in another language or format.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Safeguarding Update
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

The Trust Board is asked to note the content of this report and progress against plans.

Safeguarding training is on track for 3 year compliance.

The Trust needs to decide on the scope and frequency of CRB checks.

The Dementia Action Plan is progressing well in most areas.

Safeguarding Children plans are largely on target although changes in local authority and GP Commissioner arrangements may effect our services.

Requirements under the Mental Health Act have now been resolved via partner organisations.

We have commenced work on a Carers Strategy.

Peer reviews and formal assessments are prevalent in the area of vulnerability and safeguarding and we expect this to continue.

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 contents of the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	1.2 Continue to improve patient experience.
Annual priorities	1.2 Continue to improve patient experience.
NHS LA standards	
CQC Essential Standards Quality and Safety	Regulation 9, Outcome 4 – Care and welfare of people who use services. Regulation 10, Outcome 16 – Assessing and monitoring the quality of service provision. Regulation 17, Outcome 1 – Respecting and involving people who use services.
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:

Biyearly update to the Trust Board.

Report Title	*Safeguarding Update*
Meeting	*Trust Board*
Author	*Rachel Overfield, Chief Nurse*
Date	*27th October 2011*

Introduction

The Trust Board will be aware that both adult and child safeguarding is overseen by a Trust Safeguarding Committee chaired by the Chief Nurse. Action plans and monitoring mechanisms exist for:

- Safeguarding Children
- Serious Case Reviews (Children)
- Ofsted evaluations (Children)
- Mental Health/Capacity/Deprivation of Liberty (DoL)
- Dementia
- Adult Safeguarding
- Carers

These action plans are supported by relevant policies and/or guidelines which are informed by national policy, legal requirements and the various safeguarding boards of the local authorities.

The Trust Safeguarding Committee receives reports against the above plans and directs/requests further action as appropriate.

The following report picks out key progress and any specific points to highlight to the Trust Board.

Safeguarding Training

The Trust is required to deliver adult and child safeguarding training at Level 1 for all staff; Level 2 for staff who have regular contact with patients or families and Level 3 to staff who need to make referral decisions about vulnerable/neglected individuals. Details of who the various levels apply to is included in the Trust's Mandatory Training Matrix.

YTD the Trust is fully compliant with Level 1 training and is on trajectory for achieving the 3 year plan for Level 2 and 3. The Trust Board should be aware that because of the 3 year trajectory, not all staff have received the required level of training. Training has been targeted in such a way however, to ensure sufficient coverage of informed staff across the Trust pending full compliance.

Training is also now available for:

- Domestic Abuse
- Dementia

Both of which are over-subscribed and need to be increased. The safeguarding teams are working on ways of achieving this with colleagues from RAID and other MH colleagues.

CRB Checks

The Trust is compliant with its requirements for CRB checks. However, staff employed prior to mandatory checking, who have not subsequently changed post, will not have had a CRB whilst in the Trust's employment.

Whilst this is not technically unlawful it is a situation that the Trust should resolve. The proposed Vetting and Barring Scheme would have addressed this issue but as this is now 'postponed' the Trust will need to reconsider it's position.

This is especially timely given that the transferred Community staff have operated within a policy of 3 yearly re-checks.

Of the 5595 staff holding regulated positions within the Trust 37% have had a CRB within the last 3 years and a further 26% have had a CRB check whilst in our employment. 36% have not had a CRB check.

There is a significant cost attached to resolving this and then further costs involved in maintaining up to date checks, especially when these are not mandated.

A case is currently being written for SIRG and Executive Team discussion.

Safeguarding Children

The action plan is progressing well. Key issues include:

- Difficulty attracting applicants for Health Visitor Liasion role within our EDs.
- Completing some key policies for sign off. These are now all on track after some considerable delays.
- Ongoing issues in the Black Country of sufficient medical staff to support investigations into alleged abuse. Requires regional solutions but there has been very little progress. Currently cover is always provided but largely based on good will.
- Integration of community and acute teams, standardisation of policies, training and plans.

Serious Case Reviews (Children)

We are currently in the process of understanding what outstanding actions there are for Community services from previous case reviews to incorporate into our action plans.

There is an outstanding action for Childrens services within the acute part of the Trust that has arisen from 2 separate cases.

- The ability of the Community Children's team to share records with other members of the MD team.
    - Requires an electronic solution that makes records available to GPs, social services, acute and community teams. Unlikely to resolve in the short term but various options are being explored.

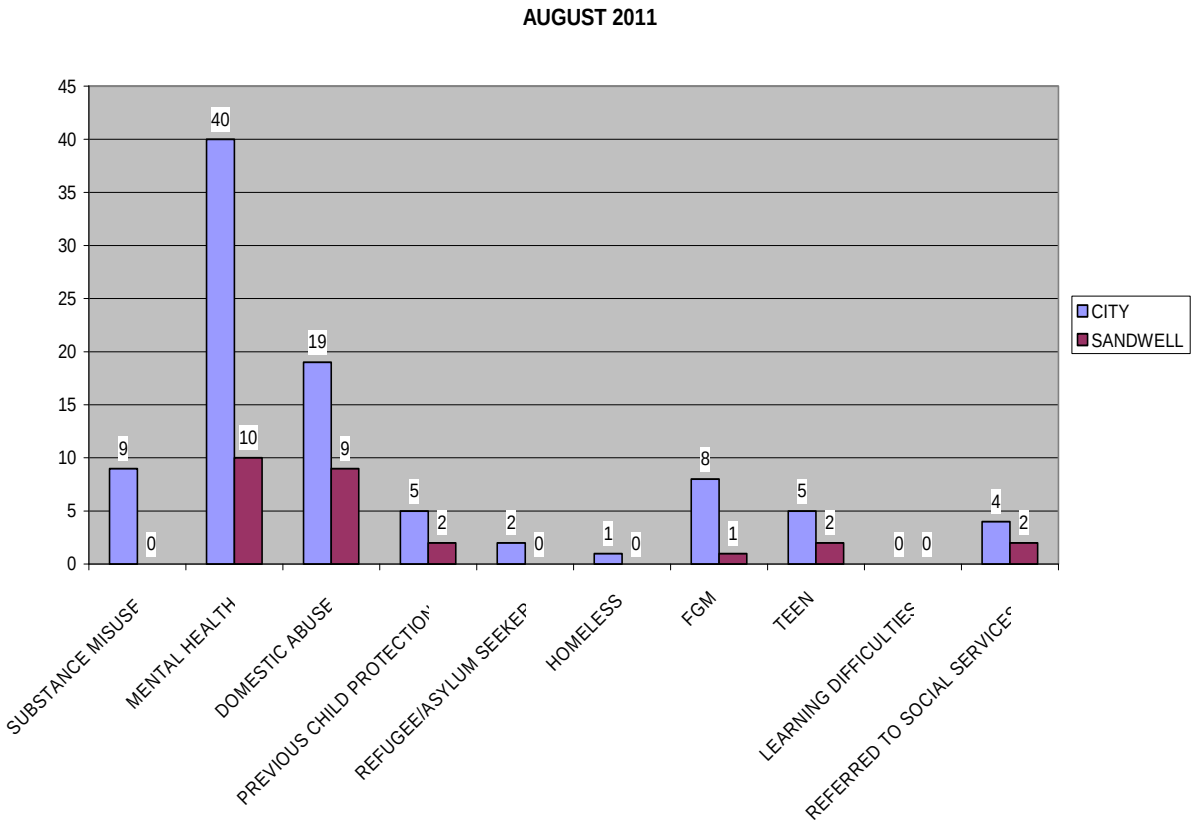
There are two outstanding actions for maternity services:

- Audit of GP bookings and referral trends
- Improving handover between midwives and health visitors

Cause for concern cases

These are maternity cases identified as being at a high risk of potential safeguarding/ child/adult protection issues. As a Trust we see a high number of these cases within the population we serve. Table 1 gives data for August to give the Trust Board some insight into the high numbers of vulnerable mothers we serve.

Table 1



Issues from Children's Safeguarding Boards (Health related)

Both Sandwell and Birmingham Boards have been undertaking significant reviews of their effectiveness following adverse Ofsted ratings. Both have new Chairs and have reviewed their membership and delivery plans. As far as health is concerned the key issues are:

- Impact of changes in social services/local authorities
  - Increased assessments falling to health and potential for delays in referrals being actioned.
- Impact of changes in police safeguarding teams
- Delivery of Ofsted/CQC action plans across changing health systems, ie ensuring plans do not get 'lost' within changes.
- Ensuring GP commissioning units/teams maintain responsibility for safeguarding issues within primary care.
- Issue of Health Visitor numbers given primary role within safeguarding for vulnerable families.

Adult Safeguarding

Staffing issues raised within the last update have now been resolved, ie learning disability and mental health liaison posts Sandwell appointed and in post. Having said this there remain inequities of service between the two hospital sites due to different funding commitments from the PCT/MH Trusts.

The Sandwell Community Adult Safeguarding Nurse has joined the existing Trust team ensuring that we now have a robust team to manage this ever increasing agenda.

Activity for the safeguarding team continues to increase as awareness amongst Trust staff grows (Table 2 and 3).

Table 2 – *Acute Referrals*

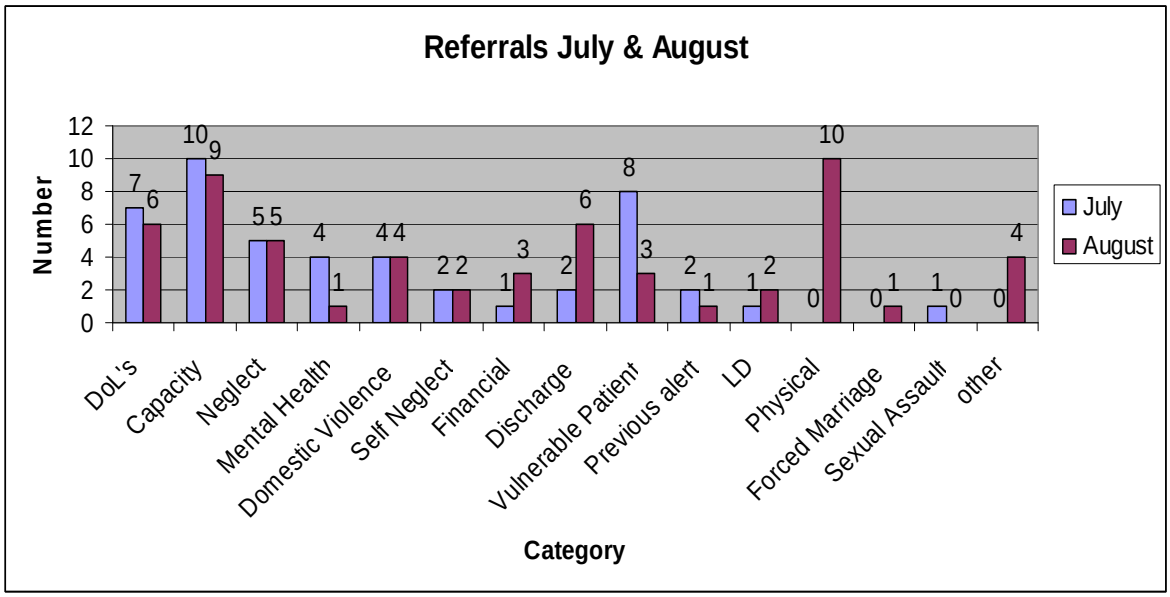
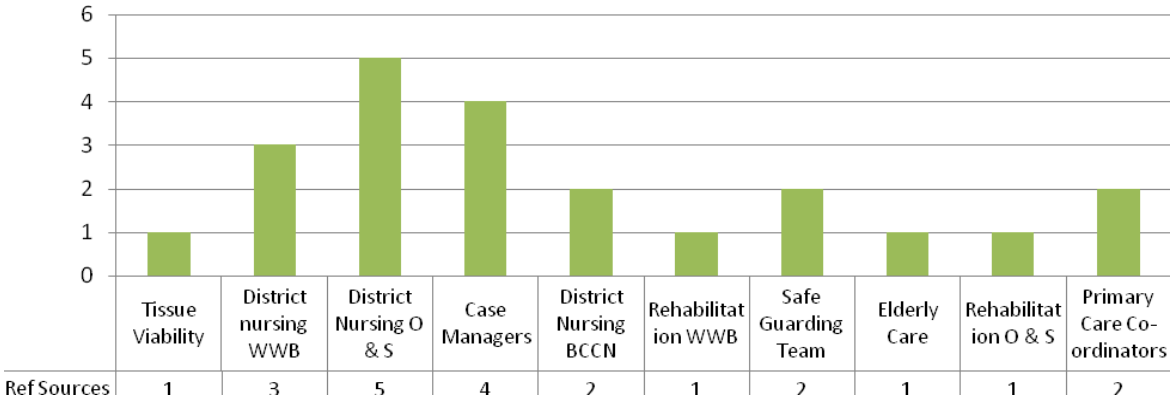


Table 3 - *Community Staff Referrals*
Referral trends (VAPs submitted) July-September 2011:



Administration of the Mental Health Act

There is now a requirement for the Mental Health Act to be administered by organisations registered with the CQC as a provider of mental health services. This means that an acute Trust either has to register to provide mental health services or establish formal agreements with partner mental health organisations to administrate on their behalf. This is especially relevant when delivering acute care to patients retained under the mental health act.

After significant discussion formal agreements have now been signed with the Black Country Partnership NHS FT and Birmingham and Solihull Mental Health FT.

National Dementia Standards

We are progressing well with this action plan especially around:

- Training Plans
- Access to dementia services and information
- Ward based information packs

- Memory clinic services and specialist assessment

We are on track to deliver actions around:

- Web page development
- Signposting to community based services
- Access to dementia advisor
- End of life care – dementia specific

We are behind target dates around:

- Specific discharge planning for this patient group
- Development of a dementia pathway between acute and community care
- Development of clinical protocols for challenging behaviours
- Screening for confusion on admission

(full action plan available if TB wish to see)

Carers Plan

The Trust is obliged to consider the needs of carers who are either admitted as patients or who care for patients admitted as part of the Equality Act, National Carer Strategy and Young Carer Strategy. We have developed an action plan which was approved by the Safeguarding Committee in September. Progress will be reported in future reports.

Suicide/Self Harm

Following 2 on-site self harm incidents a plan to mitigate potential risk of further incidents has been developed and is currently progressing. This includes:

- Reducing environmental risks, eg ligature points, in high risk areas
- Developing and implementing policies/guidelines for reducing risk
- Training of staff
- Developing a 'specialling/Nursing observation' Policy
- Monitoring activity re 'at risk' patients

Peer Review

West Midlands Quality Review Service have undertaken a review of vulnerable adult services across the region. This is available in draft and the Trust has been reported very positively following visits to 7 wards (including N4). The final report will be reported in due course.

A peer review of children's safeguarding and 'looked after children' is planned for Sandwell in November.

CQC DANi reviews targeted care associated with privacy, dignity and nutrition around vulnerable adults. This has been reported to the Trust Board separately.

Patient/Carer Views

The in-patient survey captures the views of patients with learning disability and mental health needs. This data will be reported to the next Safeguarding Steering Group to establish if patients in these groups are identifying any specific issues that we need to act on.

Community groups, eg Alzheimers Association have been included in our Community Roadshows where we are trying to establish what a good experience of health means to users of our services from these groups. The conclusions of these visits will be reported to the next Safeguarding Committee.

Conclusion

The Safeguarding agenda continues to be complex and challenging but plans exist and are progressing to develop services and staff capability to care appropriately for our most vulnerable patients.

The Trust Board is asked to note this report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Board Assurance Framework – Quarters 1 and 2
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

The Quarter 1 and 2 update on the plans to address the gaps in control and assurance against the risks to the delivery of the Trust's annual priorities is attached.

The format has changed from that used for 2010/11 to include a cross reference to other corporate documents in which the risks are mentioned and to clarify the responsibility and timescales for addressing any gaps identified.

The pre-mitigation risk scores are taken directly from the risk assessments prepared by the Executive Directors for those annual priorities for which they are individually responsible in 2011/12.

Some significant points to highlight include:

- Addressing the gaps associated with the improvements in outpatient booking system annual priority is reliant on the launch of a specific cross cutting theme within the Transformation Plan
- The gaps associated with the priority to improve and heighten awareness of the need to report and learn from incidents will be addressed by the current review of the incident reporting and investigation policy
- Gaps associated with the annual priority to deliver a £2.1m CIP and produce detailed plans to deliver a £20m annual CIP for a further three years will be met by the recently agreed plans to incorporate the CIP delivery into the Transformation Plan as Transformation Project Savings (TSPs)

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

Approval	Receipt and Noting	Discussion
	✓	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	All
Annual priorities	Provides an assessment of the risks to the delivery of the Trust's annual priorities, together with the gaps in control and assurance against them
NHSLA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Governance Board on 7 October 2011.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Board Assurance Framework (BAF) 2011/12

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

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

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

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

BOARD ASSURANCE FRAMEWORK (BAF)

2011/12

October 2011

KEY:

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

Cross Reference

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

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
STRATEGIC OBJECTIVE 1: ACCESSIBLE AND RESPONSIVE CARE										
Annual Priority 1.1 Identify and implement specific ways of improving the health of the population we serve Exec Lead: MD										
Identify and implement specific ways of improving the health of the population we serve.	Lack of focus from Directorates	Directorate QMF Reviews Specific Objectives related to public health	QMF Dashboards	Directorate QMF reviews are not yet fully integrated into the performance management system	Directorate performance not yet comprehensively reviewed at corporate level	Refresh of performance management framework and integration of Directorate reviews and Divisional reviews	Medical Director	5	3	15
Annual Priority 1.2 Ensure close and effective relationships with local GP consortia, PCT clusters and Local Authorities Exec Lead: DSOD (with MD)										
	Failure to deliver medical engagement action plan	Medical engagement action plan	Irregular review	No controls	No assurance	Regular reporting to be developed	Director of Strategy and OD Sept 2011	3	3	9
	Failure to share intelligence effectively within the trust	BD produces irregular updates	Irregular reporting of external developments	No routine reporting and sharing of intelligence	No evidence of systematic sharing of information	Regular slot in COOT to share systematically intelligence	Director of Strategy and OD Sept 2011	2	3	6
	Failure to participate fully in Cluster activities	Leads identified for each meeting/activity	Feedback from cluster activities to Executive team	Not all meetings/issues are reported back so issues	Updates/papers circulated to executives	Regular slot on exec team and COOT to review cluster	Director of Strategy and OD Sept 2011	3	3	9

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
				may be missed		activities				
	Failure to maintain close contact with Consortia	BD team ensure regular attendance at meetings and communication Attendance at PLT events GP focus published regularly Occasional meetings with CCG Leaders Variety of contact with Local Authority including through Right Care Right Here structures, Health and Wellbeing partnership and operational contact	Irregular reports back to execs and operations Publication of GP focus	No routine reporting	No systematic evidence	Regular slot on exec team and COOT to review contact and feedback Development of Client relationship management leads in Divisions	Director of Strategy and OD Sept 2011	2	3	6
Annual Priority 1.3	Deliver Access performance measures including those set out in the Operating Framework for 2011/12						Exec Lead: COO			

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
OF, CRR, IBP	Risk access areas include A&E, Stroke/TIA, DTOC and 18 weeks(Orthopaedics)	A&E, Stroke./TIA and DTOC work streams all have action plans to deliver service improvements.	EDAT Project Board has CEO chair and Executive sponsorship. ATOS also supporting transitional work to new future state. Trajectory for Stroke improvement agreed at TMB. DTOC joint work with social services in train to reduce delays and improve performance. ATOS commissioned to support work work stream on effective patient flow and bed	Lack of effective operational escalation and variable pathways pan Trust. Orthopaedic project yet to be fully scoped.	Failure to recruit ED staff.	Overseas recruitment campaign for ED medical staff. Rapid Improvement event and solutions to be determined for new ED processes in September / October. Outcome will include escalation processes. Patient flow and bed management system project to be completed in Q3, to include escalation processes.	COO March 2012 COO January 2011 COO January 2011	4	5	20

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
			management. Over all access performance targets monitored weekly via waiting list meetings to monthly reporting to PMB, TMB, F&PC to Trust Board.			Orthopaedic project to be determined by November.	COO November 2011			
Annual Priority 1.4 Continue to improve outpatients booking systems Exec Lead: COO										
OF	DNA rate and cancellation reduction	• DNA Policy • Text reminders • Letter reminders • DNA leaflet goes out with all new appointments • Improved contact centre call waits, so patients aren't kept waiting	Out patient performance reported through waiting list meetings and ultimately via PMB, TMB to F&PC/ Trust Board. QUEP project plans and project reports.	OP QUEP project to be reviewed as part of Transformation Plan to be launched in Quarter 3.	Transformation plan and reporting cycles to be developed to strengthen assurance pending Trust Board approval.	• Hospital short notice cancellations need to be minimised as this causes increase DNAs. Review of clinic profiles in train. Text reminder system to be	COO March 2011	4	4	16

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		when trying to change appointment • Cancellation on line service, to be rolled out with new appointment letters. Was due 1st September but delayed by IT dept • New FU booking system in BMEC. (15.5% to 9.85%)	Governance arrangements of QUEP feed into PMB, TMB and TB.			commissioned Quarter 3. • Divisions need to reduce cancellations at short notice, strengthening annual leave controls.				
	Lack of engagement to review rotas and job plans to profile clinics by teams to avoid cancellations	• Local work streams at Divisional level	QUEP project plans and project reports. Governance arrangements of QUEP feed into PMB, TMB and TB.	OP QUEP project to be reviewed as part of Transformation Plan and ATOS supported work.	Transformation plan and reporting cycles to be developed to strengthen assurance pending Trust Board approval.	• Transformation plan cross cutting theme TBC in autumn. Risk assessment to be revised as cross cutting them is scoped and signed off.	COO March 2011	4	4	16

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

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		protocols and escalation processes, single point of access for social service referrals, increased social service capacity	minutes of meetings. Performance monitoring via F&PC to Trust Board.							
STRATEGIC OBJECTIVE 2: HIGH QUALITY CARE										
Annual Priority 2.1 Improve reported levels of patient satisfaction Exec Lead: CN										
	Insufficient staff to deliver care.	Funded establishments. Absence controls. Effective rostering. Establishment reviews. Ratio monitoring. Bank availability.	Ratio reports. Ward reviews. Complaints numbers. Incident numbers. Clinical outcomes.	Flexible beds. Insufficient bank staff to meet need.	None identified	No unplanned use of flexible beds. Winter planning. Over-recruitment of staff. Regular establishment reviews.	Oct 2011 CN/COO	5	4	20
	Staff lack skills and competency to deliver care.	Training plans. Specific targeted training. Recruitment effective.	Audit care. Training numbers. Ward Team Challenge.	Some areas of training under funded. Release of staff for training.	None identified	Various bids to secure funding. Review L&D function. New MT	Dec 2011 CN	4	4	16

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		PDR process.				process.				
	Poor staff attitude/ motivation.	Customer care training. Leadership development. Complaints/ PALS monitoring. Patient stories.	Complaints. Observations of care audits. Patient surveys. Patient feedback.	Effective leadership in all areas.	None identified	Reconfiguration of Ward Managers. Leadership development programme.	Dec 2011 CN/MD	5	4	20
	Lack of clear standards and expectations.	CQC standards. HiA Nursing. Trust objectives. Individual and team objectives.	Audits against standards. CQC action plans. Job specs. Performance monitoring – ward/directorate /division.	Performance system needs embedding at directorate level.	Action plans for all CQC standards. Team objectives.	Quality and system implementation plan.	Oct 2011 DG/MD/CN	4	4	16
Annual Priority 2.2	Continue to embed Customer Care promises			Exec lead: HCE						
	There are no resources identified to fund this work and those involved already have substantive roles with other priorities Staff reluctance to change attitude	LiA Sponsor Group Ad hoc customer care sponsor group (membership revised May 2011) There is a communications and engagement governance	Minutes from LiA sponsor groups	Customer Care sponsor group not adequately minuted No schedule of meetings for customer care sponsor group	Insufficient detail in minutes	Schedule of meetings produced for customer care sponsor group Introduction of project management / admin support to customer care sponsor	September 2011 HCE	3	2	6

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		group that meets bi-annually				group and action plan				
Annual Priority 2.3 Improve the care we provide to vulnerable adults Exec Lead: CN										
	Staff unable to identify vulnerable adults due to lack of knowledge.	Safeguarding training. Dementia training. Policies. Action plans. Safeguarding team. Record keeping. Mental health and LD support.	WMQRS review. CQC review. Internal audit findings. Referral data. Obs. of care audits. Ward reviews.	Insufficient training to meet needs. Poor documentation of assessment and care planned. Policies in draft. Poor support Sandwell MH and LD. Funding RAID.	Profile at directorate and divisional level.	Record keeping review. Policies to Gov Board. Training bids. Work with partners for and support.	Nov 2011 RO	5	5	25
	Please see risks re patient satisfaction as all are relevant to this standard.									
Annual Priority 2.4 Make improvements in A & E services Exec Lead: MD										
	Lack of effective development and implementation of improvement plans (which incorporate all deliverables)	ED Action Team in place, chaired by CEO and also including COO and MD. Meets monthly and reports direct to Trust Board. Also reports to PCT Clinical Quality Group.	Monthly reports to Trust Board Performance monitoring of key standards via Corporate Performance Report. Review by West	None identified.	None identified.	Not applicable	Not applicable	3	3	9

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

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		• Whole system pathway review in progress as part of the RCRH programme.	reporting to F&PC to TB.			organisational development programme is likely to take 9 – 12 months.				
Annual Priority 2.6 Make improvements in Stroke services Exec Lead: MD										
Make improvements in Stroke services.	This is a cross-cutting service that relies on good co-ordination of care or investigation by a number of departments	Accountability for performance now focused on COTE Directorate	Stroke Dashboard	See 1.1 above. Performance Management of Directorates remains immature	None identified	See 1.1 above	MD	5	4	20
Annual Priority 2.7 Embed the Quality and Safety Strategy incorporating the FT Quality Governance Framework Exec Lead: DG										
CQC / FT / IBP / NHSLA	Failure to identify, implement and achieve credible quality improvements	▪ Performance management reviews	▪ QMF Dashboard ▪ CQC QRP ▪ CQC registration ▪ CQUIN ▪ Quality reports to the Q+S Cttee and TB ▪ Key sources of	▪ Corporate and directorate level quality goals ▪ Inconsistent governance arrangements at divisional / directorate level	▪ Not yet tested against quality element of Monitor'compliance framework.	▪ Develop an Annual Quality Improvement Plan ▪ Undertake a self-assessment against Monitor's	December 11 DG November 11 DG	**2**	**3**	**6**

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
			local intelligence			quality requirements and action areas for improvement ▪ Organisational governance framework to be developed and rolled out	December 11 KD			
Annual Priority 2.8 Improve and heighten awareness of the need to report and learn from incidents Exec Lead: DG										
	Inability to learn leading to unsafe environment and practices for patients and staff	Incident reporting. Investigation processes. Sharing of incident data and lessons. Training.	Quarterly Integrated risk reports. Specific committee minutes. Risk newsletters.	Not meeting deadlines for reporting and investigation of incidents. Risk management discussion/involvement at directorate/divisional level. Investigations of amber incidents consistently.	Robust process for following up amber incidents and investigations. Serious incident report to the Trust Board – repeated incidents	Review of incident reporting and investigation policy. Ownership of processes at divisional/directorate level.	DG March 2012	2	5	10
Annual Priority 2.9 Deliver the CQUiN targets Exec Lead: CN/MD/COO										
	Poor data from Community division for:	Business development unit.	Monthly data.		Monthly data not available always.	BDU understand what is	Oct 2011. CN	5	2	10

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

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

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		Board dates planned. Quarterly review completed for Q1.	Board, reporting ultimately to PMB, TMB, and via F&PC to Trust Board .	fully developed.		Cross cutting project charter to be completed with project plan as part of Transformation Plan to be launched in Quarter 3 - 4. Peer review to be agreed.				
Annual Priority 3.2 Deliver the agreed changes in activity required as part of the 'Right Care, Right Here' programmeExec Lead: COO										
IBP, CRR	• Robustness of demand management from GP's • Clinical engagement to effect and deliver change • Robust project management related to decommissioni	• Decommissioning schemes have been identified. Robustness of plans is being reviewed in August / September. • Regular decommissioning meetings with external stakeholders	Project delivery plans for each scheme and monitoring process. Monthly monitoring with RCRH working group and Partnership Board.	None identified	Robustness of plans	Transformation Plan to move from current to future state to be agreed in Quarter 3. The delivery of the plan will be supported by the Transformation Support Office which will provide	RB December 2011	4	4	16

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	ng	• RCRH pathway review programme and governance structure				processes, systems and expertise to ensure robust service transformation and project plans. Case to go to Trust Board in September with recruitment and launch by end Quarter 3.				
Annual Priority 3.3 Play a key role in the local community, actively promoting healthy lifestyles and health education Exec Lead: HCE										
	There are no resources identified to fund this work and those involved already have substantive roles with other priorities	*Communications and engagement governance group meets bi-annually*	Minutes from Comms and Engagement Governance meeting next due Sept 2011	Existing governance meeting membership and frequency not sufficient	Insufficient detail available in meeting minutes	Increased frequency of Comms and Engagement Governance Group and Establishment of Health Promotion reference group, admin support at both	HCE; 31st October 2011	4	1	4
Annual Priority 3.4 Develop a local response to the national plans for Heath Visiting Exec Lead: CN										

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

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
						explore options for use of Rowley Regis.				
STRATEGIC OBJECTIVE 4: GOOD USE OF RESOURCES										
Annual Priority 4.1 Deliver a £21.1m CIP and produce detailed plans to deliver a £20m annual CIP for a further three years Exec Lead: DFPM										
	Delay in schemes required to produce benefit as from 1 April. Absence of acceptable replacement schemes where 'slippage' has occurred. Movement of schemes away from recurrent impact to non-recurrent causing underlying problems into future year(s). Challenging targets over 3 year future	Detailed line-by-line cost improvement programme established, reviewed and set at start of year. Prompt monitoring of delivery at PMB, F&PMC, divisional reviews. Established mechanism to capture deviations and set process for evaluating and approving corrective action.	Cost improvement reporting by line and theme. External and internal reporting of reporting of performance at variety of levels within organisation. Routine reporting on progress towards identifying future productivity, quality and efficiency gains.	Project summary of each scheme could be strengthened and placed into a common format as recommended.	Consideration required for strengthening CIP reporting to the Board despite Board member attendance at F&PC where CIPs performance considered.	Proposal for revised CIP reporting at TB level. All future CIPs to be summarised as part of a composite benefits realisation schedule.	Improvements to be considered at F&PC in September – DFPM Format for CIP capture moving forward to be agreed by M7 - DFPM	3	3	9

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	period.	Programme supported by QUEP schemes aimed at bringing cross cutting actions together for monitoring and managing Trustwide. Additional resources identified to work on future year savings plans from a strategic startpoint leading to detailed benefits realisation.								
Annual Priority 4.2	Achieve a £2m surplus		Exec Lead: DFPM							
	Under-delivery of efficiency savings, unplanned costs arising especially where these are not offset by	Budget management system, timely and robust reporting to Trust Board, F&PMC, PMB	Audit Committee sign-off of independent internal and external audit plans that test functioning of	Final details of elective referral mechanism with main commissioners requires finalisation.	None identified.	Detailed proposal under consideration by PCTs in terms of referral mechanism	Resolution required by time Sept admitted patient care data is validated.	3	3	9

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	additional income for activity above targeted levels.	together with Qrtrly divisional reviews and attendance at F&PMC all provides robust system of checks and corrective action where necessary.	financial systems. Transparent reporting of use of resources via detailed schedules to Finance Committee.			operation in certain unique specialities.				
	CQUIN delivery below levels required placing commissioners in a position to withhold target related payments	Review of CQUIN delivery occurs at Trust Board, F&PMC, PMB and TMB as well as in direct routine meetings with divisions.	Clear reporting of the thresholds required and year to date activity.	Strengthen performance tracking within Chief Operating officer's meeting with general management teams.	Timely requirement to assure Board of the data quality and sources used in assessing performance.	COO to review inclusion of dedicated CQUIN review in addition to attention paid at TMB	Q3 for data assurance taking this to either AC or G&S – DFPM, also Q3 for formalising into COO processes - COO	3	3	9
Annual Priority 4.3 Reduce Premium Rate Working Exec Lead: COO										
IBP,	• Lack of filled training post from the Deanery • Reliance on additional list to meet	• Divisional level work in train to decrease premium rate working. • Demand and capacity review	Assurance at service level in local CIP plans and related monitoring.	Authorisation at local level/ Divisional level only.	No pan Trust authorisation process or reports of additional capacity usage.	• Trust wide controls to be implemented to authorise premium rate working. • Productivity	RB October 2011	4	5	20

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	performance targets • Inadequate systems and controls to authorise premium rate working • Financial pressure as premium rate working not funded	of Trauma and Orthopaedic in progress (see annual priority 2.5)				and efficiency opportunities to be realised through cross cutting themes of Transformation Plan (TBA in September)				
Annual Priority 4.4 Develop plans to improve the service line position of the Trust Exec Lead: DSOD										
	Inability to distinguish which HRGs within each specialty make a contribution	SLR QUEP	QUEP reporting	Closer integration with SLM QUEP and CIP required	None	Strengthening of CIP and SLM project management through TSO creation	DSOD	3	3	9
	Factors outside of project control worsen SLR position eg tariff changes or other plans such as decommissioning	None	None	Decommissioning programme does not consider SLR position	None	To be identified	DSOD	4	3	12

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	Failure to deliver CIPs for the specialty	CIP management	CIP reporting	Closer integration with SLM QUEP and CIP required	None	To be identified	DSOD	2	3	6
STRATEGIC OBJECTIVE 5: 21ST CENTURY FACILITIES										
Annual Priority 5.1 Begin to procure a new hospital Exec Lead: DENHP										
	Delay in project plan continues and impacts on FT application timescale, due to change in requirements, technical difficulties, change in staffing at DH, further delay in final part of approval process. Delay beyond October 2011 risks integrity of OBC	Rapid response to all queries and requests for information from the DH and Treasury. Continue to work with senior stakeholders and decision makers to ensure best chance of approval.	Project Board minutes reports on progress. Gateway review reports.	None Known	None known	Not applicable	DE/NHP	4	4	15
Annual Priority 5.2 Continue to improve current facilities Exec Lead: DENHP										
	Non-completion of capital schemes on	Project teams established where necessary.	Monthly reports to SIRG and Annual Estates	None identified	None identified	None applicable	DE/NHP	2	3	6

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	agreed programme	All items on the capital programme have a nominated lead	Strategy to Trust Board							
Annual Priority 5.3	Develop detailed plans for the development of the community estate					Exec Lead: DENHP				
	Limited project resource capacity to develop plans, through clinical engagement, due to competing priorities on the same management resource	Project Plan for delivery of feasibility studies. Regular meetings with CPT to ensure completion of feasibility studies Monthly RCRH Community Facilities Programme Group to monitor progress. SRT and CPT utilising capacity available as a consequence of the delay to the Midland Metropolitan Hospital Business Case being	Community Facilities Programme Team – reports on progress	None identified	None identified	None applicable	DE/NHP	4	3	12

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		approved. Identified key personnel in SRT and CPT for community workstream								
STRATEGIC OBJECTIVE 6: AN EFFECTIVE ORGANISATION										
Annual Priority 6.1 Make significant progress towards becoming a Foundation Trust Exec Lead: DSOD										
	Performance failure delays FT progress	*FT programme structure Performance management framework*	FT programme management Regular reports to FT programme Board and Trust Board Monthly risk assessment Deloitte review of readiness	None identified	None identified	None applicable	DSOD	2	4	8
	Inability to resolve Outline Business Case approval nad prudential borrowing code	Maintain contact with DH	Reporting of progress to Board members formally and informally	None identified	None identified	None applicable	DSOD	2	4	8

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	issues									
Annual Priority 6.2 Deliver a set of Organisational Development activities including a stronger voice for front line staff Exec Lead: DSOD										
	Failure to develop comprehensive OD framework	OD framework action plan	Irregular reporting of progress to Executive Team	No regular reporting and discussion	No comprehensive assurance	Development of OD steering group	Set up by Sept 2011	3	3	9
	Failure to deliver model of staff engagement and incentive system	Owning the Future pilots and action plan	Irregular discussion at exec team Reporting of progress to CEO	No formal controls	No comprehensive assurance	OD steering group will oversee progress and receive regular reports	Set up by Sept 2011	3	3	9
Annual Priority 6.3 Develop our clinical systems and processes to reduce variability and ensure safe, error free care Exec Lead: MD										
	Lack of Standards across the Trust	Development of standards and ongoing audit methodology	Outputs from audit	Audit process not yet in place	Reporting process not yet developed	Introduction of self-assessment tool for directorates and clinical departments, with reporting through the QMF	Medical Director Q3 11/12	5	4	20
Annual Priority 6.4 Improve staff satisfaction, health and wellbeing Exec Lead: CN (with DSOD)										
	Failure to deliver health and well being action plan.	Sickness absence monitoring. Action plans. H&WB Committee.	Monthly reporting to PMB and TMB. Quarterly to TB. Staff survey.	Facilitator only funded to March 2012. Sickness policy under review	'Pulse checks' not in place yet.	Policy to TMB November. Funding bids for facilitator.	March 2012. CN/DSOD	4	3	12

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		Workforce QuEP. Facilitator for H&WB. HR support. Sickness absence policy	'Pulse checks'. OH referrals. Trend data.	with JCNC.						
	Failure to improve staff survey results.	Action plan/matrix developed to ensure actions for improvement are identified and achieved. Ensure robust staff communication activity to highlight findings and actions being taken as a result	Monitor delivery of action plan and communication activity and provide regular reports to LiA Sponsor Group	None identified	None identified	Not applicable	DSOD	2	3	6
Annual Priority 6.5 Agree an IT strategy, including and affordable route to procurement of an Electronic Patient Record Exec Lead: MD										
	Uncertainty about capacity to develop and deliver a complex and affordable strategy	Nil as yet	Nil as yet	No Controls in place as yet	Assurance processes not yet developed	Oversight of project group will be developed and monitored through the OD strategy	MD November 11	3	5	15
Annual Priority 6.6 Continue to develop and implement the Trust's approach to sustainability and transport and access Exec Lead: DENHP										
	Failure to meet	Monthly	On-going work	Plans are	Assurance on	IA to assurance	First target	4	3	12

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	carbon management targets for CO^2 reduction	monitoring via Sustainability Working Group and quarterly monitoring/ reporting to Trust Board	with sustainability champions at departmental level to assist in affecting a cultural change and implementing improvements in energy awareness and promoting alternatives modes of transport and travel. Target to achieve 20% increase in champion numbers in 2011 and by 2013/14 have a champion in all areas. Target to achieve 50% of champions with	developed and reported on by same department (some external assurance form professional bodies)	whole plan required	of plans required	completion of 15% reduction on 2008/09 baseline by 2013/14 and cultural change before move to new hospital – DE/NHP			

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
			Level 2 qualifications by 2013/14. Implementation of carbon management software to produce accurate and live baseline information across the scope of utilities, transport and waste. Commence the measurement of procurement baseline in line with SCO2PE from DoH. Introduction of public transport plans with appointment letters							
Annual Priority 6.7	Develop a training plan that reflects service needs, is resources and supports the workforce plan						Exec Lead: CN			

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	Failure to develop training plan that meets service needs.	Annual process understood and in place. Lead manager. Template etc to support. PDR process to inform. L&D Committee.	Regular reports to L&D Committee.	None identified	None identified	Not applicable	CN	2	3	6
	Failure to secure sufficient resources to support training needs.	Annual allocation from SHA. Some recurrent internal funding. L&D Department. Access to other funding sources. Locality Boards.	Regular reports to L&D Committee.	Insufficient funding to support all needs identified.	None identified	Funding bids. Reallocate and prioritise funding available.	March 2012. RO	4	2	8

Executive Lead

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Annual Audit Letter
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	KPMG LLP
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

The annual audit letter summarises the key issues arising from the work that the Trust's external auditors, KPMG LLP have carried out during 2010-11.

The letter highlights both areas of good performance and provides recommendations designed to help the Trust improve performance in coming years.

The scope of the audit covers use of resources and a review of the financial statements and the Trusts Statement on Internal Control. The audit opinion highlights that the published accounts present a true and fair view of the Trust's financial affairs and that the processes and procedures adopted in producing the accounts were sound.

The letter was presented to the Audit Committee for review on 8 September 11 and after review by the Trust Board will be published on the Trust's website.

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 letter and key messages contained within

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Financial reporting – The Trust produces annual accounts in accordance with relevant standards and timetables, supported by comprehensive working papers

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

Financial	**X**	
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	**X**	Satisfies the statutory responsibilities and powers of the appointed auditors as set out in the Audit Commission Act 1998
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Audit Committee on 8 September 2011

KPMG

cutting through complexity™

SWBTB (10/11) 207 (a)

Sandwell and West Birmingham Hospitals NHS Trust

Annual Audit Letter 2010/11

September 2011

Contents

The contacts at KPMG in connection with this report are:

Mike McDonagh
Engagement Lead
Tel: 020 7694 5546
michael.a.mcdonagh@kpmg.co.uk

Andrew Bostock
Director
Tel:0121 232 3694
andrew.bostock@kpmg.co.uk

Sarah-Ann Moore
Manager
Tel:0121 232 3694
sarah-ann.moore@kpmg.co.uk

Ben Stone
Assistant Manager
Tel:0121 232 3579
ben.stone@kpmg.co.uk

This report is addressed to Sandwell and West Birmingham Hospitals NHS Trust (the Trust) and has been prepared for the sole use of the Trust. We take no responsibility to any member of staff acting in their individual capacities, or to third parties. The Audit Commission has issued a document entitled Statement of Responsibilities of Auditors and Audited Bodies. This summarises where the responsibilities of auditors begin and end and what is expected from the audited body. We draw your attention to this document.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

If you have any concerns or are dissatisfied with any part of KPMG's work, in the first instance you should contact Andrew Bostock who is the engagement lead to the Trust or Trevor Rees, the national contact partner for all of KPMG's work with the Audit Commission. After this, if you still dissatisfied with how your complaint has been handled you can access the Audit Commission's complaints procedure. You can contact the Complaints Unit by phone (0844 798 3131), by email (complaints@audit-commission.gov.uk), through the audit commission website (www.audit-commission.gov.uk/aboutus/contactus), by textphone/minicom (020 7630 0421), or via post to Complaints Unit Manager, Audit Commission, Westward House, Lime Kiln Close, Stoke Gifford, Bristol, BS34 8SR.

Background

This Annual Audit Letter (the letter) summarises the key issues arising from our 2010/11 audit at Sandwell and West Birmingham Hospitals NHS Trust (the Trust). Although this letter is addressed to the Directors of the Trust, it is also intended to communicate these issues to key external stakeholders, including members of the public. It is the responsibility of the Trust to publish the letter on the Trust's website at http://www.swbh.nhs.uk.

In the letter we highlight those areas where we have identified good performance during our work with the Trust. We also provide a brief summary of the areas in which we have raised recommendations throughout the year to help the Trust improve performance. We have reported all the issues in this letter to the Trust throughout the year and a list of all reports we have issued and the number of recommendations raised in each is provided in Appendix A. We have provided a summary of recommendations raised in 2010/11 that are due and where work is ongoing in Appendix B.

Scope of our audit

The statutory responsibilities and powers of appointed auditors are set out in the Audit Commission Act 1998. Our main responsibility is to carry out an audit that meets the requirements of the Audit Commission's Code of Audit Practice (the Code) which requires us to report on:

Use of Resources (UoR)	Sandwell and West Birmingham Hospitals NHS Trust ('the Trust') is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources and regularly reviewing the adequacy and effectiveness of these arrangements. Our responsibility is to satisfy ourselves that the Trust has proper arrangements in place by reviewing and examining evidence relevant to its corporate performance management and financial management arrangements and reporting on these arrangements. We reflect our judgements from the use of resources work in the value for money (VfM) conclusion. Our conclusion provides assurance on the Trust's arrangements for achievement economy, efficiency and effectiveness in its use of resources. We have also carried out specific work around Cost Improvement Plans (CIPs) and Quality Accounts which informed our VfM conclusion.
Financial Statements	The Trust is responsible for putting in place systems of internal control to ensure the regularity and lawfulness of transactions, to maintain proper accounting records and to prepare financial statements that give a true and fair view of its financial position and expenditure and income. The Trust is required to publish a Statement on Internal Control (SIC) with its financial statements. We audit the financial statements and provide our opinion as to whether they give a true and fair view of the Trust's financial position and expenditure and income, and whether they have been prepared in accordance with the relevant accounting policies directed by the Secretary of State.

Fees

Our fee for the main Trust audit in 2010/11 was £ 180,380 plus VAT. This fee was in line with that highlighted within our agreed audit plan and represented a £20,000 reduction on the prior year audit fee. A further £15,000 has been charged for 2010/11 in respect of the audit of the Quality Account. The Quality Account element of the fee was communicated and agreed with the Audit Committee in May 2011 following the release of the April 2011 Audit Commission guidance.

Use of Resources	We concluded that the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Our VfM opinion was informed by: ■ our structured risk based assessment of the Trust's general VfM arrangements; ■ our review of the Trust's CIP or Quality and Efficiency Programme (QuEP) arrangements, the results of which were reported to the Trust in our Interim Report in May 2011; and ■ our review of data quality and governance arrangements in respect of the Trust's Quality Account, for which a separate report was issued to management in July 2011. We also undertook a nationally mandated review of the Trust's 2009/10 reference costs submission to the Department of Health (DH), which formed part of the Payments by Results assurance framework. The results of which were reported to the Trust in May 2011. We made three recommendations for performance improvement as a result of our work in respect of UoR relating to the Trust's CIP and QuEP arrangements. These were in respect of staff and clinical engagement in CIP planning, the process for changes to CIPs and non recurrent schemes and the process for CIP scheme set-up and progress monitoring. Quick implementation of these recommendations will be important for the Trust given the scale of the financial challenge that the Trust faces in 2011/12 – a CIP of £21.7m. Progress against these recommendations is included in Appendix B.
Financial Statements including the Statement on Internal Control	We issued an unqualified opinion on the Trust's accounts on 9 June 2011. This means that we believe the accounts gave a true and fair view of the financial affairs of the Trust and of the income and expenditure recorded during the year. The Trust incurred a retained deficit of £6.9m for the year following charges for impairments of Property, Plant and Equipment of £9.5m (£36.5m in 2009/10) and an IFRIC12 adjustment of £455k (being the revenue impact of bringing PFI assets onto the balance sheet under IFRS, deducted to bring NHS Trusts in line with HM Treasury reporting). These were accounting entries only and did not result in a cash charge to the Trust. Prior to these costs, the Trust would have recorded a surplus of £2.2m. For the purposes of the financial performance, this 'technical deficit' did not result in a breach of the Trust's duties to achieve financial balance and therefore did not impact on our Use of Resources conclusion. We noted that there were no material unadjusted audit differences arising from the audit. There was one audit difference that was not adjusted in relation to £4.3m of deferred income. We identified a number of minor presentational changes/adjustments to the draft accounts all which were agreed and addressed by management in the final financial statements. The SIC was compliant with NHS guidance, reflected the Trust's control environment and was consistent with the financial statements. We reviewed the Trust's Remuneration Report, which was prepared in accordance with NHS guidance. We have reviewed the Trust's draft Annual Report. Once we have a final version we intend to issue an opinion on the Trust's summarised financial statements.

Headlines (cont.)

Financial Statements including the SIC continued	We raised four recommendations for the attention of the Audit Committee as a result of our 2010/11 audit work on the Financial Statements and SIC. These were in respect of clearance of suspense codes, Better Payment Practice Code compliance reporting, disclosure of operating segments and the timeliness of the Trust's Annual Report review. These recommendations can be found in Appendix A. All of our recommendations were accepted by management and progress has been demonstrated in year.
Whole of Government Accounts	Following the clarification of ISA 600 audits of group financial statements, the National Audit Office issued guidance in April 2011 regarding the work auditors of NHS Trusts are required to undertake in order to provide assurance for the Whole of Government Accounts consolidation. We brought this requirement to the Audit Committee's attention in our Interim Report, and worked with the Finance team to ensure the Trust was aware of its responsibilities and our requirements. Our audit included a specific review of the appropriate processes and controls in place at the Trust to identify counter party transactions with other bodies within the WGA consolidation including those outside of the NHS, for example HMRC. We did not identify any issues through this work.
Quality Accounts	In March 2011 the Audit Commission issued guidance regarding the review of Trusts' quality accounts. This took the form of a review of the Trust's arrangements for satisfying itself that the Quality Account is fairly stated, prepared in accordance with relevant requirements, and sample testing of two performance indicators for Clostridium difficile (C-Diff) and 62 day cancer waits. We completed our review of the Trust's overall arrangements and reviewed the Trust's Quality Account in June 2011. We presented our report to the Director of Finance and Performance and the Medical Director in July 2011. We were not required to give an assurance opinion on the Trust's Quality Account for 2010/11 as this review constituted a 'dry-run' exercise for the attention of management. We identified seven performance improvement observations as a result of our work with one requiring urgent attention. The key areas for development were in relation to completeness of data underpinning the 62 day cancer wait performance indicator, policies and procedure notes in respect of compiling the data to report the 62 day cancer waits and C-Diff indicators and completeness of audit trail for the overall Quality Account. It is important that the Trust focuses on these areas and delivers robust data quality across all of its functions.
Public Interest Reporting	We have a duty to refer any matter to the Secretary of State if we have a reason to believe that the Trust is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency. We also have a duty to consider whether, in the public interest, to report on any matter that comes to our attention in order for it to be considered by the Trust or brought to the attention of the public. We have considered our responsibilities in relation to public interest reporting throughout the audit process. There are no matters in the public interest that we wish to raise at this time.
Fraud	We have a responsibility to consider fraud and we addressed this in our assessment of the Trust's controls framework. We have also reviewed the Trust's arrangements for the prevention and detection of fraud and corruption. This work is complete and has not identified any matters which we wish to draw to your attention. We are required by the Audit Commission to carry out work on the Trust's LCFS arrangements with respect to participation in the National Fraud Initiative. We will carry out this work in October 2011 and report to Audit Committee as part of our Interim Report in 2012.

Appendix A

Summary of reports issued and recommendations raised

This Appendix summarises the reports and documents that we have issued as part of the 2010/11 Audit Process and the number of recommendations made.

Document	Date Reported	Reported to
Refreshed 2010/11 Audit Plan	February 2011	Audit Committee
Audit Committee Progress Reports	February and May 2011	Audit Committee
Interim Report (including Cost Improvement Plan Review)	May 2011	Audit Committee
Reference Cost Review	May 2011	Audit Committee
2011/12 Audit Plan	May 2011	Audit Committee
ISA 260 Audit Report	June 2011	Audit Committee
Quality Accounts Review	July 2011	Management

Document	Recommendations made			
	Total	Not yet due	Implemented	Ongoing/ outstanding
Interim Report (including Cost Improvement Plan Review)	4	-	1	3
Reference Cost Review	3	-	1	2
ISA 260 Audit Report	3	1	-	2
Quality Accounts Review	7	7	-	-
Total	**17**	**8**	**2**	**7**

Appendix B

Recommendations from 2010/11

This Appendix summarises recommendations raised in 2010/11 that are due and where work is ongoing. There are no outstanding recommendations from previous years.

From the ISA 260 audit report – June 2011		
Risk	**Issue, impact and recommendation**	**Update as at September 2011**
Low	**Better Payments Practice Code** Our audit review of the Trust's calculations identified that the Trust approximates the start date for the 30 payment period by taking the original invoice date and adding 3 days. This approach is used because in many instances the invoice receipt date is not recorded or is not fully reliable because documents are received at various points around the Trust and not forwarded to the finance team in a timely fashion. We acknowledge that the Trust recognises the need to improve its BPPC performance and has made progress in 2010/11. However, the Trust should continue its work to improve the accuracy and timeliness of invoice registering and recording, including encouraging invoices to be forwarded to finance in the first instance. *Trust response:* *Agreed. An improvement plan has been taken to both the Finance and Performance Committee and Audit Committee. The Trust continues to monitor and report its progress against the plan.* *Director of Finance and Performance* *Ongoing*	A progress report has been prepared for the Audit Committee and features on the September Agenda. The report confirms that progress is being made, especially as the Pharmacy interface process between the JACS system and Oracle Financials is up and running. *Director of Finance and Performance*
Low	**Segmental Reporting** The Trust has continued to disclose one reporting segment having considered the relevant accounting standard, IFRS 8. While the Trust's decision to report as a single "SWB Hospitals" segment in 2010/11 is appropriate, this is unlikely to be the case in 2011/12 particularly following the Trust's acquisition of community services from Sandwell PCT under "Transforming Community Services (TCS)". These non-acute services will likely be reported separately to the Trust Board (the Chief Operating Decision Maker). Following its ongoing implementation and embedding of Service Line Reporting and the impact of the acquisition of community services the Trust should prepare a paper for Audit Committee that sets out the Trust's position against the criteria outlined in IFRS 8. This should then inform the decision as to whether the Trust should disclose segmental performance. *Trust response:* *Agreed. The Trust notes this issue and in particular anticipates the requirement to disclose separately the newly acquired community services. A detailed paper will be brought to the Audit Committee to outline and agree the proposed approach.* *Director of Finance and Performance* *September 2011*	The proposed response to IFRS 8 is planned for the Audit Committee on 2nd December 2011. *Director of Finance and Performance*

From the Interim audit report – May 2011			
	Risk	**Issue, impact and recommendation**	**Update as at September 2011**
	● Low	**Changes to CIPs and non recurrent schemes** Exception reports showing where CIPs are showing an adverse variance are presented to PMB and F&PC. However our review of documentation noted instances where non recurrent schemes were put in place to offset slippage on recurring schemes and where transfers from reserves were used to offset slippage but the approval process for transfer was not clearly evident from the documentation. The majority (82.2%) of the Trust's CIP is recurrent but the balance of non-recurrent savings is high in the context of other organisations. Our discussion with Trust officers indicates that the Trust recognises that to deliver the challenging savings targets that it faces in the future it must focus on and achieve recurrent, longer term savings (i.e. through its partnership working and pathway redesign) and that there may also exist an opportunity for education at a divisional level around what should be appropriately classified as "non recurrent". FMB should explicitly approve any changes to CIP and this should be reflected in the minutes and the nature of the replacement scheme, ie recurrent vs non-recurrent documented. If the overall total of savings required changes materially in value or nature in-year then the revised programme should ultimately be approved by the F&PC on behalf of the Board. Financial reports should show clearly the split between recurrent and non-recurrent savings achieved, including details of any reserve transfers, to provide greater transparency with regard to underlying activity/cost pressures. The need to maximise the level of recurrent schemes should be re-iterated throughout the planning process and when determining replacement schemes.	Partially implemented. The main CIP report has been amended to highlight the split of recurrent and non-recurrent schemes and continues to follow the discipline of requiring divisional & corporate management leads to submit exception reports together with proposed replacement schemes. Performance Management Board (PMB) approval processes are clearer as are Finance and Performance Committee (F&PC) owing to the inclusion of a 'reserve movement' appendix to the main financial schedules. F&PC have had full oversight of the relevant divisional recovery plans including rephased CIPs where appropriate. Material changes will be approved by F&PC and the nature of CIP reporting at Trust Board level is being reviewed in light of Foundation Trust practice. The current planning work on Strategic savings which has involved considerable engagement across the organisation has been used to re-iterate medium recurrent saving requirements. *Director of Finance and Performance*

From the Interim audit report – May 2011		
Risk	**Issue, impact and recommendation**	**Update as at September 2011**
Medium	**Clinical and staff engagement** Staff engagement, both in respect of clinicians and wider operational staff, is essential in ensuring that the Trust identifies all potential opportunities, that schemes are deliverable and that the impact on quality of care is understood and monitored. Our discussions identified that delivery leads recognise the need for further engagement with clinicians both in terms of generating ideas and in ensuring the success of schemes. Our work also identified that there is a perception amongst delivery leads that staff below Divisional General Manager (DGM) do not yet have adequate input into the identification of schemes and there is no existent Trust wide strategy for collating and considering wider staff into the process. The Trust should review how it engages staff in QUEP/ CIP process in future to ensure that the QUEP/ CIPs process and schemes are embedded at all levels within the organisation and ideas for innovation in working practices and captured. The Trust should consider divisional and cross divisional engagement – including for example, workshops and cross-service meetings at which the importance of CIPs is emphasised to staff and employees are given the opportunity to raise any concerns over quality of care arising from savings and indentify potential cross-cutting QuEP schemes. The Trust has the framework in place to implement this through the Listening into Action initiative.	Agreed. The financial context facing the Trust is a key component of the forthcoming Consultant Contract and the cross divisional events held recently at the Botanical Gardens and Bethal convention centres is promoting the engagement process. The messages and approach will need to be cascaded as the Trust moves through planning for next year and beyond. The makeup of the TSO (transformation support office) is being shaped and it is intended that it should have engagement as a key feature. The savings plans currently go through an evaluation process regarding risk via the Quality and Safety Committee. *Ongoing.* *Director of Finance and Performance*
Medium	**CIP scheme set up and monitoring of achievement** The Trust has a standard format for reporting progress of CIPs but does not use a standard document or format to record at the outset of the scheme how the saving will be delivered, what constitutes achievement of an individual scheme, what costs will be incurred in implementing the scheme (i.e., what the net saving is) and what milestones are in place for longer-term schemes. Inherent in many CIP schemes is a cost associated with delivering that scheme either in terms of additional staff required or in terms of investment to deliver the long term savings. Through our discussions with Trust officers and review of scheme documentation, it was identified that the Trust does not consistently capture the associated costs of implementing a CIP scheme nor monitor net savings. A standard document (mini-Project Initiation Document or PID) should be used at the outset of each QUEP/ CIP scheme to set out how the saving will be delivered, what constitutes achievement of an individual scheme, what costs will be incurred in implementing the scheme (i.e., what the net saving is), what impact the scheme will have on quality of care and what milestones are in place for longer-term schemes. Schemes should then be measured and reported against these criteria. Criteria such as scheme value, clinical risk or complexity should be embedded in the CIP process to ensure that the level of documentation retained is appropriate for the size and complexity of each scheme. Completion of the PID for each scheme should be a requirement for scheme approval.	Agreed. There are a number of versions available and the Trust will evaluate these and choose one for use. This additional rigour will flow from our current work with our advisors regarding future CIP planning. *Autumn 2011.* *Director of Finance and Performance*

Recommendations from 2010/11

From the Reference Costs report – May 2011			
	Risk	**Issue, impact and recommendation**	**Update as at September 2011**
	Medium	The Trust does not involve clinicians and service managers in the process of validating cost apportionments. Without reviewing costing methodologies and allocations with clinicians and service managers, there is a risk that some cost apportionments will be incorrect for reference cost purposes. The costing team should validate cost apportionments and ensure a robust methodology is adopted for apportioning costs. Clinicians and service managers should be involved in this validation in order to benefit from their expertise and improve the accuracy and robustness of service data. *Trust response:* *The Reference Cost process may be viewed as part of a wider process of service line reporting and service line management. SLR activity and cost data is reviewed at divisional reviews and the Trust runs directorate level quality management meetings that take place quarterly, involving clinicians and service managers, where SLR data for each specialty is discussed and corrected. This process benefits reference costs data quality as both SLR and reference costs are based on the same source information.* *Ian Kendall, Head of Financial Planning* *Apr –Jun 2011*	The Trust has a routine process emerging where matters of accuracy can be discussed with speciality leads. The profile of work includes sharing the component parts of the costs of the specialties concerned and leads are invited to challenge and improve apportionments. This process of gradual improvement in the accuracy of costings will continue. *Director of Finance and Performance*
	Medium	Some of the activity information received by the costing team consisted of high-level activity numbers without any detailed breakdown or working papers received from the services. There is a risk that activity information may prove to be inaccurate if not validated. The Head of Financial Planning should ensure that all activity data is validated before being used for reference costs in the interest of robustness and accuracy of the 2010/11 reference costs submission . *Trust response:* *All activity is collected from the most appropriate sources and validated where practical so to do. As a minimum all activity is evidenced by email correspondence from the appropriate departmental manager. The Trust regards this as sufficient validation for the reference cost submission but continues to work towards generating full patient level data where required for PLICS.* *Ian Kendall, Head of Financial Planning* *Apr –Jun 2011*	The Trust recognises its responsibility to undertake some general work on its data quality assurance. Where appropriate, this can be extended to reporting of activity for costing purposes. This builds on the work arising from the Audit Commission's publication 'Taking it on Trust.' *Director of Finance and Performance*

KPMG

cutting through complexity™

SWBTB (10/11) 207 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – September 2011
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

The report provides an update on the financial performance of the Trust for September 2011.

For September, the Trust generated a "bottom line" surplus of £144,000 which is £59,000 higher than the planned position (as measured against the DoH performance target).

For the year to date, the Trust has a surplus of £249,000 which is £46,000 worse than the planned position

Capital expenditure for the year to date is £2,067,000 and the cash balance at 30th September was £36.1m.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

NOTE the contents of the report and endorse any corrective actions required to ensure that the Trust achieves its financial targets.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Compliance with financial management and governance standards.

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

Financial		Potential impact on trust financial performance targets.
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		Potential impact of higher than planned expenditure on trust financial performance.

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 18 October 2011; Finance and Performance Management Committee on 20 October 2011.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2011

EXECUTIVE SUMMARY

• For the month of September 2011, the Trust delivered a "bottom line" surplus of £144,000 compared to a planned surplus of £85,000 (as measured against the DoH performance target).

• For the year to date, the Trust has a surplus of £249,000 compared with a planned surplus of £295,000 so generating an adverse variance from plan of (£46,000).

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were approximately 168 below plan. After taking into account the impact of agency staff, actual wte numbers are 77 below planned levels. This compares with a position last month of 39 below plan. Total pay expenditure for the month, inclusive of agency costs, is broadly in line with plan.

• The month-end cash balance was approximately £20m above the planned level.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	59	(46)	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	52	(85)	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	(1)	(276)	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(464)	(659)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	77	23	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	20,055	20,055	>= Plan	> = 95% of plan	< 95% of plan

Note: positive variances are favourable, negative variances unfavourable

Performance Against Key Financial Targets

Target	Year to Date Plan £000	Year to Date Actual £000
Income and Expenditure	295	249
Capital Resource Limit	19,192	2,067
External Financing Limit	---	20,055
Return on Assets Employed	3.50%	3.50%

2011/2012 Summary Income & Expenditure Performance at September 2011	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	374,267	31,369	31,752	383	187,121	187,477	356	375,267
Other Income	39,909	3,469	3,603	134	19,612	20,106	494	40,609
Operating Expenses	(390,609)	(32,939)	(33,404)	(465)	(195,558)	(196,493)	(935)	(392,384)
EBITDA	23,567	1,899	1,951	52	11,175	11,090	(85)	23,492
Interest Receivable	25	2	9	7	12	51	39	100
Depreciation & Amortisation	(13,269)	(1,106)	(1,106)	0	(6,635)	(6,635)	0	(13,269)
PDC Dividend	(5,803)	(484)	(484)	0	(2,901)	(2,901)	0	(5,803)
Interest Payable	(2,156)	(180)	(180)	0	(1,078)	(1,078)	0	(2,156)
Net Surplus/(Deficit)	**2,364**	**131**	**190**	**59**	**573**	**527**	**(46)**	**2,364**
IFRS/Impairment Related Adjustments	(557)	(46)	(46)	0	(278)	(278)	0	(557)
SURPLUS/(DEFICIT) FOR DOH TARGET	**1,807**	**85**	**144**	**59**	**295**	**249**	**(46)**	**1,807**

The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. IFRS and impairment adjustments are technical, non cash related items which are discounted when assessing performance against this target.

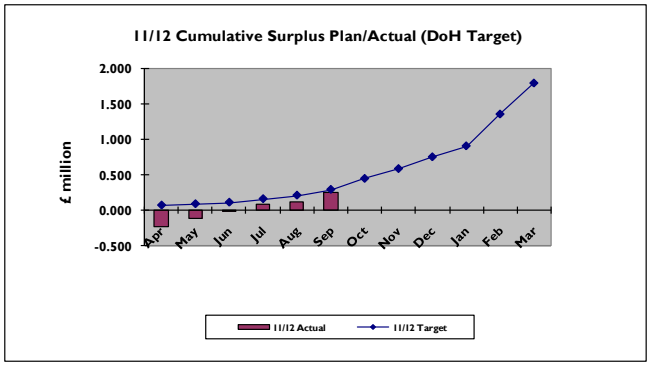
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2011

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Overall bottom-line performance delivered an actual surplus of £144,000 in September against a plan of £85,000. The resultant £59,000 favourable increases the Trust's surplus for the first 6 months to £249,000. This position is £46,000 below targeted levels.



Divisional Performance

• For September, with the exception of corporate services and reserves & miscellaneous, divisional performance has generally been broadly in line with plan or better.

• There has been a significant improvement in month against activity and income targets, particularly manifested in Surgery A although with smaller impacts across most front line divisions. However, planned activity levels for August (against which performance is assessed for the September report) were significantly lower than previous months, reflecting the normal reduction in activity, particularly elective activity, during the holiday period. Planned activity and income will rise in September and it is expected that actual activity will follow a similar pattern.

• Surgery A, Anaesthetics and Critical Care has generated a net in month surplus of £92,000 mainly as a result of actual income and activity being above plan, whereas expenditure was more closely aligned to budgeted levels. Surgery B, Womens & Children, Pathology, Facilities and Estates have all generated small in-month deficits.

• The only significant adverse in-month variance relates to corporate services and this is accounted for by the decision to non recurrently remove budgets from a number of corporate divisions to strengthen the Trust's overall financial position as part of the recovery plan. Without this adjustment, corporate divisions would have generated favourable budgetary variances.

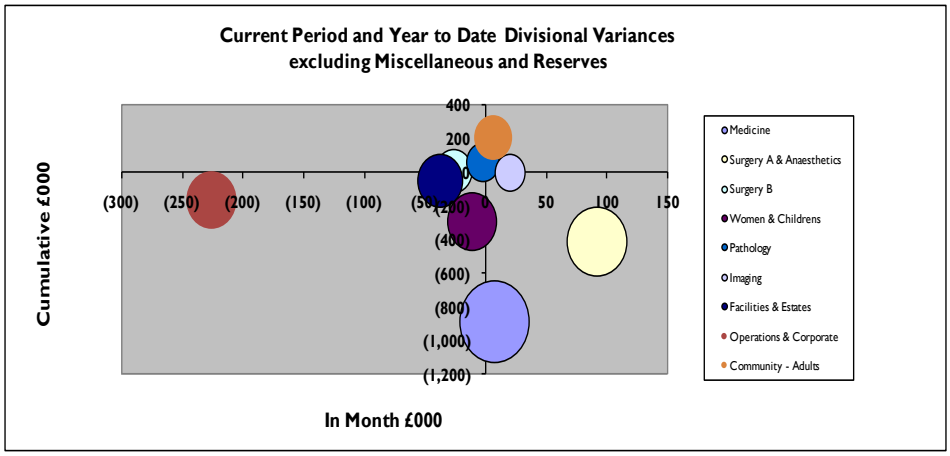
• There are some on going signs of improvement in September, particularly a further, albeit relatively small, reduction in agency spend, a reduction in bank expenditure and a general fall in wte numbers. Although pay expenditure remains in line with plan, this reflects a short term reduction in expenditure plans owing to the non recurrent reduction in corporate budgets. Without this, pay expenditure in these areas would have shown an underspend against budgeted levels.

•In spite of these improvements, concerted management of performance will need to be maintained for the remainder of the year in order to ensure that financial targets are met. Additionally, the implementation of a longer term sustainable cost reduction programme is being rapidly progressed as part of the Trust's work on its strategic efficiency programme.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

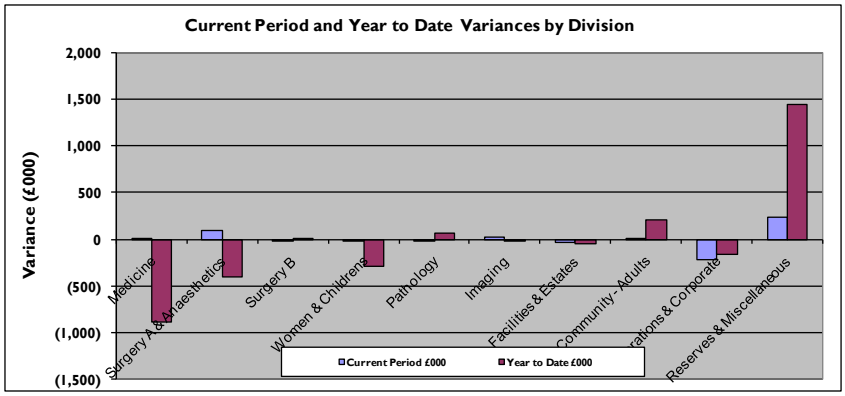
Financial Performance Report – September 2011



The tables adjacent and below show year to date adverse performance for Medicine, Surgery A and Womens & Childrens but generally with more positive in month variances (with the significant exception of corporate services).

Divisional Variances from Plan

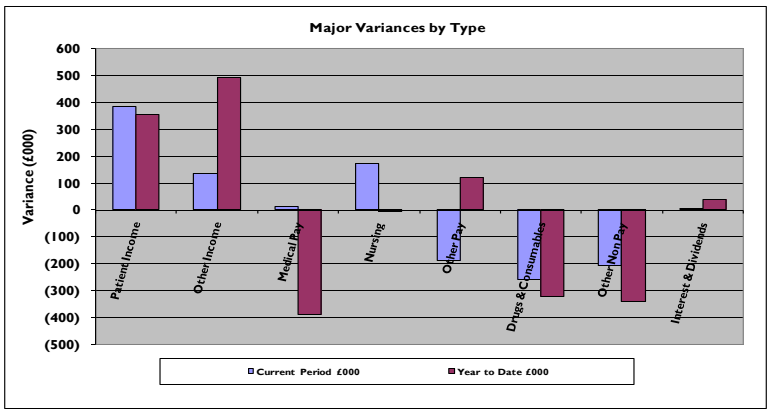
	Current Period £000	Year to Date £000
Medicine	7	(887)
Surgery A & Anaesthetics	92	(409)
Surgery B	(26)	7
Women & Childrens	(11)	(292)
Pathology	(2)	62
Imaging	20	(2)
Facilities & Estates	(38)	(47)
Community - Adults	6	206
Operations & Corporate	(226)	(163)
Reserves & Miscellaneous	230	1,442



For September, income shows a positive variance as do medical and nursing pay groups whilst other pay and key non pay areas have delivered adverse in month variances (other pay primarily being the result of the reduction in corporate budgets outlined above).

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	383	356
Other Income	134	494
Medical Pay	12	(388)
Nursing	173	(7)
Other Pay	(186)	119
Drugs & Consumables	(257)	(320)
Other Non Pay	(207)	(339)
Interest & Dividends	7	39



Sandwell and West Birmingham Hospitals NHS

NHS Trust

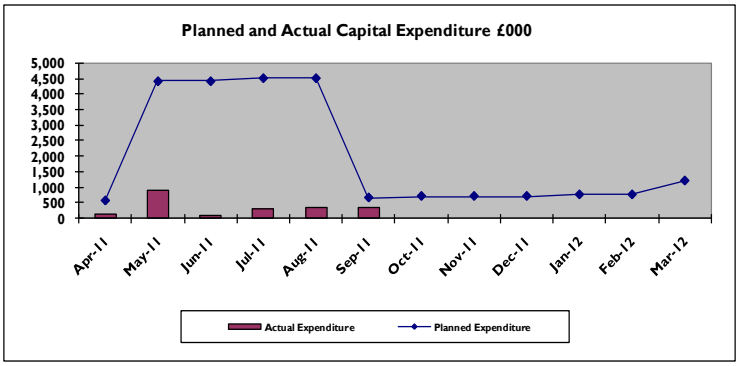
Financial Performance Report – September 2011

Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph.

• The profile (particularly the high level of planned expenditure between May and September) reflects the original expected pattern of Grove Lane land transactions. No expenditure has yet been incurred for the year to date although progress is being made on acquisitions and expenditure will then flow through to the capital programme.

• September expenditure was, similar to previous periods, at very low levels, even after taking into account the delay in land purchases.

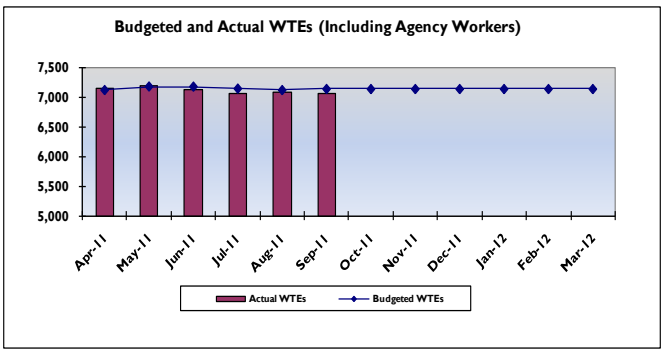


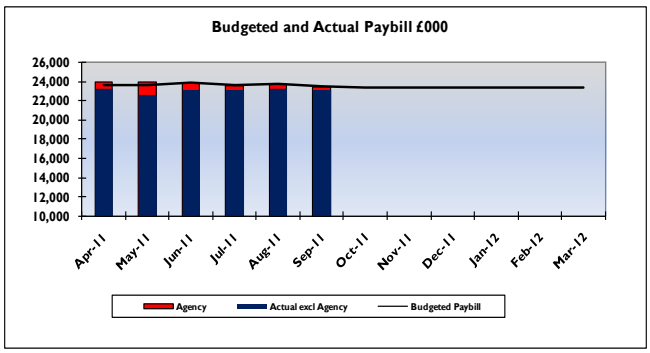
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 77 below plan for September compared with 39 below plan in August. Excluding the impact of agency staff, wte numbers are around 168 below plan. Actual wtes have fallen by approximately 20 compared with August and are 53 lower than the average for the first five months of the year.

• Total pay costs (including agency workers) are approximately in line with budgeted levels for the month with higher than planned levels of spend being incurred for management and administration and estates (driven by adjustments to corporate budgets) and scientific and therapeutic categories offset by lower than planned spend in other pay groups.

• Expenditure for agency staff in September was £459,000 compared with £490,000 in August, an average of £627,000 for the year to date and a September 2010 spend of £594,000. The biggest single group accounting for agency expenditure remains medical staffing.





Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2011

Pay Variance by Pay Group

• The table below provides an analysis of all pay costs by major staff category with actual expenditure analysed for substantive, bank and agency costs.

Analysis of Total Pay Costs by Staff Group

	Year to Date to September					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	37,992	36,326		2,054	38,380	(388)
Management	7,703	7,485		0	7,485	218
Administration & Estates	15,914	14,888	583	517	15,988	(74)
Healthcare Assistants & Support Staff	15,020	14,109	1,112	153	15,374	(354)
Nursing and Midwifery	43,574	41,298	1,608	675	43,581	(7)
Scientific, Therapeutic & Technical	22,004	21,358		363	21,721	283
Other Pay	46	0			0	46
Total Pay Costs	142,253	135,465	3,303	3,761	142,529	(276)

NOTE: Minor variations may occur as a result of roundings

Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the statutory accounts for the year ended 31st March 2011.

• Cash balances at 30th September are approximately £36.1m which is around £6.4m higher than at 31st August.

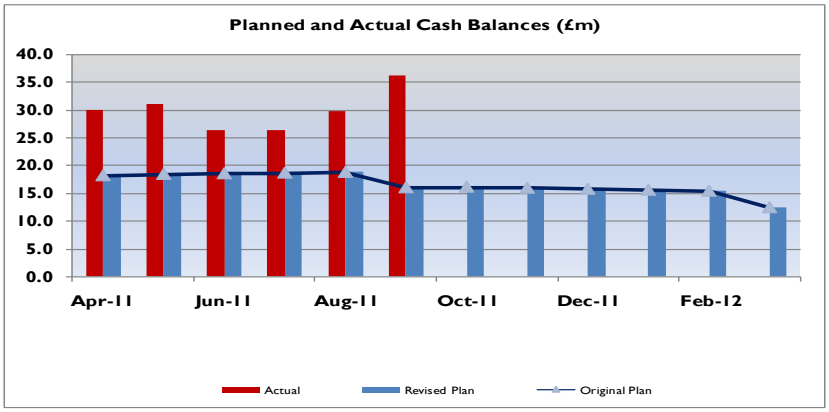
Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at 1st April 2011 £000	Balance at 30th September 2011 £000
Non Current Assets	Intangible Assets	1,077	1,027
	Tangible Assets	216,199	211,631
	Investments	0	0
	Receivables	649	650
Current Assets	Inventories	3,531	3,584
	Receivables and Accrued Income	12,652	14,131
	Investments	0	0
	Cash	20,666	36,086
Current Liabilities	Payables and Accrued Expenditure	(33,513)	(38,817)
	Loans	0	(8,000)
	Borrowings	(1,262)	(1,250)
	Provisions	(4,943)	(3,958)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	0	0
	Borrowings	(31,271)	(30,772)
	Provisions	(2,237)	(2,237)
		181,548	182,075
Financed By			
Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	36,573	36,573
	Donated Asset Reserve	2,099	2,099
	Government Grant Reserve	1,662	1,662
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(28,075)	(27,548)
		181,548	182,075

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2011



Cash Forecast

• A forecast of the expected cash position for the next 12 months is shown in the table below.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT September 2011

ACTUAL/FORECAST	Sep-11 £000s	Oct-11 £000s	Nov-11 £000s	Dec-11 £000s	Jan-12 £000s	Feb-12 £000s	Mar-12 £000s	Apr-12 £000s	May-12 £000s	Jun-12 £000s	Jul-12 £000s	Aug-12 £000s	Sep-12 £000s
Receipts													
SLAs: Sandwell PCT	**15,419**	14,729	14,729	14,729	14,729	14,729	14,729	14,434	14,434	14,434	14,434	14,434	14,434
HoB PCT	**7,315**	7,314	7,314	7,314	7,314	7,314	7,314	7,168	7,168	7,168	7,168	7,168	7,168
Associated PCTs	**6,198**	5,425	5,425	5,425	5,425	5,425	5,425	5,317	5,317	5,317	5,317	5,317	5,317
Pan Birmingham LSCG	**1,377**	1,376	1,376	1,376	1,376	1,376	1,376	1,348	1,348	1,348	1,348	1,348	1,348
Other SLAs	**462**	462	462	462	462	462	462	453	453	453	453	453	453
Over Performance Payments	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Education & Training	**1,361**	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255
Loans	**8,000**												
Other Receipts	**4,240**	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Total Receipts	**44,372**	33,061	33,061	33,061	33,061	33,061	33,061	32,475	32,475	32,475	32,475	32,475	32,475
Payments													
Payroll	**13,701**	13,500	13,500	13,500	13,250	13,250	13,250	12,985	12,985	12,985	12,985	12,985	12,985
Tax, NI and Pensions	**9,267**	9,310	9,310	9,310	9,250	9,250	14,750	9,065	9,065	9,065	9,065	9,065	9,065
Non Pay - NHS	**3,922**	1,750	1,750	1,750	1,750	1,750	1,750	1,715	1,715	1,715	1,715	1,715	1,715
Non Pay - Trade	**7,268**	7,050	7,050	5,550	7,050	6,550	8,392	8,224	7,224	7,224	7,474	7,474	7,474
Non Pay - Capital	**427**	4,750	4,750	500	750	750	3,750	500	500	500	500	500	500
PDC Dividend	**2,902**						2,928						2,900
Repayment of Loans							1,000						1,000
Interest							34						30
BTC Unitary Charge	**396**	400	400	400	400	400	800	415	415	415	415	415	415
Other Payments	**43**	200	200	200	200	200	200	200	200	200	200	200	200
Total Payments	**37,926**	36,960	36,960	31,210	32,650	32,150	46,854	33,104	32,104	32,104	32,354	32,354	36,284
Cash Brought Forward	**29,640**	36,086	32,187	28,288	30,139	30,550	31,461	17,668	17,039	17,409	17,780	17,901	18,022
Net Receipts/(Payments)	**6,446**	(3,899)	(3,899)	1,851	411	911	(13,793)	(629)	371	371	121	121	(3,809)
Cash Carried Forward	**36,086**	32,187	28,288	30,139	30,550	31,461	17,668	17,039	17,409	17,780	17,901	18,022	14,212

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

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2011

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	5.6%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	99.2%	4
Return on Assets	Surplus before dividends over average assets employed	1.7%	2
I&E Surplus Margin	I&E Surplus as % of total income	0.3%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	34.0	4
Overall Rating			**2.8**

Risk Ratings

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

• An adjustment has now been made to the liquidity ratio to reflect an uncommitted overdraft facility (which would be in place as an FT) as this more accurately reflects performance against the Monitor risk rating regime. The changes the Liquid Ratio score from 2 to 4.

• Return on Assets and I&E Surplus Margin are lower than would normally be expected due to relatively low levels of surplus being delivered.

External Focus

• Further indicators of a difficult financial position for the NHS and potential year end deficits for a number of organisations continue to emerge.

• The Department of Health's report on the first quarter of 2011/12 has identified six trusts and three PCTs which are forecasting deficits at the year end. Although the overall numbers are still small, this is a significant increase on the position reported previously by the DoH. The predicted aggregated deficit of the six trusts is £170m with a further £56m for the three PCTs. This is set against the requirement for the NHS to generate £20bn in QIPP savings over the coming years.

• Within the West Midlands, two PCTs and four trusts are reporting deficits at the end of Quarter 1 although, at this point, all organisations are forecasting a year end position of break even or better.

• The Trust's main commissioners (Sandwell Primary Care Trust and Heart of Birmingham teaching Primary Care Trust) continue to forecast achievement of their start of year plans and consequently are not reporting significant in year financial pressure.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2011

Conclusions

• The Trust generated an actual surplus of £144,000 during September bringing its financial performance for the first six months of the year to an overall surplus of £249,000, including the matched utilisation of brought forward Right Care, Right Here balances in August.

•The Trust's year to date performance against both its Department of Health control total (i.e. the bottom line budget position it must meet) and the statutory accounts target shows a deficit of (£46,000) against the planned position.

• The £144,000 surplus in September is £59,000 better than planned for the month.

• Year to date capital expenditure was £2,067,000 which remains significantly lower than plan although the bulk of the shortfall relates to the actual phasing of acquisition compared to the original plan for the Grove Lane site. However, expenditure on other capital items also remains relatively slow.

•At 30th September, cash balances are approximately £20.1m higher than the cash plan which is around £6.4m greater than the position at 31st August. This in part reflects receipt of the proceeds to ensure resources are in place associated with the Grove Lane acquisition plan.

• The monthly performance across most divisions is generally better than or marginally short of planned positions. Year to date performance reflects the adjustments made to budgets linked with the implementation of special measures in Medicine and Surgery A, Anaesthetics & Critical Care. The only significant in month deficit in September was recorded by corporate divisions although this was wholly the result of non recurrent adjustments made to budgets linked with the implementation of recovery measures across the Trust.

• Monitoring and review of the recovery measures implemented in Medicine & Emergency Care and Surgery A, Anaesthetics & Critical Care continues on a regular basis and work is well underway with the Women and Children Division as a result of sustained adverse performance in this area. The current situation will be kept under review and further action taken when and if this is deemed necessary.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report; and

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

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – September 2011.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Financial Management Board and Trust Management Board on 18 October 2011. Finance and Performance Management Committee on 20 October 2011.

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY & PERFORMANCE MONITORING REPORT - SEPTEMBER 2011

EXECUTIVE SUMMARY

Note	Comments
	A colour coded Key identifies which Indicators which comprise the NHS Performance Framework, Monitor's FT Compliance Framework and the SHA Performance Framework.
a	The overall percentage of **Cancelled Operations** increased slightly to 0.8% during September. The majority of cancellations were recorded on the City site across a number of specialties.
b	**Delayed Transfers of Care** reduced on both sites, and was 5.4% overall for the month. Census data at the end of September indicates that of the delays, 40% are attributable to Local Authorities and 60% attributable to the NHS.
c	**Stroke Care** - provisional data for the month of September indicates that the percentage of patients who spent at least 90% of their hospital stay on a Stroke Unit remained above 80% and is 82.6% for the year to date. **TIA** outpatient performance (the percentage of High Risk patients who were treated within 24 hours from initial presentation to the medical profession) improved to 55.6% during the month. Provisional data indicates the proportion of Emergency Stroke Admissions receiving a scan within 24 hours fell slightly within month, year to date performance remains greater than 90%.
d	**Accident & Emergency Clinical Quality Indicators** - performance against the 5 Headline Clinical Quality Indicators is indicated. For the purpose of performance monitoring the indicators are grouped into two groups, timeliness and patient impact. Organisations will be regarded as achieving the required minimum level of performance where robust data shows they have achieved the thresholds for at least one indicator in each of the two groups, which for the month has been achieved. Year to date performance is aggregated from the months of August and September, which with October's performance is to be used by the Department of Health to assess Q3 performance. A/E 4-hour wait performance for the month was 95.00% (95.45% year to date).
e	There were 8 cases of **C Diff** reported across the Trust during the month of September, 4 on each acute site. Numbers remain within the trajectory for the month and the year to date. There remain no cases of **MRSA Bacteraemia** reported for the year to date. Data for MSSA Bacteraemia and E Coli Bacteraemia is also included in the report.
f	There were 0 Breaches of **Same Sex Accommodation** reported during the month of September.
g	In excess of 3200 staff have received a PDR for the 6-month period to date, this is equivalent to a rate of 79%. Overall **Mandatory Training** compliance at the end of September decreased slightly to 81.4%.
h	**CQUIN -** The range of schemes agreed with commissioners and their financial values are included within the report.
	VTE (Venous Thromboembolism) Risk Assessment - this CQUIN continues from 2010 / 2011. Performance in excess of the 90% threshold has been achieved for each month year to date.
	Patient Experience Acute Services (Personal Needs) - this CQUIN also continues from 2010 / 2011. Composite of response to 5 inpatient survey questions. Goal to improve responsiveness to personal needs of patients. Survey to be conducted between October and January, for patients who had an inpatient episode between July and August. Target is an improvement (increase) of 2 percentage points on 2010 / 11 baseline.
	Smoking Cessation (training) Acute Services - the target is to train 90% of frontline staff in key specialties (Oral Surgery, Gastroenterology, MAU, Respiratory Medicine, A/E, Cardiology and pre-op assessment to identify smoking and provide brief advice. Training was scheduled to commence mid September. Approximately 500 frontline staff have been identified to require training.
	Smoking Cessation (delivery) Acute Services - a target of 2000 referrals to the smoking cessation service within the year. The current trajectory (1000) is being met with 1086 referrals for the 6 months year to date.
	End Of Life Care (Acute Services) - The Acute and Community schemes are harmonised to deliver an Increase (by 10% on baseline (56%)) in people on a supportive care pathway dying in the place of their choice by Quarter 4. Performance for the most recent month (July) for which data is available is 100%.
	Medicines Management (Missed Doses) - Decrease (by 10% on Q1 baseline) in avoidable medicines omissions. Baseline (Quarter 1) established at 59% with reduction to 53.1% required by March 2012. Performance during July was 67.9%.
	Nutritional Assessment - target is for 75% adults reported as having had a nutritional assessment within 12 hours of admission (not in assessment units) using a validated tool (e.g. MUST). Data for August indicates 90.6% patients assessed.
	Enhanced Recovery - the implementation of an enhanced recovery model for 4 specified procedures in 4 surgical specialties. Specific details of this scheme are currently being finalised.
	Stroke Discharge - 90% of patients discharged meet 5 set criteria such as discharge information, clinical contact within 48 hours and community contact details. A process to capture and report data is being set up. a project plan is in place with a trajectory to deliver this target by January 2012.
	Mortality Review - target to review 60% of all qualifying (adult) deaths within hospital during March 2012. During the month of August 45.2% of deaths were reviewed compared with a target for the month of 35%, with a straight line trajectory to the final target of 60%.
	Alcohol Screening - 80% (throughout Q4) of patients (aged 16+) within agreed groups (Emergency Department, EAU, MAU and Gastroenterology OP to have an alcohol assessment and be offered advice. Nursing staff and junior doctors are currently receiving training in alcohol awareness and screening. It is anticipated that systems will be in place for Quarter 3, in advance of the Quarter 4 period of assessment.

Comments

h

Patient Experience Community Services (Personal Needs) - comprises composite of response to 6 national patient survey questions of patients receiving care at home by the district nursing service. Composite score of 69 required.

End Of Life Care (Community Services) - The Acute and Community schemes are harmonised to deliver an Increase (by 10% on Q1 baseline) in people on a supportive care pathway dying in the place of their choice by Quarter 4. Baseline identified as 26.73%, target is 36.73%. Performance for the month of August was 25.6%.

Health Visiting - Children on the Health Visitor Case List who have had a full developmental review at 2 years and 6 months. Target 70% during Q4. Performance during August increased to 56.2%.

Falls Assessment - Increase (by 30% on baseline of 25% (determined by manual audit)) in the percentage of patients on the district nursing caseload who have a falls assessment. Performance during the month of August further improved 40.1% (trajectory 40%).

Smoking Cessation (training) Community Services - the target is to train 80% of frontline staff (by end Quarter 2) in District Nursing, Diabetes, Community Heart Failure and Chiropody services. 98.3% of staff are reported to have received training to date.

Smoking Cessation (delivery) Community Services - a target of 90% smokers seen by agreed services (Musculo-Skeletal, Diabetes, Heart Failure and COS) will have received an offer of brief intervention and onward referral to cessation services. 83.9% of patients were referred during the month of August.

Access to Chemotherapy Out of Hospital is aimed at increasing the volume of chemotherapy / anti-cancer drug deliveries made either at the patient's home or in a community setting closer to the patient's home. The targets are to increase the number of patients in receipt of Herceptin at Home by 15 during 2011 / 2012, and to provide a total of 500 (non-Herceptin) deliveries (drugs, not patients) by year end. Most recent data (April - September) 11 additional patients have received Herceptin at Home (trajectory 6), but only 31 non-Herceptin home deliveries have been made, compared with a trajectory for the period of 40.

Improving Access to Organs for Transplant comprises 5 separate measures (each with a specific target) which relate to improving the availability of organs for transplant based upon the recommendations of the Organs for Donation Task Force. The Trust will collect and collate data in conjunction with the NHS Blood and Transplant special health authority. Data has been captured internally for the 6 months year to date. The Trust met each of the measures for each month.

Screening for Retinopathy of Prematurity. A target of 90% has been set for babies born during the 5 month period September 2011 - January 2012 inclusive. Provisional data for August indicates a screening rate of 80%.

Auditing Neonatal Pathways requires the Trust to complete a audit template designed to identify where, why and how often transfers occur which fall outside the agreed newborn network pathways. The audit has been completed for each of the 6months year to date.

i

Quality and Efficiency Programme - performance relative to a number of QuEP schemes is included in the report. The majority of indicators which comprise the various schemes have identified performance targets, trajectories and thresholds identified. Some of the indicators feature elsewhere in the report, but are also included in this section for completeness.

j

Detailed analysis of **Financial Performance** is contained within a separate paper to this meeting.

k

For the period April - August inclusive overall referrals are approximately 6800 (8.6%) fewer and GP Referrals are approximately 4300 (8.0%) fewer than the corresponding period last year.

Overall Referrals from Sandwell, HOB and Other (non-Sandwell / HOB) PCTs are approximately 3000 (7.6%), 1250 (5.8%) and 2500 (14.0%) less respectively for the five months year to date than for the same period last year.

l

Activity (trust-wide) to date is compared with the contracted activity plan for **2011 / 2012** - Month and Year to Date.

	Month			
	Actual	Plan	Variance	%
IP Elective	889	1069	-180	-16.8
Day case	4474	4221	253	6.0
IPE plus DC	5363	5290	73	1.4
IP Non-Elective	4420	4995	-575	-11.5
OP New	13439	13271	168	1.3
OP Review	35261	34582	679	2.0
OP Review:New	2.62	2.61	0.01	0.4
AE Type I	14057	14378	-321	-2.2
AE Type II	3074	2855	219	7.7

Year to Date			
Actual	Plan	Variance	%
5425	5887	-462	-7.8
26562	23239	3323	14.3
31987	29126	2861	9.8
26837	29734	-2897	-9.7
79418	73062	6356	8.7
209649	190392	19257	10.1
2.64	2.61	0.03	1.1
88892	92054	-3162	-3.4
19170	18278	892	4.9

Activity to date is compared with **2010 / 11** for the corresponding period

	2010 / 11	2011 / 12	Variance	%
IP Elective	5940	5425	-515	-8.7
Day case	27011	26562	-449	-1.7
IPE plus DC	32951	31987	-964	-2.9
IP Non-Elective	30669	26837	-3832	-12.5
OP New	82097	79418	-2679	-3.3
OP Review	223302	209649	-13653	-6.1
OP Review:New	2.72	2.64	-0.08	-2.9
AE Type I	93548	88892	-4656	-5.0
AE Type II	18832	19170	338	1.8

Overall Elective activity for the month and year to date continues to be in excess of the plans for the respective periods, by 1.4% and 9.8% respectively. Non elective activity is 11.5% less than plan for the month and 9.7% less than plan for the first 6 months of the year. Outpatient New and Review activity continues to exceed the plan for the year to date by 8.7% and 10.1% respectively. The Follow Up to New Outpatient Ratio improved (reduced) during the month to 2.62. Activity across all categories reported is less than that delivered during the corresponding period last year (as indicated) with the exception of Type II (BMEC) A&E attendances.

m

Ambulance Turnaround - the proportion of ambulances waiting greater than 30 minutes increased to 40% during the month (West Midlands average 34.1%). There were also 177 instances recorded of ambulances with a turnaround time in excess of 60 mins.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary performance assessed against the NHS FT Governance Risk Rating (FT Compliance Report)
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning & Performance Management and Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

The report provides an assessment of the Trust's performance mapped against the indicators which comprise the NHS Performance Framework.

Service Performance (September and Quarter 2):

There is 1 area of underperformance during the month of September and Quarter 2 (aggregated data), Delayed Transfers of Care. For both periods this attracts a score of 2.79 with the Trust classified as Performing.

Performance against the A&E Clinical Indicator 'Time to Initial Assessment 95th Percentile' during both month and quarter did not meet the indicator threshold of equal to or less than 15 minutes, nor did performance against the 'Left Department Without Being Seen' meet the threshold of =<5.00% during September, but in each case the other indicator within the Timeliness or Patient Impact grouping respectively, did meet the indicator threshold, thus satisfying the requirement for at least 1 indicator in each of the 2 groups to be met in order to attract the maximum score of 3 for each.

(Formal assessment of A&E Clinical Indicator performance for Quarter 2 will be based upon the performance during July, with Quarter 3 performance based upon the aggregate of August, September and October)

Financial Performance (September) - The weighted overall score remains 2.90 and is classified as Performing. Underperformance is indicated September in 3 areas; Better Payment Practice Code (Value), Better Payment Practice Code (Volume) and Creditor Days.

Foundation Trust Compliance Summary report:

There were no areas of underperformance reported within the framework during the month of September or during Quarter 2 (aggregated data). As such the overall score for the month and quarter is 0.0, with a GREEN Governance Rating.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 18 October 2011. Finance and Performance Management Committee on 20 October 2011.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2011/12

Operational Standards and Targets

Indicator		Weight	Thresholds		July 2011	Score	Weight x Score	August 2011	Score	Weight x Score	September 2011	Score	Weight x Score	Quarter 2 2011	Score	Weight x Score
			Performing	Underperforming												
A/E Waits less than 4-hours		1.00	95.00%	94.00%	96.80%	3	3.00	94.40%	2	2.00	95.00%	3	3.00	95.02%	3	3.00
A/E Unplanned re-attendance rate	{Patient Impact Group}	2.00	=<5.00%	>5.00%	1.70%	3	6.00	2.14%	3	6.00	2.60%	3	6.00	2.14%	3	6.00
A/E Left Department without being seen rate			=<5.00%	>5.00%	4.58%			4.52%			5.08%			4.70%		
A/E Time to Initial Assessment - 95th centile	{Timeliness Group}		=<15mins	>15mins	23.00			25.00			22.00			23.00		
A/E Time to treatment in department (median)			=<60mins	>60mins	60.00			55.00			54.00			56.00		
Cancelled Operations - 28 day breaches		1.00	5.0%	15.0%	0%	3	3.00	0%	3	3.00	0%	3	3.00	0%	3	3.00
MRSA Bacteraemia		1.00	0	>1.0SD	0	3	3.00	0	3	3.00	0	3	3.00	0	3	3.00
Clostridium Difficile		1.00	0	>1.0SD	4	3	3.00	7	3	3.00	8	3	3.00	19	3	3.00
18-weeks RTT Admitted 95 Percentile(weeks)		0.50	<=23.0	>27.7	18	3	1.50	19	3	1.50	<=23.0*	3	1.50	<=23.0*	3	1.50
18-weeks RTT Non Admitted 95 Percentile(weeks)		0.50	<=18.3	>18.3	13	3	1.50	14	3	1.50	<=18.3*	3	1.50	<=18.3*	3	1.50
18-weeks RTT Incomplete Pathway 95 percentile (weeks)		0.50	<=28.0	>36.0	16	3	1.50	16	3	1.50	<=28.0*	3	1.50	<=28.0*	3	1.50
18-weeks RTT 90% Admitted		0.75	=>90.0%	85.0%	95.1%	3	2.25	94.6%	3	2.25	=>90.0%*	3	2.25	=>90.0%*	3	2.25
18-weeks RTT 95% Non -Admitted		0.75	=>95.0%	90.0%	98.9%	3	2.25	97.5%	3	2.25	=>95.0%*	3	2.25	=>95.0%*	3	2.25
Cancer - 2 week GP Referral to 1st OP Appointment		0.50	93.0%	88.0%	93.2%	3	1.50	94.9%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms		0.50	93.0%	88.0%	96.9%	3	1.50	94.9%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers		0.25	96.0%	91.0%	98.8%	3	0.75	98.9%	3	0.75	>96.0%*	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)		0.25	94.0%	89.0%	98.0%	3	0.75	98.1%	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)		0.25	98.0%	93.0%	100.0%	3	0.75	100.0%	3	0.75	>98.0%*	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)		0.25	94.0%	89.0%	100.0%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers		0.50	85.0%	80.0%	86.5%	3	1.50	87.9%	3	1.50	>85.0%*	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening		0.50	90.0%	85.0%	100.0%	3	1.50	100.0%	3	1.50	>90.0%*	3	1.50	>90.0%*	3	1.50
Stroke (Stay on Stroke Unit)		1.00	80.0%	60.0%	82.93%	3	3.00	90.00%	3	3.00	86.10%	3	3.00	86.70%	3	3.00
Delayed Transfers of Care		1.00	3.5%	5.0%	8.30%	0	0.00	7.80%	0	0.00	5.40%	0	0.00	7.20%	0	0.00
Sum		**14.00**														
Average Score							**2.79**			**2.71**	* projected		**2.79**	* projected		**2.79**

Scoring:	
Underperforming	0
Performance Under Review	2
Performing	3

Assessment Thresholds	
Underperforming if less than	2.1
Performance Under Review if between	2.1 and 2.4
Performing if greater than	2.4

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2011/12

Financial Indicators

Criteria	Metric	Weight (%)		SCORING 3	SCORING 2	SCORING 1	2011 / 2012 July	Score	Weight x Score	2011 / 2012 August	Score	Weight x Score	2011 / 2012 September	Score	Weight x Score
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	0.00%	3	0.15	0.00%	3	0.15	0.00%	3	0.15
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	0.02%	3	0.6	0.06%	3	0.6	0.06%	3	0.6
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	5.30%	3	0.15	5.38%	3	0.15	5.34%	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
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	5.70%	3	0.15	5.70%	3	0.15	5.65%	3	0.15
	Rate of Change in Forecast Surplus o 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
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	0.44%	3	0.15	0.44%	3	0.15	0.43%	3	0.15
	EBITDA Margin (%)		5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	5.70%	3	0.15	5.70%	3	0.15	5.65%	3	0.15
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	82.00%	2	0.05	84.00%	2	0.05	77.00%	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	86.00%	2	0.05	85.00%	2	0.05	83.00%	2	0.05
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	1.00	3	0.15	1.02	3	0.15	1.22	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	15.30	3	0.15	14.50	3	0.15	12.97	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	38.84	2	0.1	40.55	2	0.1	34.25	2	0.1
						Weighted Overall Score			2.90			2.90			2.90

*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:	Corporate Objectives 2011/12 – Progress Report (Quarter 2)
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy and OD
AUTHOR:	Ann Charlesworth – Head of Corporate Planning
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

The report contains a summary of progress at the end of Quarter 2, towards the achievement of the Trust's Corporate Objectives set out in the Annual Plan 2011/12.

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	Outlines progress towards those objectives
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Trust Management Board on 18 October 2011.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ANNUAL PLAN 2011/12
CORPORATE OBJECTIVES PROGRESS REPORT (QUARTER TWO)

INTRODUCTION

The Trust's Annual Plan for 2011/12 set a series of corporate objectives for the year to ensure that we make progress towards our six strategic objectives. Progress on the majority of these objectives is reported to the Board at regular intervals either through routine monthly reports on finance and performance or through specific progress reports. Progress across all objectives is also reported quarterly to ensure the Board has a clear overview of our position.

QUARTER TWO PROGRESS

A summary of the position on each objective at the end of Quarter 2 is set out in the table that accompanies this report. An overview of the Q2 RAG assessment for each objective is set out in the table below.

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
1. Accessible and Responsive Care				
1.1 Identify & implement specific ways to improve health of popn.				
1.2 Close & effective relationship with GP consortia, PCT clusters & Local Authorities				
1.3 Deliver access performance measures				
1.4 Continue to improve outpatient booking systems				
1.5 Improve patient flow from admission through discharge to home				
2. High Quality Care				
2.1 Improve reported levels of patient satisfaction				
2.2 Continue to embed Customer Care promises				
2.3 Improve the care we provide to vulnerable adults				
2.4 Make improvements in A&E services				
2.5 Make improvements in Trauma & Orthopaedic services				
2.6 Make improvements in Stroke services				
2.7 Embed the Quality & Safety Strategy				
2.8 Reporting and learning from incidents				
2.9 Deliver the CQUIN targets				
3. Care Closer to Home				
3.1 Successful integration of adult & children's community services				
3.2 Deliver changes in activity as part of RCRH programme				
3.3 Actively promote healthy lifestyles and health education				
3.4 Develop local response to national plans for Health Visiting				
3.5 Make fuller use of Rowley Regis Community Hospital				

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
4. Good Use of Resources				
4.1 Deliver £21.1m CIP & plans for £20m CIP for further 3 years				
4.2 Achieve a £2m surplus				
4.3 Reduce premium rate working				
4.4 Develop plans to improve service line position of the Trust				
5. 21st Century Facilities				
5.1 Begin to procure a new hospital				
5.2 Continue to improve current facilities				
5.3 Develop detailed plans for development of community estate				
6. An Effective NHS Organisation				
6.1 Make significant progress towards becoming a Foundation Trust				
6.2 Organisational Development activities – stronger voice for staff				
6.3 Clinical systems & processes – safe, error free care				
6.4 Improve staff satisfaction, health and well being				
6.5 Agree IT strategy inc. route to procurement of EPR				
6.6 Continue approach to sustainability, transport and access				
6.7 Develop resourced Training Plan to support workforce plan				

At the end of quarter two, 14 of our 33 objectives are now assessed as green. The two objectives identified at the end of quarter one as red (3.2 Deliver Changes as part of RCRH Programme and 5.1 Begin to Procure a New Hospital), remain the same at the end of quarter two. The remaining 17 objectives have been identified as amber.

Three objectives have been changed from green to amber:

- Objective 3.3 - delays identified in relation to promoting healthy lifestyles and health education.
- Objective 6.1 - timetable delay to Foundation Trust status as a result of the OBC delay.
- Objective 6.5 - IT strategy is delayed pending completion of an IM&T review.

CONCLUSION AND RECOMMENDATIONS

This report and the accompanying table present an overview of the position on our corporate objectives for 2011/12 at the end of Quarter 2. The Trust Board is recommended to:

- NOTE the progress made on the corporate objectives at Q2.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
TRUST OBJECTIVES 2011/12: QUARTER TWO PROGRESS REPORT

PROGRESS REPORTING

Progress with many of the corporate objectives will be reported to the Board monthly through for example the monthly performance and finance reports (e.g. progress with 2011/12 financial plan and progress with national access targets) or through specific monthly reports (e.g. 'Right Care Right Here' programme reports). In addition to this and in order to ensure that the Board has a clear view of progress across the corporate objectives as a whole it is intended to report progress quarterly, as we have in previous years, using a traffic-light based system at the following Board meetings:

- Q1 position reported to July Board meeting;
- Q2 position reported to October Board meeting;
- Q3 position reported to January Board meeting;
- Q4 position reported to April Board meeting.

CATEGORISATION

Progress with the actions in the plan has been assessed on the scale set out in the table below.

Status	
3	Progressing as planned or completed
2	Some delay but expect to be completed as planned
1	Significant delay – unlikely to be completed as planned

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
1.	***Accessible and Responsive Care***				
1.1	**Identify and implement specific ways of improving the health of the population we serve.** **DO'D**	• Catalogue of relevant indicators drawn from primary care but mapped to each directorate • Discussions with Directors of Public Health to establish priorities • Identify data sources and create data flow for each indicator • Incorporate indicators into SWBH QMF dashboards for each directorate or specialty • Incorporate indicators into a Clinical Quality dashboard for RCRH		• Some indicators identified. Mapping process due for August • Q2 Dashboard development delayed due to competing priorities • Process agreed for defining and assuring data quality in QMF	**2**
1.2	**Ensure close and effective relationships with local GP consortia, PCT Clusters and Local Authorities.** **MS (with DO'D)**	• Deliver on medical engagement LIA action plan. • Identify leaders and opinion formers in each consortium and continue active engagement. • Promote and improve direct contacts between directorates and primary care clinicians. • Trust represented by Executive or senior Medical leads at all Cluster meetings for Birmingham and Solihull and the Black Country. • Integrate work of Business Development Team with representatives from each Division.	Consortia emerging, regular contact established but lack of systematic approach involving clinical divisions	• Continuing uncertainty about future form and federating relationships with Commissioning groups has led to delay in setting up formal engagement structures • First joint meeting between BD and Divisions arranged to discuss GP relationships • Senior input to cluster meetings achieved • October GP engagement meeting cancelled	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
		• Improve flow of information and communication between hospital doctors and GPs.			
1.3	**Deliver Access performance measures including those set out in the Operating Framework for 2011/12.** **RB**	• New A&E standards.	Not available Not available Not available Not available Not available 96.99%	A/E Clinical Quality Indicators: - Total time (hrs:mins) in Dep't (95th centile) Actual 4:02 (Sept 2011) (Target <4:00) - Time (mins) to Initial Assessment (95th centile). Actual 23 mins (Sept 2011)(Target =<15) - Time (mins) to Treatment in Dep't (median) Actual 56 mins (Sept 2011)(Target =<60) - Unplanned reattendance rate (%) Actual 2.14% (Q2)(Target =<5.0) - Left Dep't without being seen rate (%) Actual 4.70% (Q2)(Target =<5.0) A/E 4-hour waits - 95.02% (Q2)(Target =>95.00) Rapid Improvement Event scheduled October to inform transformation programme for Urgent Care going forward.	**2**
		• 18 weeks referral to treatment standard maintained (95th percentile).	20 weeks (March 2011) 16 weeks (March 2011)	18 weeks RTT Standards: - Admitted Care (weeks) (95th centile) Actual 19 weeks (Aug 2011)(Target =<23) - Non-Admitted (weeks)(95th centile) Actual 14 weeks (Aug 2011)(Target =<18.3)	
		• Cancer waiting times (2 wks, 31 days & 62 days) standards maintained.	94.5%	Cancer Waiting Times: - 2 weeks all cancers (%) Actual 93.9% (June/Aug 2011)(Target =>93)	

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
		     • GUM 48 hr access standard maintained. • Rapid access chest pain standard (2 wk) maintained.	94.7% 99.7% 88.0% 100% 100%	- 2 weeks Breast Symptomatic (%) Actual 96.6% (June/Aug 2011)(Target =>93) - 31 days diagnosis to treatment (%) Actual 98.9% (June/Aug 2011)(Target =>96) - 62 days urgent GP referral to treatment (%) Actual 86.7% (June/Aug 2011)(Target =>85) GUM 48 hour access: - Patients Offered App't within 48 hours (%) Actual 100% (Q2) (Target =>98%) Rapid Access Chest Pain: - Patients seen <14 days following urgent GP referral Actual 100% (July/Aug) (Target =>98%)	
1.4	**Continue to improve outpatient booking systems.** **RB**	• Hospital short notice cancellations reduced so that less than 20% of total are short notice. • DNA rate reduced to less than 10%. • Hospital initiated cancellations reduced to less than 15% of appts made in month.	(35% in Feb) (12% in Feb) (16% in Feb)	- Short notice cancellations actual 37.9% (Sept 2011) - DNA Rate New OP appointments actual 13.2% (Sept 2011) - DNA Rate Review OP appointments actual 11.4% (Sept 2011) - Hospital initiated cancellations actual 14.0% (Sept 2011)	**2**
1.5	**Improve patient flow from admission through discharge to home care / after care.** **RB**	• Acute delayed discharges reduced to less than 4% of acute beds. • Average hospital length of stay maintained at less than 4.5 days. • Numbers of very long stay patients (>28 days) reduced to 150 or less.	(5% in Feb) (4.4 in Feb) (187 in Feb)	- Acute delayed discharges actual 7.2% (Q2) Multiagency work stream in train to improve performance. - Average length of stay actual 4.3 days (June/Aug 2011) - Long Stay Patients >28 days actual 142 (Sept 2011)	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
		• Reduced readmissions within 30 days.	(8.0% following initial Elective or Non Elective Admission)	- Readmission Rate actual 6.7% (Q2 2011) Rapid Improvement Event scheduled for October to inform high impact change programme to support patient flow.	
2.	***High Quality Care***				
2.1	**Improve reported levels of patient satisfaction.** **RO (with all Execs)**	• Establish systems to seek patient/carer/user views that ensure all groups are represented. • Establish reporting and feedback systems of patient views at the Trust, Division, Directorate and Department level. • To ensure action plans exist and are delivered against areas of dissatisfaction/requiring improvement. • To have a list of priority patient experience improvement themes/topics and corporately plan and deliver the action. • Ensure external views are fed into internal feedback systems. • To deliver CQUIN target for patient experience improvement. • To measure behaviours against Trust Promises. • To develop an approach to 'customer care' training.		• Numbers of patient survey responses have now increased significantly. • Quarterly reports to divisions, directorates and wards. • Priority actions identified and being progressed. • Reports requested based on: - ethnicity - age - gender Next print run to include Consultant name.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
2.2	**Continue to embed Customer Care promises.** **JK**	• Refresh the customer care promise action plan in line with the feedback from Hot Topics. • Regular analysis of patient survey results and complaints by customer care promises. • Revised recruitment, induction and appraisal processes focusing on customer care.		Customer care promise action plan has been refreshed with feedback from hot topics and following the establishment of a new sponsor group. Progress has been made with a revised induction programme, greater publicity of the promises both externally and internally through use of IT and there is evidence that the promises are being embedded more widely across the organisation.	**3**
2.3	**Improve the care we provide to vulnerable adults.** **RO**	• Ensure systems and processes for vulnerable adults are embedded in all clinical areas – including Deprivation of Liberty, Safeguarding, and Mental Health. • Deliver level 1 and 2 training targets. • Relevant policies are in place. • Delivery of targets set within dementia action plan. • Establishment of domestic violence training. • Achievement of standards/rules of the Mental Health Act. • CQC and NHSLA standards met. • Nutrition CQUIN achieved. • Falls and pressure damage targets achieved.		WMQRS visit – report pending but feedback positive. Task and Finish Group for Nutrition, Privacy and Dignity working well. Action plans shared with the Trust Board. Pressure damage/falls continue to reduce in number and severity. Nutrition audits improving.	**3**
2.4	**Make improvements in A&E services.** **JA**	• Build on the work from 2010/11 in respect of integration. • Ensure that newly developed systems become embedded and continue to support safer and	Baseline to be established at EDAT from evaluation new national	EDAT meeting monthly. Consultant recruitment complete but middle grade vulnerable. Rapid Improvement Event held to feed into Development Plan – to be presented to EDAT	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
		more responsive care. • Ensure that the agreed financial investments lead to the successful recruitment of high quality Clinical staff (Medical and Nursing). • Implement systems to monitor and manage performance in respect of the new ED quality standards.	quality standards (not previously monitored)	21/10. Key incident trends improved but erratic compliance with pro-formas – under review	
2.5	**Make improvements in Trauma and Orthopaedic services.** **RB**	• 18 week waiting time standard achieved for orthopaedics (c. 70% in 18 weeks in Feb). • Workforce plan agreed and delivered for T&O wards. • Improved service line position for T&O. • Improved outpatient performance (reduced cancellations, short notice cancellations and review rates).	74.4% (March 2011)	- 18 week Admitted RTT 80.4% (Aug 2011) Discussions with Medical Director regarding plans for T&O have been held - specialty currently developing measures to improve efficiency and throughput as well as implementing decommissioning measures.	**2**
2.6	**Make improvements in Stroke services.** **DO'D**	• Stroke dashboard fully populated and incorporated into the Quality Management Framework. • Ensure that performance remains in the top Quartile nationally. • Continued improvements in KPIs for Stroke and TIA pathways. • Ensure robust management structure for stroke services including clarity on reporting lines and accountability. • Develop an option appraisal in partnership with commissioners		• Stroke dashboard continues to evolve. • Trajectories agreed for delivery of performance to attract best practice tariff. • Business case approved by SIRG being implemented • Additional Stroke Consultant appointed 10/10/11, to start in January 2012. Post covered by locum in the interim. • Weekend ward rounds covering Stroke and TIA across sites commenced 8/10/11 with imaging slots for high risk TIA delivered. • Work on high risk TIA pathway continues. • Progress continues on option appraisal for	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
		to ensure optimal configuration of Acute and rehabilitation components of stroke/TIA services and pathways.		reconfiguration.	
2.7	**Embed the Quality and Safety Strategy incorporating the FT Quality Governance Framework.** **KD**	• Achieve the plan developed to ensure effective implementation of the Quality and Safety Strategy. • Positive outcomes to support the Trust's top 3 quality related priorities.		• Quality and safety improvement framework determined, including the key enablers and drivers. • Directorate quality goals identified at the Consultant Conference; these are now being finalised.	**3**
2.8	**Improve and heighten awareness of the need to report and learn from incidents.** **KD (with all Execs)**	• Annual rate of incident reporting increased at least 10% on previous year. • Improved position with the NRLS report as benchmarked against similar size Trusts. • Reduced number of incidents that cause harm, of a similar nature and / or within the same environment / location.	Q1 – 2242 Q2 – 2630 Q3 – 2512 Q4 – 2430 Total - 9814	• Data to the end of Q2, including those incidents not yet merged onto the live system show 6772, an increase of nearly 2000. • Electronic incident reporting rollout is almost complete and has not shown the expected dip in reporting. Training is being delivered monthly to any staff showing how to report electronically and also highlighting types of incidents to be reported. • Data for Oct 10-Mar 11 from NRLS shows a move to the middle 50% of Trusts compared to the same period in the previous year.	**3**
2.9	**Deliver the CQUIN targets** **RO/DO'D/RB**	• VTE prevention • Improve patient experience • Alcohol prevention • Smoking cessation	92.3% (Q4) 2041 referrals to smoking cessation	• VTE prevention remained on track through Q1 & Q2 (>90% for each month in Q2 (Target =>90%) • Alcohol interventions still being developed • Smoking cessation interventions still being developed (655 referrals to smoking cessation service in Q2 (Target 500)	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
		• Nutrition assessment on admission • End of life care – choice of place to die • Enhanced recovery Stroke discharge • Medicines management – missed doses • Health Visiting response times • Falls assessment	End of Life Care (Acute) 56% (Q4) Falls assessment (Community) 25% (Q4)	• 100% (most recent data end July 2011) • Baseline complete. Audit data shows improvement. • HV assessment on target. • Falls assessment Community – on target 40.1% (August 2011)	
3.	***Care Closer to Home***				
3.1	**Ensure a successful integration of adult and children's community services that has benefits for patients.** **RB (with RO)**	• Transfer successfully completed in April. • Agreed benefits realisation plan in place by end Q1. • Integration / benefits realisation delivered as planned.		Recent reviews suggest greater scope for benefits realisation than initially envisaged – revised plan to be developed.	**2**
3.2	**Deliver the agreed changes in activity required as part of the Right Care Right Here programme.** **RB**	• Decommissioning plan agreed with commissioners (value = £16m). • Plan successfully delivered by end of the year.		Decommissioning plan developed by SWBHT currently identifies 85% of the total value to be decommissioned (FYE). Validation of part year effect for 2011/12 to be completed. Actions have been agreed with PCTs regarding implementation of some of the schemes, while plans and timetables for delivery are being worked up with the Divisions.	**1**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
3.3	**Play a key role in the local community, actively promoting healthy lifestyles and health education.** **JK**	• Development and approval of health promotion strategy. • Delivery of health promotion / education LiA and resulting action plan, involving all key stakeholders. • Launch of involvement website to promote healthy lifestyles. • Lead the development of a RCRH health promotion and education strategy. • Participate in joint venture tender for lifestyle services.	No baseline for 2010/11	• Development of the strategy and launch of the engage website are taking longer than anticipated. However, in the case of the engage website, this is due to increased interest in involvement from community and other staff and a decision to upgrade the site content prior to launch. • The RCRH health promotion and education strategy has been put on hold as the communications and engagement strategy for RCRH is being reviewed by the Birmingham and Solihull Cluster communications lead following awarding of the communications and engagement contract to the cluster.	**2**
3.4	**Develop a local response to national plans for Health Visiting.** **RO**	• Implementation plan supported by PCT/SHA. • Clear recruitment plans. • Increase University commissions. • Review of team skill mix. • Retention plan in place. • New models of care developed, including family partnerships.		Implementation plan produced. Briefing paper produced for Trust Committees. SIRG paper and workforce plan produced. Increase commissions done. Pending funding agreements from Commissioners.	**3**
3.5	**Make fuller use of the facilities at Rowley Regis Community Hospital to provide care closer to home.** **RB**	• Launch of new intermediate care unit in June. • Agree and deliver plan for services at Rowley in 2011/12. • Increased numbers of outpatient clinics scheduled at Rowley.		The new Henderson Reablement Unit opened as planned in September.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
4	***Good Use of Resources***				
4.1	**Deliver a £21.1m CIP and produce detailed plans to deliver a £20m annual CIP for a further three years.** **RW (with all Execs)**	• Presentation of the line by line CIP plan for the next financial year as assessed for quality and risk, deliverability and presented to the Finance and Performance Committee as part of the Trust Board's approval of the overall plan. Continuation of the robust monitoring and management of the plan via the Performance Management Board including tracking of replacement schemes, Full year/part year effects and any shifts from recurrent categories to non-recurrent. • Develop and agree the basis of allocating operational targets as part of 3 year CIP, ensuring capacity and expertise is developed so that plans are expressed in QUiPP and QuEP categories making use of all internal and external benchmarking data, e.g. SLR. Completion target to be consistent with commencement of strategic CIP work, end of Q1. • Integration of the plan within overall financial modelling including explicit cross-model audit trails of the impact of CIPs within the external and internal		At the end of Quarter 2, the previously reported slippage on the plan has stabilised at c. £1m and is in direct proportion to the financial positions of the Surgery A and Medicine divisions with mitigating actions being pursued as part of the recovery plans. The exceptions reporting and replacement scheme protocol is in place as part of recovering the position during 11/12 including the approval of replacement schemes were appropriate. Separate bi-weekly meetings and monitoring of weekly expenditure in some areas is in place as are regular reports to PMB, FPC and Trust Board. Additional resources are being placed into the Divisions to bolster capacity in order to assist with getting back on track.	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
		financial models (e.g. LTFM, LTSM, FIMS)			
4.2	**Achieve a £2m surplus.** **RW**	• Prepare a detailed financial plan with sufficient income based resources to meet anticipated expenditure in accordance with operating framework imperatives, capacity plans and risk reserves. • Ensure that Board reporting is clear between the DH target surplus and IFRS based bottom line results that take account of on-balance sheet treatment of long term contracts • Ensure that variations in the plan are reported at the earliest opportunity together with corrective mitigating plans as developed and implemented through the Performance Management Board.		Year to date surplus of £249k. This is slightly 'off plan' but is not altering the forecast to yearend owing to the measures being adopted to improve the position. Similar to the reporting of CIP performance, enhanced reporting is provided to the Finance committee along with action plans aimed at improving CIP performance and in turn contributing to the forecast outturn as agreed at the start of the year.	**3**
4.3	**Reduce premium rate working.** **RB**	• Premium rate working reduced by £1.8m compared with 2010/11 outturn. • Theatre utilisation improved: <20% late starts, <25% early finishes, average of >3.5 cases per list).	80% prompt starts (March 2011) 46% on time finishes (March 2011) 2.9 cases per list (March 2011)	• 80% prompt starts (<15 mins late) (Sept 2011) • 55% on time finishes (<15 mins early) (Sept 2011) • 3.0 average cases per list (Sept 2011)	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
4.4	**Develop plans to improve the service line position of the Trust.** **MS**	• Identify three services. • Evaluate baseline position. • Develop improvement plan for each service.	Three services identified – Orthopaedics, Obstetrics and Dermatology	• Baseline position being verified through audit of input costs • Impact of CIP delivery being assessed • Benchmark services identified and other Trusts contacted to provide benchmark data • Obstetrics developing plans to market services to repatriate work • Orthopaedics and Dermatology identifying which service elements are main contributors to deficits	**2**
5	***21st Century Facilities***				
5.1	**Begin to Procure a new hospital.** **GS**	• OJEU notice placed. • GVD executed. • Clarity on Deed on Safeguard achieved.	Awaiting OBC approval.	Progress halted, awaiting approval from DH and HMT. DH resolving FTPBC/PFI issues.	**1**
5.2	**Continue to improve current facilities.** **GS**	• Updated Estates Strategy. • Capital programme on plan. • Satisfactory environmental assessments (CQC, Hygiene Code, PEAT etc).	2010/11 Capital Programme delivered to plan.	Capital programme for 2011/12 agreed, being implemented.	**3**
5.3	**Develop detailed plans for the development of the community estate.** **GS**	• RCRH Community Facilities Programme Team embedded. • Programme for development agreed. • Initial projects commenced.	Engagement with PCTs commenced.	RCRH Community Facilities Programme team established, feasibility work being undertaken.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
6	***An Effective NHS Organisation***				
6.1	**Make significant progress towards becoming a Foundation Trust.** **MS**	• Develop a detailed project plan. • Ensure delivery of all milestones in the project plan. • Secure any additional support required for the application including stakeholder support.	Project structure set up	• IBP submitted on time • TFA agreed • Delayed by at least four months due to delay in OBC approval	**2**
6.2	**Deliver a set of Organisational Development activities including a stronger voice for front line staff.** **MS**	• Develop an OD framework and action plan to support FT application. • Deliver a model of staff engagement and incentive system.	Lack of coherent set of OD activities	• Framework developed • Organising for Excellence Steering Group agreed • OtF staff ambassadors being piloted in community services and pathology • Ambassador elections and welcome event held	2
6.3	**Develop our clinical systems and processes to reduce variability and ensure safe, error free care.** **DO'D**	• Continue diagnostic project in respect of Clinical Back Office Systems. • Establish Project Board to deliver on Paperlite and Clinical Back Office Projects. • Relevant processes (including SBAR for reliable clinical handover, "kitemarking" clinical offices and departments for information standards & root cause analysis) developed and embedded in all clinical departments.		• Paperlite and Clinical Back Office projects on track and expected to deliver 1st phase implementation by September • Standards out to consultation • Q2: Standards now adopted • Self assessment tool under development • E-requesting and acknowledgement being rolled out with 2 directorates going live with pilots in September and October • Completion date renegotiated to Q4	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
6.4	**Improve staff satisfaction, health and wellbeing.** **MS/RO**	• System of gathering staff views throughout the year. • Identify actions arising from staff views. • Publish staff survey results. • Regular communications to staff. • Health and Wellbeing action plan – delivery against timescales. • Reduction in sickness absence. • Measurable improvements in survey results. • Links to OD/OTF plans around staff engagement and ownership.		• Reduced sickness rates being achieved. Trust and regional targets being met • Significant improvement in staff satisfaction score in 2010 but still below national average • Health and wellbeing action plan being delivered to timescales, new focus on nutrition advice	**3**
6.5	**Agree an IT strategy including an affordable route to procurement of an Electronic Patient Record.** **DO'D**	• Programme board set up and running. • Option appraisal complete. • Decision-making process agreed and underway.		• 1st workshop held to develop a plan for the plan • Relatively little progress in developing the strategy • Project delayed until IM&T review complete	**2**
6.6	**Continue to develop and implement the Trust's approach to sustainability and transport and access.** **GS**	• Carbon Management Plan agreed. • Sustainability action plan on target. • Review and update travel plan.	Sustainability Action Plan being implemented.	Sustainability action plan and carbon management plan on track.	**3**
6.7	**Develop a training plan that reflects service needs, is resourced and supports the workforce plan.** **RO**	• Trust Training Plan developed by May. • Funding to support plan agreed June/July. • LBR and JIF funding identified. • Commissions with higher education institutions agreed.		Training plan developed and submitted to SHA. LBR funding agreed. Non-medical commissions agreed. No change.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Two (September 2011)**	**Red /Amber /Green Assessment**
		• L&D Committee monitoring of plan. • Plan clearly linked to workforce plan due September. • Learning Hub/Health tech proposal written and presented to relevant parties.			

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Right Care Right Here Progress Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	27 October, 2011

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 September 2011.

It covers:

- Progress of the RCRH Programme.
- Progress with the Recommissioning schemes as agreed in the LDP.

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:

1. NOTE the progress made with the Right Care Right Here Programme.
2. NOTE progress with identifying and delivering recommissioning schemes.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Care Closer to Home: • Deliver the agreed changes in activity required as part of the Right Care Right Here programme. • Make fuller use of the facilities at Rowley Regis Community Hospital to provide care closer to home.
Annual priorities	
NHS LA standards	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Monthly progress report to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT OCTOBER 2011

INTRODUCTION

The Right Care Right Here Programme is the partnership of SWBH, HoB tPCT, Sandwell PCT and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. This brief paper provides a progress report for the Trust Board on the work of the Programme as at the end of August 2011. It summarises the Right Care Right Here Programme Director's report and the RCRH Service Redesign Report that were presented to the Right Care Right Here Partnership Board at the end of August.

The work of the Right Care Right Here Programme and involvement of the Trust in this is also discussed on a monthly basis at the Trust's Right Care Right Here Implementation Board meetings.

PROJECT PERFORMANCE

The RCRH Programme has developed a new format for reporting activity performance related to service redesign. These reports are included in Appendix 1 for information. They attempt to summarise overall progress with the Programme in key areas by providing data for the first four months of 2011/12 and comparing it with actual performance in 2010/11, the trajectory in the RCRH Activity and Capacity (A&C) for 2011/12 and the targets in the A&C model for 2016/17.

In summary activity trends for April-July 2011 show:

- Inpatient Activity: Our Acute Occupied Bed Days (OBDs; in Summary A, figure 1) are 5% below 2010/11 levels but 18% above the 2011/12 trajectory. This includes a reduction in our emergency inpatient OBDs but a slight increase in our elective inpatient OBDs compared to the same period in 2010/11 (Summary A, figures 4 and 5).

- Community OBDs (in Summary B, figure 3) are 10% above 2010/11 levels but 11% below the 2011/12 trajectory.

- It is envisaged that the intermediate care/re-ablement beds opened at Rowley Regis Hospital in September will increase the Community OBDs and assist in reducing our Acute OBDs).

- Emergency Department Attendances: Our Emergency Department (ED) attendances (in Summary A, figure 3) are 2% below 2010/11 levels, but 12% above the 2011/12 trajectory.

- The Urgent Care Centre attendances (in Summary B, figure 2) are 11% above 2010/11 levels and 86% above the 2011/12 trajectory.

- Outpatient Attendances: Our acute Outpatient Activity (in Summary A, figure 3) is 5% below 2010/11 levels but on the 2011/12 trajectory.

- Community Outpatient Activity (including our community and new Community Provider activity, in Summary B, figure 1) is 5% below the 2010/11 levels but 221% above the 2011/12 trajectory although still some way (48%) from the 2016/17 trajectory.

- Referrals to acute services have shown a 4% reduction since the end of 2010/11 (in Summary B, figure 4).

At this stage it therefore appears that across all three categories, our acute activity is showing a downward trend but with further work required to ensure maintenance of this trend (acute outpatient attendances) or achievement of 2011/12 trajectories (ED attendances and acute OBDs) and ongoing progress towards the 2016/17 position. It is anticipated that the Recommissioning work (see below) will help to achieve this.

In terms of previous projects established through specific exemplars and individual re-design initiatives performance in terms of activity is now captured within the above summaries.

CARE PATHWAY AND SPECIALITY REVIEWS

The approved, redesigned Cardiology care pathways have now been published on the three local views of Map of Medicine. (Sandwell, Heart of Birmingham and Intelligent Commissioning Forum - ICoF). The pathways are: -

- Heart Failure
- Acute Coronary Syndrome
- Cardio Vascular Disease Risk Management
- Ectopic Beats
- Arrhythmias

The RCRH Programme is having ongoing discussions with commissioners about arrangements to enable access to ECG tests in community settings in order to fully activate these pathways.

The remaining fourteen approved redesigned pathways will be published to the local views in Map of Medicine in October and November.

The Rheumatology Review continues and so far has included a stock-take of local services and initiatives, the identification of a programme budget, the development of a local model of care and an assessment of the potential workforce implications of the review. The deadline for completion of the Review has been extended to allow some more detailed work and the aim is to present the proposals arising from the Review to the RCRH Partnership in November.

TRANSFER OF ACTIVITY (RECOMMISSIONING)

There have been ongoing discussions across the local health economy regarding implementation of the LDP agreement to transfer a range of services, activity and related income from secondary care to community and primary care during 2011/12 in line with the RCRH Programme. The Trust and GP commissioners have identified a number of specific schemes which have now been agreed and for which implementation plans are now being developed. These schemes are now collectively known as the Recommissioning Programme.

The LDP agreement set a target of transferring-recommissioning activity worth £16.2million and to date the Trust and PCTs have identified schemes that will result in the transfer of activity worth £13.8million over a full year. Work is ongoing within the Trust and PCTs to identify additional schemes.

For the period April – August 2011 there has been a transfer of activity worth £1.1 million which is a slight deterioration in position since the last report primarily due to activity targets for August being set very low. A number of the schemes are due to commence in the Autumn and so an improvement in performance is expected over the next few months.

RCRH PROGRAMME MANAGEMENT STRUCTURE

The RCRH Programme had planned to hold a half day workshop at the end of September to debate how governance arrangements should be changed to be made more effective in delivering service transformation in accordance with the Programme's aims. In view of the ongoing debate around GP Clinical Commissioning Group/Consortia configuration and the NHS reforms it was decided to postpone this event until early January 2012, by which time these issues should have been resolved.

RECOMMENDATIONS

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.
2. NOTE progress with identifying and delivering recommissioning schemes.

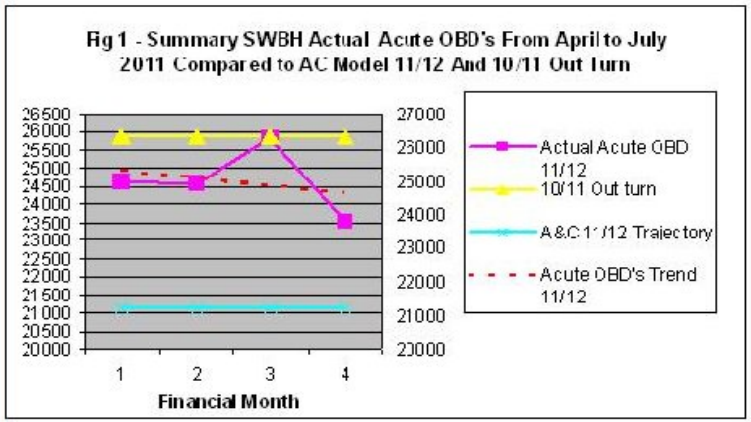
Jayne Dunn
Redesign Director – Right Care Right Here
18th October 2011

APPENDIX 1 - RCRH Activity Summaries

Personal :: Summary PBR reports

Summary A - RCRH Programme Board Reports For the Acute Sector From Apr-Jul 2011/12

right care right here



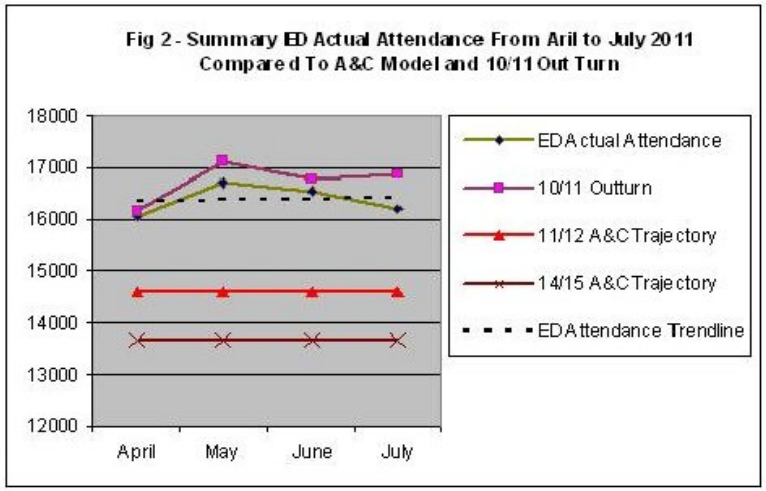


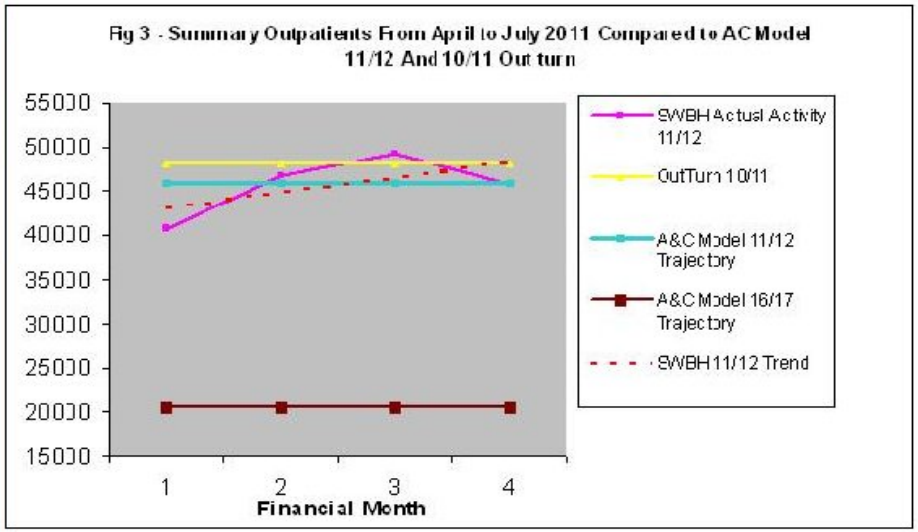
Fig 1 – At Month 4 actual Acute OBD's cumulative are 5% lower than 10/11 Outturn and 18% above modelled 11/12 A&C trajectory. We are 52% above 16/17 trajectory.

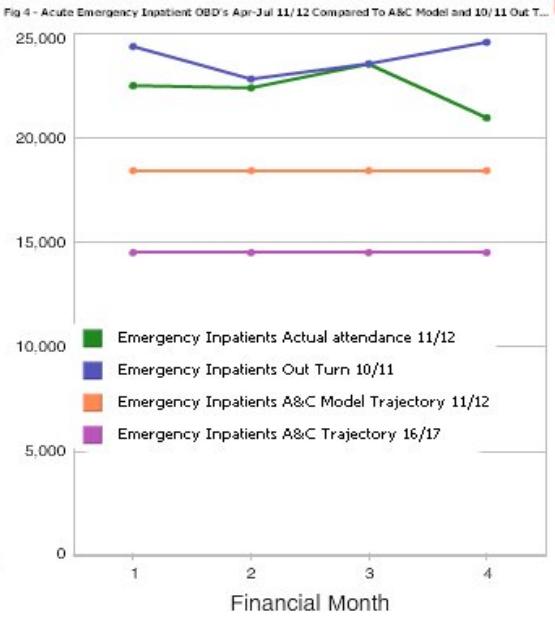
Fig 2 – ED Attendances are 2.0% less than 10/11 outturn and 12% above modelled 11/12 trajectory. The trend for actual ED attendance 11/12 appears to be declining over

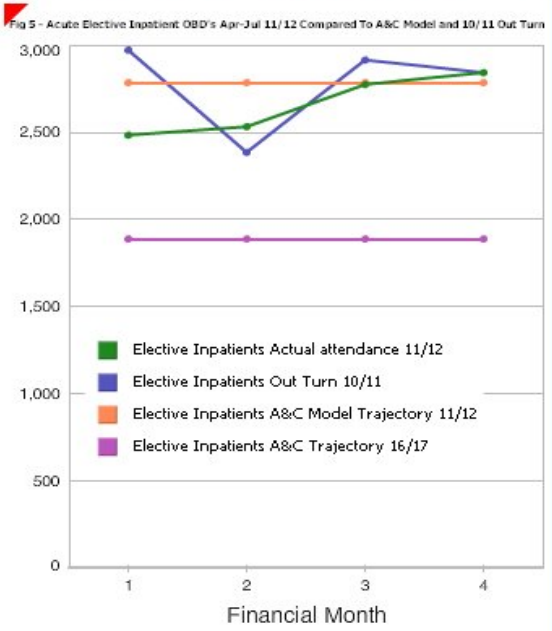
Fig 3 – At Month 4 outpatient cumulative activity is 5% less than 10/11 outturn and 0.3% below modelled 11/12 Trajectory. Actual outpatient activity is 122% above

Fig 4 – At Month 4 Non Elective (emergency) OBD's are 6.3% lower than 10/11 Outturn and 21% above modelled 11/12 A&C trajectory. We are 46% above 16/17 trajectory to date.

Fig 5 – Acute Elective Inpatient OBD's are 4.3% below 10/11 outturn and 4.6% below modelled 11/12 A&C model trajectory. We are 41% above modelled 16/17 trajectory. Note elective inpatient demand for this financial year







Personal :: Summary PBR Community reports

Summary B - RCRH Programme Board Reports For Community Sector From April to July 2011

Fig 1 Summary Community Outpatients From April To June 2011 Compared to A&C Model and 10/11 Out Turn

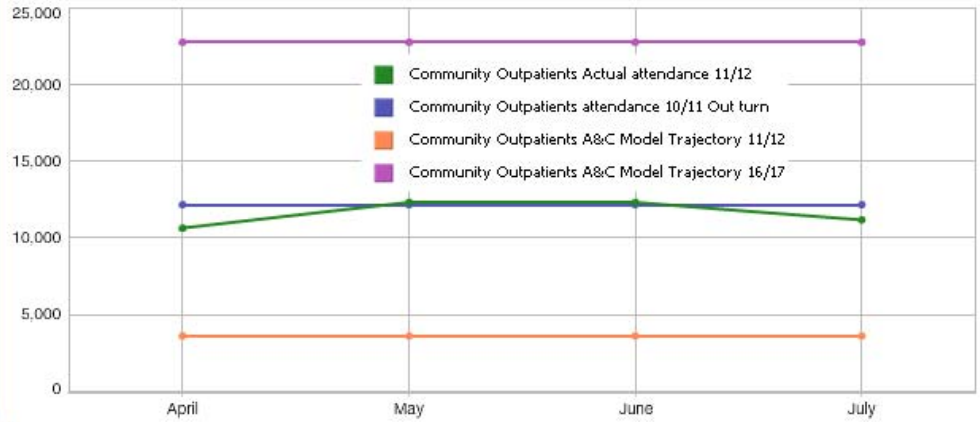


Fig 1 – At Month 4 community outpatient attendance is 4.6% less than 10/11 outturn. In comparison to the A&C model it is 221% above 2011/12 Trajectory and 48% less than 2016/17 trajectory.

Fig 2 – Urgent Care Centre attendance is 11.4% above 10/11 outturn. Even though the trend appears to be declining over the last few months we are still over performing in comparison to last years outturn. We are 30% above 16/17 Trajectory and 86% above 11/12.

Fig 3 – Community OBD's are 11% above 10/11 outturn and 10% below modelled trajectory for 11/12. To meet 11/12 trajectory we need to introduce 16,154 new OBD's . The introduction of these new beds commences September 2011 and thus the trajectory will need to be phased in from that point onwards. Note Community OBDS includes:

Leasowes IC Centre
Barthalomew Lodge Nursing Home
Waterside Nursing Home
Greenhaven Care Home
Moseley Hall

Fig 4 – Show referral activity which includes GP as well as other types. At month 4 referrals are 10% below last years out turn.

Fig 2 Summary UCC Attendance From April To June 2011 Compared to A&C Model and 10/11 Out Turn

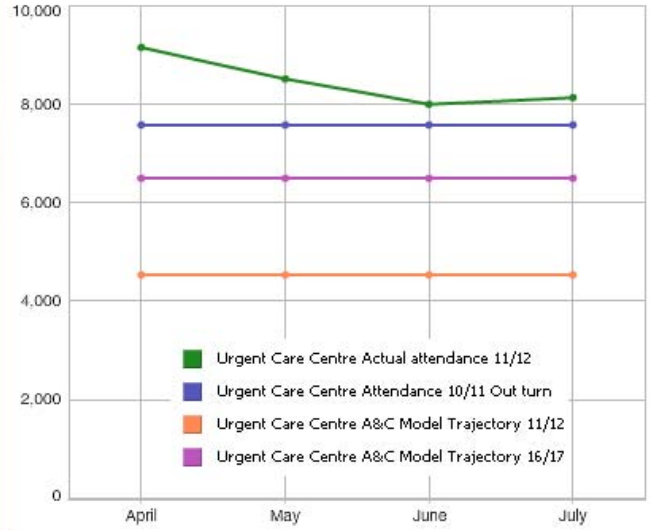


Fig 3 Summary Community OBD's From April To June 2011 Compared to A&C Model and 10/11 Out T...

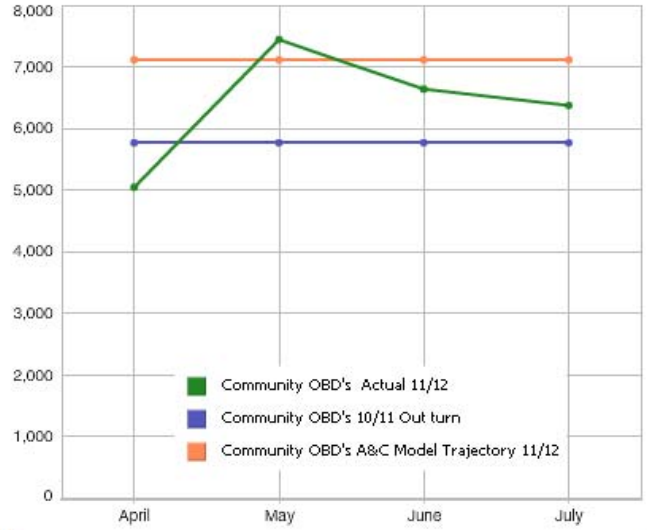
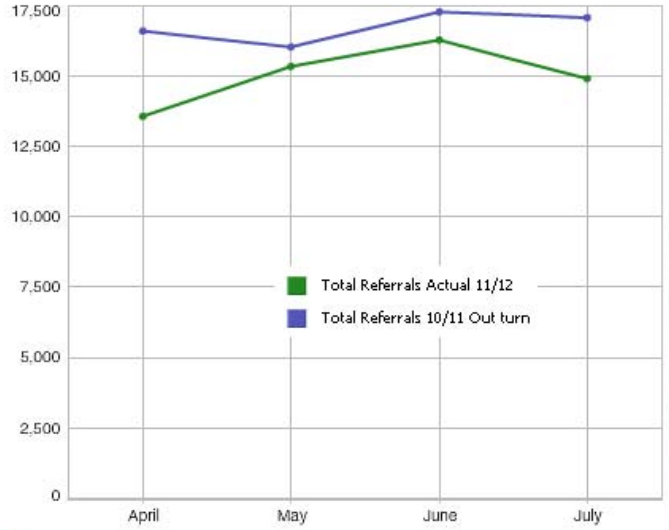


Fig 4 Summary Referrals From April To June 2011 Compared to 10/11 Out Turn



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Foundation Trust Programme: Project Director's Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy & Organisational Development
AUTHOR:	Mike Sharon, Director of Strategy & Organisational Development
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

The Project Director's report gives an update on:

- Activities this period
- Activities next period
- Issues for resolution and risks in next period

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	An Effective Organisation
Annual priorities	Make Significant progress towards becoming a Foundation Trust
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

FT Programme Board on 27 October 2011

FT Programme Director Report October 2011 – Overall status - Amber

Activities this period

- Agreed TFA with reworked timeline
- Redrafted LTFM to meet PBC borrowing ratios
- Exec team members half day workshop to review risks and downside case
- Commenced detailed HDD1 planning
- Board member one to one interviews with Deloitte commenced
- Soft Mock Board to Board arranged for 25 November

Activities next period

- Prepare for soft mock Board to Board
- Produce version 2 IBP first draft
- Commission legal review of Constitution
- Commence HDD1 (end of November)
- Deloitte to complete Board one to ones and update feedback report
- Re-draft constitution
- Review membership strategy

Issues for resolution and risks in next period

- DH formal feedback on OBC expected

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT Programme Board – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 29 September 2011

Present:	Mrs Sue Davis [Chair]	Mr Mike Sharon	
	Mr Roger Trotman	Miss Rachel Barlow	
	Dr Sarindar Sahota	Miss Rachel Overfield	
	Mrs Gianjeet Hunjan	Mr Donal O'Donoghue	
	Prof Derek Alderson	Mr Graham Seager	
	Mrs Olwen Dutton	Miss Kam Dhami	
	Mr John Adler	Mrs Jessamy Kinghorn	
	Mr Robert White	Miss Neetu Sharma	
Guests:	Mr Gus Miah [Deloitte]	Ms Claire Williams [Deloitte]	
Secretariat:	Mr Simon Grainger-Payne		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
No apologies for absence were tendered.	
2 Minutes of the previous meeting	**SWBFT (7/11) 047**
Subject to minor amendment, the minutes of the previous meeting were accepted as a true and accurate record of the discussions held on 28 July 2011.	
AGREEMENT: The minutes of the previous meeting were approved.	
3 Update on actions arising from previous meetings	**Verbal**
It was noted that there were no overdue actions or actions that required escalating for attention.	
4 FT Programme Critical Path	**SWBFT (9/11) 049** **SWBFT (9/11) 049 (a)**
The FT Programme Board received and noted the updated FT Programme Critical Path.	

5 FT workstream high level milestone plan	**SWBFT (9/11) 050** **SWBFT (9/11) 050 (a)**
The FT Programme Board received and noted the updated FT Programme Critical Path.	
6 Programme Director's report	**SWBFT (9/11) 052** **SWBFT (9/11) 052 (a)**
The FT Programme Board received and noted the FT Programme Director's report. The Board was advised that an assessment against Monitor's Quality Governance Framework would be discussed at the next meeting.	
7 IBP feedback from NHS West Midlands	**SWBFT (9/11) 053** **SWBFT (9/11) 053 (a)**
The feedback following the review of the Trust's Integrated Business Plan (IBP) by the NHS West Midlands was considered. It was noted that the various workstream leads would be responsible for responding to the recommendations made. Mr Sharon highlighted that the feedback had been complimentary of the IBP that had been submitted.	
8 Deloitte Board development activities	**SWBFT (9/11) 057**
Mr Miah and Ms Williams, representing Deloitte LLP joined the meeting to present an update on the outcomes of the recent Board development activities. The Board was advised that two reviews of the IBP had been undertaken by Deloitte and that the report on the Committee observations was currently being finalised. It was highlighted that there had been good feedback about the Trust Board received from the staff focus groups and stakeholder reviews. The key messages from the work were reported to centre on the contingency plans, should the funding for or approval of the Outline Business Case not be gained. Mr Sharon suggested that an agreed process by which these plans would be developed should be agreed shortly. It was highlighted that there may be disconnect between the Trust vision of the frontline staff and that of the senior management. The Chair responded that the organisation's vision had been developed in a considered and informed manner, although she acknowledged that further consideration needed to be given to ensuring the points of view were harmonised. In terms of Board visibility Mr Miah reported that feedback received had suggested a degree of variability according to the individual. Although key Non Executive Directors (NEDs) were well known throughout the organisation, it was suggested that a good programme of engagement was needed to ensure that the profile of all NEDs and Executive Directors was raised. It was highlighted that the visibility of the Chair and Chief Executive was particularly pleasing according to	

the stakeholder surveys. It was suggested that the visibility of all members of the Board needed to be balanced between both City and Sandwell Hospital sites. The Chair suggested that better use of Trust Board days at Sandwell Hospital could be made to address this recommendation, with Board members having lunch in public places where possible. Mr Miah highlighted that the Board observation work had suggested that there needed to be a greater degree of consideration of the discussions held by the Board committees at Trust Board meetings. The Board was advised that the details of the planned level of reductions in activity needed to be communicated to GPs. It was suggested that discussions with GPs needed to be held to articulate the decommissioning work and the plans to grow activity in some targeted specialities. In terms of communications, the Board was advised that the surveys had suggested that the value of the daily staff communications had been questioned by staff. Regarding performance, it had been suggested that the handling of poor performing staff was an issue. Mrs Davis noted that this had been a theme previously raised by staff within staff surveys. Miss Overfield agreed that there was a need to look at trends for capability outcomes. It was suggested that there was little evidence to support that changes had been made in the organisation in response to feedback from patients, carers and the public. The Board highlighted that there were clear examples of where such changes had been made but agreed that promotion and communication of these instances needed to be improved. Mr O'Donoghue added that some of the changes were agreed by Board Committees or interim Committees therefore there were occasions where the decisions were not recognised as being made directly by the Board. The Chair suggested that a briefing as to the discussions held and decisions made by the Board should be circulated after each Trust Board meeting. Mr Adler advised that it was the intention that the 'Hot Topics' bulletin should be used for this purpose, however he agreed that the Board decisions needed to be made more explicit. Mr Miah advised that Monitor was keen to see evidence of changes made as a result of complaints, concerns or Serious Untoward Incidents. Mr Adler suggested that there may be a possibility of auditing feedback received and how changes were made in response to this. Mr Miah and Ms Williams were thanked for their informative report. Mr Adler asked that a summary of the key points, together with the Trust response be presented at the next meeting.	
ACTION: **Mr Sharon to organise for a summary of the key points of the Board Development feedback, together with the Trust response**	

be presented at the next meeting	
9 Programme risk register	**SWBFT (9/11) 056** **SWBFT (9/11) 056 (a)**
The FT Programme Board received and noted the FT Programme Risk Register.	
10 'Organising for Excellence' briefing	**SWBFT (9/11) 058** **SWBFT (9/11) 058 (a)**
Mr Adler presented the proposal to establish an 'Organising for Excellence' programme. It was reported that Service Line Reporting was to be upgraded to a project it in its own right within the framework. The plans were also highlighted to include the development of an annual quality improvement framework. The FT Programme Board was asked for and gave its support to the 'Organising for Excellence' concept. Professor Alderson remarked that the plans were very clear. In terms of the further consultancy input to the plans to develop a Transformation Support Office (TSO), a proposal was presented to the Board that the Atos consultants be engaged to undertake the implementation stage of the work at a cost of c. £138k. It was noted that the profile of the roles within the TSO was to consist of staff already in post from across the Trust. The FT Programme Board agreed to the proposal.	
AGREEMENT: The FT Programme Board agreed that the Atos consultants should be engaged to support the implementation phase of the TSO establishment	
11 Seminar session: Long Term Financial Model	**Hard copy papers**
RW advised that there was a significant challenge to the Trust in future in terms of affordability and the need to meet Cost Improvement targets. The Board was informed that the recent reference costs work suggested that there was a lower level of savings that the Trust could make than initially expected. In terms of the CIPs, it was highlighted that current forecasts suggest an average CIP of 5.5% over four years totalling £115m if costs were included which were associated with activity reductions. It was noted that although the targets were challenging, they were achievable. Mr Trotman suggested that the Trust should aim at reaching reference costs levels of less than 100.	
12 Matters for information	
12.1 Monitor FT Bulletin	**SWBFT (9/11) 054**
It was highlighted that the latest Monitor FT Bulletin advertised opportunities to	

join the accelerated Service Line Management Programme. The FT Programme Board agreed that the Trust should participate if possible.	
12.2 Compliance Framework 2011/12 – updated 19 September 2011	**SWBFT (9/11) 055**
Miss Sharma advised that the Compliance Framework 2011/12 had been updated and she highlighted the key changes. It was noted that community services metrics had now been built into the document. It was agreed that there was a need to check that the key measures were incorporated into the Trust's corporate performance dashboard.	
ACTION: Mr White to arrange for a check to be made to determine whether the key measures within the Compliance Framework are built into the corporate performance dashboard and raise with the Finance and Performance Management Committee if required	
13 Any other business	**Verbal**
Mr Sharon tabled a copy of the latest Tripartite Formal Agreement (TFA). He advised that in conjunction with the TFA, a revised high-level milestone and critical path had been developed, which factored in a two-month delay due to the continued wait for the Outline Business Case (OBC) to be approved. The Board was advised that NHS West Midlands had recently asked that a revised TFA be submitted, therefore discussions were ongoing with the Department of Health concerning the likely date that the OBC might be approved. Mr Adler highlighted that the milestone concerning the resolution of the adherence with the Prudential Borrowing Code (PBC) was likely to be removed from the TFA, given the potential adverse impact on the progress with the new hospital plans. Mr White highlighted that should this be the case, the Trust's Financial Risk Rating would fall to 2. Mr Adler advised that recent feedback from the McKinsey review of trusts planning a PFI venture had reported that it was regarded that the Trust's scheme was affordable and deliverable. It was agreed that at a future meeting, the risks concerning continued delay to the approval of the OBC should be considered. During the meeting, notification was received from the Department of Heath that the likely date of the approval of the OBC was to be December 2011. The FT Programme Board was asked for its approval to submit the TFA with the inclusion of a milestone around OBC approval in December 2011 and the removal of the milestone concerning adherence to the PBC. The Board approved this submission.	
AGREEMENT: The FT Programme Board gave its approval to submit the TFA with the inclusion of a milestone around OBC approval in December 2011 and the removal of the milestone concerning	

adherence to the PBC	
14 Details of next meeting	**Verbal**
The next FT Programme Board meeting will be held on 27 October 2011 at 1300h in the Boardroom at Sandwell Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Sustainable Development Management Plan Update
SPONSORING DIRECTOR:	Graham Seager, Director of Estates/New Hospital Project
AUTHOR:	Rob Banks, Head of Estates
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

The purpose of this paper is to update the Trust Board on progress with regards to sustainability.

KEY POINTS:
Reporting progress on:-

Carbon Management Plan (CMP)
Carbon Management Software
IT Powersave Management Software
Carbon Reduction Commitment (CRC)
Sustainability Event
Sustainability and Environmental Policy
Waste Management – Recycling Scheme
Communications – Intranet / Internet

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

Approval	Receipt and Noting	Discussion
	✓	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to:

- Note the current progress in relation to Sustainability against key points

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Improve the environmental sustainability of the Trust's operations by responding to the national carbon reduction strategy
Annual priorities	Cost Improvement Programme Carbon Reduction Programme European Emissions Trading Scheme (EU ETS) Carbon Reduction Commitment (CRC)
NHS LA standards	
Core Standards	Regulation 11
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**	Potential for cost efficiencies through sustainability projects as developed through Carbon Management Plan, Sustainability Event and Sustainability Champions and Supporters, (increased awareness), Waste Recycling Scheme
Business and market share		
Clinical		
Workforce	**X**	Promotion and link to Health and Wellbeing projects Potential for reduction in staff sickness levels Training for Sustainability Champions
Environmental	**X**	Reduction in SWBH carbon emissions baseline
Legal & Policy	**X**	Compliance with Climate Change Bill 2008 Good corporate citizen targets Carbon Reduction Commitment (CRC) European Emissions Trading Scheme (EU ETS) Sustainability and Environmental Policy
Equality and Diversity		
Patient Experience	**X**	Provide patients with options for public transport
Communications & Media		
Risks		Non compliance with : Climate Change Bill 2008 Good Corporate Citizen Staff morale and engagement Carbon emission reductions affected Missed cost saving and efficiency opportunities

		Potential Increase in CRC allowances

PREVIOUS CONSIDERATION:

Sustainability Working Group (SWG) reviews areas of work discussed in this paper

Sustainability Update

Trust Board – 27 October 2011

1. Introduction

The purpose of this report is to update the Trust Board on progress to date with implementing the Trust's sustainability agenda.

2. Sustainability Champions and Supporters

The number of Sustainability Champions has increased from 46 to 91 since April 2011 through a drive in internal communications (including regular updates, sustainability staff questionnaire), presentation at divisional managers meetings, and the offering of training programmes.

As a result of a Sustainability Champions competition that ran from mid-July to the end of September, our Sustainability Champions recruited 107 members of staff become 'Sustainability Supporters'. A Sustainability Supporter is a member of staff that is keen to 'do their bit' but cannot (due to work/time constraints) fully commit to becoming a Sustainability Champion. Small prizes were awarded for first, second and third places to thank our Sustainability Champions for all of their hard work.

Presentations at Divisional Mangers meetings and team meetings on the importance of sustainability and efficient use of resources have further engaged and encouraged staff. These meetings have increased the visibility of Sustainability and boosted the number of Sustainability Champions across the Trust.

3. Carbon Management Plan (CMP)

The Trust has started work on the Carbon Management Plan to deliver savings of approx 15% of the 2008/09 baseline (22,184 tonnes of Carbon).

To reflect changes in the Trust's organisational structure (i.e. the addition of staff and some buildings from Transforming Community Services); we will be working to re-align our carbon emissions baseline from 2008/9 to 2010/11. This work will be on-going over the next few months and the Board will be updated on progress in April 2012 and asked to consider and approve of an updated CMP.

Progress on expenditure of SIRG approved 2011/12 expenditure:

Project	Project notes	Cost of project (£)	Estimated annual savings (per annum)	
			Financial (£)	Carbon (CO2)
Solar PV	Out to tender for the supply, installation and commissioning of a 50KW Solar PV system to Rowley	Capital £150k	£16.4k	24 tonnes
Boiler replacement	Specification in progress for replacement boiler at City Hospital to generate 6% gas saving on October to March 2012/13	Capital £200k	£59k	473 tonnes
Waste bins and recycle points	Procurement of additional waste bins and recycle points	Capital £7k (October 2011)	To be confirmed once in place	To be confirmed once in place

Consultancy Services for Energy review	Procurement of consultancy services for energy review of Birmingham Treatment Centre (BTC) to align 16% energy target	Capital £7.5k (October 2011)	Circa 16% reduction in energy costs for BTC	16% reduction in energy usage (and carbon)
Building Management System (BMS) Strategy upgrade	Procurement of BMS strategy upgrade for energy saving	Capital £5.6k (October 2011)	To be confirmed	To be confirmed
Central dishwasher at City Hospital	Procurement of central dishwasher at City Hospital to reduce water consumption and need for steam generation	Capital £15k (September 2011)	£7,095	Circa 24 tonnes

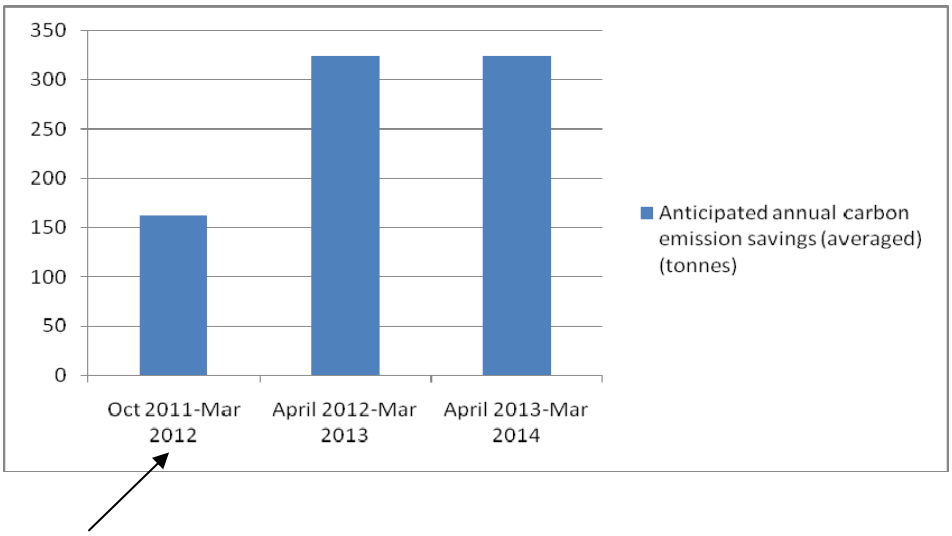
3.1. Carbon Management Software

Carbon management software was installed on 31st August 2011 to help us measure and manage our carbon emissions associated with energy, transport, and waste and water consumption. When updated with monthly data, the software will provide real-time information. It will act as a repository for data and other information (e.g. utility bills) related to carbon, whilst also allowing us to create reports for internal and external communications and reporting.

3.2. IT Powersave Management Software

To help the Trust save unnecessary waste in energy, new IT powersave software has been installed on most of the Trust computers. It will eventually be rolled out to a total of 3,800 computers over the next few weeks. The powersave software will automatically shut down non-emergency computers at the end of the day. Figure 1 illustrates the anticipated carbon savings through installing the powersave software.

Figure 1: Anticipated annual carbon savings through powersave software (October 2011 – March 2014)



Software installed October 2011 (only includes final 6 months of 2011/12)

4. Carbon Reduction Commitment (CRC)

The CRC is a mandatory carbon emissions reporting and pricing scheme to cover all organisations using more than 6,000MWh per year of electricity. The Trust is part of this scheme and successfully submitted the necessary reports in July 2011. A paper has been submitted to the Finance Committee to identify additional monies required for budgets going forward and will be made part of the on going Estates Business Planning.

5. Sustainability Event

The Estates department organised a Sustainability and Environment event for staff on 13th October 2011 to celebrate the launch of the Carbon Management Plan and all associated strategies. The aim of this event was to gain further support across the organisation and demonstrate the successes we have achieved to date.

65 members of staff attended the event. After the presentations, staff were invited to network and visit the stands. Five stands were organised:

- Health and Well Being
- Bikes for the NHS (to promote the Trust Cycle Scheme)
- E.On, (to promote energy saving measures)
- Sustainability Champions stand (to promote our Champions). A further 15 Sustainability Champions were recruited at the event
- Watt Bikes (indoor bikes for training and testing your power output, pedalling technique and heart rate)

6. Sustainability and Environmental Policy

The Sustainability and Environmental Policy was approved by Trust Board in July 2011 and is available on the Trust intranet (http://swbhweb/upload/pdf/Sustainability_Policy_SWBH_ORG800.pdf). This Policy was developed to co-ordinate all works being undertaken by SWBH in terms of Carbon Reduction, Carbon Management and Environmental Management. The aim is that this policy will further engage staff, emphasise the importance of sustainability and embed sustainable working practices across the organisation. At the Sustainability event, an introduction to the Policy was presented and the importance of managers recruiting Sustainability Champions from there areas.

7. Waste Management – Recycling Scheme

In August 2011, a new waste recycling scheme was introduced at City Hospital, starting at Summerfield House and Brookfield House at City Hospital and will be rolled out in stages across the Trust. Large bins are being placed around the site with colour-coded lids indicating if they are for paper, plastic or general waste.

The new recycling scheme will reduce the amount of waste we send to landfill, saving money and helping us meet our waste carbon reduction target of 10 per cent by 2013/14 (based on the 2008/9 baseline).

8. Communications – Intranet / Internet

A new Environment/Sustainability section has been added to the external SWBH website (http://www.swbh.nhs.uk/about-us/environment/what-are-we-doing) to engage the public in actions we are taking to reduce our impact on the environment.

The internal intranet site has also been modified so staff can keep updated and track our progress (http://swbhweb/server.php?show=nav.000001058).

A number of articles have been issued in Staff Comms and Heartbeat updating staff on sustainability-related projects (waste recycling scheme, IT powersave management software, cycling, etc).

9. Next Steps

- Promotion of Sustainability Champions and Supporters (uptake and training opportunities), Carbon Management Plan, continue to roll the waste recycling scheme across City Hospital, regular input of data into carbon management software, annual CRC reporting, and regular communications to staff
- Realign Carbon Management Plan to incorporate changes through TCS and submit for approval April 2012.
- Utilise data available from Carbon software to monitor, action and inform staff of progress against targets

10. Recommendations

The Trust Board is asked to:

- Note the current progress in relation to Sustainability Champions, CRC, Carbon Management Plan, Sustainability Event, Sustainability and Environmental Policy, Waste Management and Communications

Rob Banks
Head of Estates

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Transforming Community Services: Post Transaction Integration and Benefits Realisation
SPONSORING DIRECTOR:	Rachel Barlow, Chief Operating Officer
AUTHOR:	Matthew Dodd, Deputy Chief Operating Officer
DATE OF MEETING:	27 October 2011

SUMMARY OF KEY POINTS:

A progress report on the post transaction integration and benefits realisation plan for Sandwell Community Healthcare Adult and Children's Services was submitted to the Trust Board in June 2011. This outlined two workstreams that the Trust needed to deliver post-integration:

- Organisational Integration Planning (critical activities to maintain service and business continuity from April 2011 – early July 2011)
- Organisational Integration Delivery (implementing service transformation to deliver the benefits of integration, from June 2011 onwards)

This paper provides a progress report on delivery of these two workstreams.

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	High Quality Care
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

Financial	**X**	Opportunities to reconfigure services and activity flows for the whole Trust
Business and market share	**X**	Opportunities to develop better links with primary care
Clinical	**X**	Ability to implement seamless patient pathways Better communication between clinicians between community and acute services
Workforce	**X**	Opportunities to share skills and develop greater flexibility and overlap between cute and community sectors
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience	**X**	The ability to increase choice and allow patients to receive care closer to home is a key part of good patient experience
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Meeting of the Trust Board in June 2011

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRANSFORMING COMMUNITY SERVICES: POST TRANSACTION INTEGRATION & BENEFITS REALISATION

PROGRESS REPORT FOR TRUST BOARD – OCTOBER 2011

INTRODUCTION

A progress report on the post transaction integration and benefits realisation plan for Sandwell Community Healthcare Adult and Children's Services was submitted to the Trust Board in June 2011. This outlined two workstreams that the Trust needed to deliver post-integration:

- Organisational Integration Planning (critical activities to maintain service and business continuity from April 2011 – early July 2011)
- Organisational Integration Delivery (implementing service transformation to deliver the benefits of integration, from June 2011 onwards)

This paper provides a progress report on delivery of these two workstreams.

ORGANISATIONAL INTEGRATION PLANNING

The key outcome of this stage was to commence operations as a single organisation. It considered all critical activities required between Day 1 and Day 100 to ensure a seamless handover and maintain service and business continuity for both staff and patients during this period.

The actions associated with the first 100 days post integration are identified below:

Programme Management: The management structures for both community services have been established. The retirement in September 2011 of the Divisional General Manager for the Community Adult Health Division has been managed by placing another experienced community manager into this role on an interim basis, thereby maintaining stability and continuity. There has been a commitment to establishing Management Boards for both services with membership from front line staff and from GPs. The first meeting of this board for the Community Adult Health Division took place in July.

Service Planning: The Division/Directorate have developed key performance indicators that have been integrated with the corporate Trust monitoring reports. The Community Adult Health Division produced its Annual Plan and the key objectives are monitored monthly.

HR and Workforce: Policy harmonisation continues, with recruitment policies coming together. There is a standardised process across the organisation for workforce planning.

Finance: The community finance systems have been fully integrated into SWBHT systems.

Communications and Engagement: The Division and Directorate have been pilots for the implementation of 'Owning the Future', in particular the selection of ambassadors. A welcome event for ambassadors was held in July and ambassadors for the management boards have been identified, and have attended their first Board meetings. Ambassadors from the Community Adult Health Division have met with the Head of IM&T to discuss IT issues experienced by front line staff. A group of ambassadors have also attended a Forum meeting at John Lewis to develop further their understanding of the benefits of this model and way of working.

IM&T: Prior to integration, it was agreed that initially, IT support to the community systems would be purchased from the existing team then in the PCT. This team has now moved over to SWBHT and is integrated with other IM&T staff at Sandwell General Hospital.

STAGE 3: ORGANISATIONAL INTEGRATION DELIVERY

The organisational integration delivery phase focuses on the delivery of service transformation and integration to evidence and deliver the benefits to be derived following this acquisition.

A brief description of the key areas that are being considered is given below:

Service Planning: One of the transformation projects being developed by the Trust is around securing the benefits of integration. As part of the organisation's development work with ATOS the Community Adult Health Division has developed its Community Project Charters. A management review of District Nursing services is planned, while work continues to be undertaken with other divisions to identify means of helping them to decommission their activity, as well as reducing acute length of stay through work on admission avoidance and discharge processes. The Community Orthopaedic service is contributing to decommissioning through the provision of injections for orthopaedic patients. This service will be provided for Birmingham patients as well as for Sandwell.

Finance: A review is being undertaken of the finance support function in order to develop a structure best placed to meet both the organisation's and users' needs

IM&T: Community staff now have access to the Clinical Data Archive. This is aimed at improving communication and timeliness around notes, tests and patient pathways.

Commissioners: Sandwell PCT commissioned additional beds at Rowley Regis Hospital earlier this year. The 22 bedded Henderson Reablement Unit at Rowley Regis Hospital opened in September 2011. This unit is run by the Community Adult Health Division, with GP medical support, and will develop new models of care. An official opening ceremony is planned for late October.

Prior to integration, Sandwell commissioners identified five areas that they will monitor as part of benefits realisation. These are:

- Greater patient choice within End of Life care
- Expansion of the Community Orthopaedic Service
- Enhanced clinical leadership to support transformation and learning
- Implementation of RCRH cardiology strategic model of care
- Holistic community diabetes service

A visioning event has been held with End of Life services to agree how resources across the Trust may best be used. The Community Orthopaedic Service are expanding their injection service in line with the decommissioning programme, while also offering an orthopaedic triage service for the Black Country Commissioning Group. The Sandwell Health Alliance Consortium is planning to commission this service from November. With regards to diabetes services however, progress on integration and development of services has been slow and a recovery plan is being developed.

CONCLUSION AND RECOMMENDATIONS

This paper has provided the Trust Board with a progress on the integration and benefits realisation work that has been undertaken since June 2011. The Trust Board is recommended to:

1. NOTE the progress report on the two workstreams

2. NOTE the work around integration that is ongoing

Matthew Dodd
18th October 2011