Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 6 November 2008 at 1430h

Members

Mrs S Davis	(SD)	[Chair]
Cllr B Thomas	(BT)	
Ms I Bartram	(IB)	
Mr R Trotman	(RT)	
Dr S Sahota	(SS)	
Mrs G Hunjan	(GH)	
Prof D Alderson	(DA)	
Mr J Adler	(JA)	
Mr D O'Donoghue	(DO)	
Mr R Kirby	(RK)	
Mr R White	(RW)	
Mrs R Stevens	(RS)	

In Attendance

Mr T Atack	(TA)
Mr G Seager	(GS)
Ms K Dhami	(KD)
Mr C Holden	(CH)
Mrs J Kinghorn	(JK)
Mrs D Gospel	(DG)
Ms J Whalley	(JW)

Secretariat

Mr S Grainger-Payne	(SGP)

Item	Title	Reference No.	Lead
1	**Apologies for absence**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Chair's opening comments**	**Verbal**	**Chair**
4	**Minutes of the previous meeting** *To approve the minutes of the meeting held 2 October 2008 as true and accurate records of discussions*	**SWBTB (10/08) 108**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (10/08) 108 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	MATTERS FOR DISCUSSION AND DEBATE		
7	**'Listening into Action' – Update on progress**	**Presentation**	**JA**
	MATTERS FOR APPROVAL		
8	**Single tender action – Locum GP service**	**SWBTB (11/08) 128**	**RW**
	MATTERS FOR INFORMATION/NOTING		
9	**Strategy and Development**		
9.1	'Towards 2010' programme: progress report	SWBTB (11/08) 120 SWBTB (11/08) 120 (a)	RK
9.2	New acute hospital project: progress report	SWBTB (11/08) 127 SWBTB (11/08) 127 (a)	GS

10	**Performance Management**		
10.1	Monthly performance monitoring report	SWBTB (11/08) 112 SWBTB (11/08) 112 (a)	RW
10.2	Monthly finance report	SWBTB (11/08) 113 SWBTB (11/08) 113 (a)	RW
10.3	Quarterly progress against corporate objectives	SWBTB (11/08) 121 SWBTB (11/08) 121 (a)	RK
11	**Governance and Operational Management**		
11.1	Nursing workforce pilot	SWBTB (11/08) 129 SWBTB (11/08) 129 (a)	RS
11.2	Single Equality Scheme update	SWBTB (11/08) 126 SWBTB (11/08) 126 (a) SWBTB (11/08) 126 (b) SWBTB (11/08) 126 (c)	RS
11.3	Infection control quarterly report	SWBTB (11/08) 114 SWBTB (11/08) 114 (a)	RS
11.4	Infection control assurance framework	SWBTB (11/08) 115 SWBTB (11/08) 115 (a)	RS
11.5	Cleanliness report	SWBTB (11/08) 116 SWBTB (11/08) 116 (a)	RS
11.6	Matrons report	SWBTB (11/08) 117 SWBTB (11/08) 117 (a)	RS
11.7	Safeguarding adults	SWBTB (11/08) 124 SWBTB (11/08) 124 (a)	RS
11.8	Learning disability action plan	SWBTB (11/08) 125 SWBTB (11/08) 125 (a)	RS
11.9	Patient experience action plan	SWBTB (11/08) 118 SWBTB (11/08) 118 (a)	RS
11.10	Annual health check 2007/08 – Trust performance report	SWBTB (11/08) 119 SWBTB (11/08) 119 (a)	JA
12	**Update from the Board Committees**		
12.1	Finance and Performance Management		
▶	Minutes from meeting held 25 September 2008	SWBFC (9/08) 049	RT
12.2	Audit		
▶	Minutes from the meeting held on 11 September 2008	SWBAC (9/08) 037	GH
12.3	Governance and Risk Management		
▶	Minutes from the meeting held on 18 September 2008	SWBGR (9/08) 035	IB
13	**Any other business**	**Verbal**	**All**
14	**Details of next meeting** *The next public Trust Board will be held on 6 November 2008 at 1430h in the Churchvale/Hollyoak Rooms, Sandwell Hospital*	**Verbal**	**Chair**
15	**Exclusion of the press and public** *To resolve that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).*	**Verbal**	**Chair**

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Board (Public Session) – Version 0.3

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 2 October 2008 at 14.30 hrs

Present:	Mrs Sue Davis [Chair]	Mrs Gianjeet Hunjan	Mr Donal O'Donoghue
	Mr Roger Trotman	Dr Sarindar Sahota	Mr Robert White
	Ms Isobel Bartram	Mr John Adler	Mrs Rachel Stevens
	Cllr B Thomas	Mr Richard Kirby	
In Attendance:	Mr Tim Atack	Mr Graham Seager	
	Mr Colin Holden	Miss Judith Whalley	
	Miss Kam Dhami	Mrs Jessamy Kinghorn	
Guests:	Ms K Barber [SHA]		
Apologies:	Prof D Alderson		

Minutes	**Paper Reference**
1. Apologies for absence	**Verbal**
The Chair noted apologies for absence from Professor Derek Alderson.	
2. Declaration of interests	**Verbal**
There were no declarations of interests expressed.	
3. Chair's opening comments	**Verbal**
The Chair welcomed Ms Kate Barber from the West Midlands Strategic Health Authority (SHA) who attended to observe the meeting as part of the Trust's assessment of readiness for Foundation Status. The Chair thanked all who had been involved with the organisation of, and participation in the recent AGM, which was noted to have been a tremendous success.	
4. Minutes of the previous meeting	**SWBTB (9/08) 093**
Subject to minor amendment, the minutes of the meeting held on 4 September 08 were approved as a true and accurate record of discussions held.	
AGREEMENT: The minutes of the previous meeting on 4 September were approved	

5 Update on actions from previous meetings	**SWBTB (9/08) 093 (a)**
There were no actions outstanding or overdue.	
6 Questions from members of the public	**Verbal**
There were no questions from the public.	
7 Foundation Trust application	**SWBTB (10/08) 106** **SWBTB (10/08) 106 (a)**
Richard Kirby explained that the Foundation Trust (FT) application is the culmination of much preparatory work since summer 2005, when it was decided that the Trust should apply for FT authorisation. The Trust Board was formally asked to approve the set of material generated in support of the FT application. It was noted that the material had been reviewed in depth by Board members at a prior FT seminar meeting. The Board was reminded of the reason for the application: to provide an effective framework in which to operate within the diverse population that the Trust serves. FT status is also envisaged to provide an opportunity to explore different organisational structures and grant more flexibility in the way the Trust's money is spent, particularly in relation to the 2010 plans. Sarindar Sahota congratulated all staff and directors on the success of the membership recruitment, particularly in some of the communities known to be hard to reach. The Chair agreed that membership recruitment activities have worked very well and engagement has been good. Roger Trotman also congratulated Mr Kirby and team on the success of this work. He asked whether any comments received by the SHA on the Integrated Business Plan are to be incorporated into the version due for presentation to the Department of Health. He was advised that this was the case and it is anticipated that presentation to the DoH will follow the imminent Historical Due Diligence exercise. Little challenge to the core principles and models in the IBP is expected however. The Chair asked if there was a sense of how the Trust's IBP looks in comparison to those submitted by other Trusts. Mr Kirby advised that the document is lengthy, although this is reflective of the complexity of the issues faced by the Trust; the document is however, of average length in comparison to other submissions. Graham Seager enquired if, looking to the future, there was any evidence of a pattern of approvals by Monitor. He was informed that Monitor has limited capacity for assessing applications, therefore the application will be reviewed as capacity becomes available following submission. The preparation for the establishment of the Council of Governors is expected to start once the application for FT status has been submitted to Monitor, currently anticipated for January 2009. By this time an election process will be in place, which will create a shadow Council of Governors until authorisation is granted. A tender is currently being prepared to select the organisation which will run the election process. This is likely to be issued by Christmas. John Adler reported that a Listening into Action initiative has been undertaken to articulate the Trust's vision in a more digestible format. It was pleasing to note that all staff attending the workshop were familiar with the Trust's vision and aware of the future plans. The Board unanimously approved the submission for Foundation Trust status to the	

SHA.	
AGREEMENT: The Trust Board approved the submission of the application for Foundation Status	
8 Blood transfusion policy	**SWBTB (10/08) 096** **SWBTB (10/08) 096 (a)** **SWBTB (10/08) 096 (b)** **SWBTB (10/08) 096 (c)**
Donal O'Donoghue presented the blood transfusion policy to the Trust Board for approval in line with the requirement to do so set out in the Trust's policy for the management of policies. The National Patient Safety Agency (NPSA) has recently issued new requirements affecting all staff involved in blood transfusion, including the need to be trained and competency assessed by November 2010. These stringent requirements are aimed at minimising transfusion errors and therefore reducing morbidity and deaths associated with these actions. A number of major changes have been needed to ensure that the Trust complies with these NPSA stipulations, although the main challenge concerns the training requirement. There are currently 2000 staff participating in some part of the blood transfusion process, 50% of which need to be trained by May 2009. Following the initial training, an annual update will be required. Gianjeet Hunjan asked in what timescales the request for blood needed to be received to fit in with the process. Mr O'Donoghue advised that a cross match cannot be performed more than four weeks in excess of blood being required, as the blood deteriorates. The request should therefore ideally coincide with a preoperative clinic or the management of elective surgery cases. In relation to the information on page 15 of the policy, Mrs Hunjan asked how long used blood bags were kept before disposal. She was advised that as any adverse reactions are apparent within one to two days blood bags are only retained for one week. On page 18, Mrs Hunjan questioned whether the rate of adverse reactions was higher than other Trusts given the diverse population served by the Trust. Mr O'Donoghue advised that there does not appear to be any significant departure from the national trend and there have been no fatalities to his knowledge. Rachel Stevens confirmed this view. Robert White reported that significant investment is planned in a system to ensure full traceability of products involved in blood transfusions. Colin Holden remarked that in terms of the requirement to demonstrate competence, it is important to include the level of competence required within the KSFs of some of the ancillary staff, such as porters handling blood products. Mr O'Donoghue agreed that this requirement needs to be integrated into the plans for implementation of the policy. Richard Kirby suggested that as part of the policy, greater consideration should be given to the method of obtaining consent from patients who are unable to speak English. Although the policy does not impact on the current consent guidance, Mr O'Donoghue acknowledged that this suggestion was important. Roger Trotman noted that the policy is due for immediate review. He was advised	

that this would only be necessary if additional national guidelines are published and Mr O'Donoghue agreed that this would be clarified within the policy. John Adler suggested that the Initial Equality Impact Assessment (IEIA) should be amended to reflect the issues concerning blood transfusion in relation to Jehovah's Witness patients, although the existence of a separate policy covering this guidance in more detail should be acknowledged. Mr O'Donoghue agreed to amend the policy and IEIA to reflect this discussion. Isobel Bartram suggested that the treatment of patients refusing transfusion in general should be covered in more detail. Mr O'Donoghue summarised that the complexity of the policy is reflective of the considerable legislation governing the blood transfusion process. The Trust Board agreed to delegate Mr O'Donoghue with the authority to make the amendments to the policy suggested and on this basis approved the revised blood transfusion policy.	
ACTION: **Donal O'Donoghue to amend the blood transfusion policy to reflect suggestions made at the meeting** **AGREEMENT:** **Subject to the suggested amendments being made the Trust Board approved the blood transfusion policy**	
9 Smoking cessation policy	**SWBTB (10/08) 095** **SWBTB (10/08) 095 (a)**
Donal O'Donoghue presented a policy to encourage smoking cessation prior to surgery. Although the policy has been devised by Sandwell PCT, the Trust is acknowledged to be instrumental to the successful implementation of the policy. The key element of the policy is that patients will be offered the opportunity of smoking cessation therapy when an operation is planned. A concern was raised about the presentation of the policy, to ensure that it is clear to patients that the waiting time for treatment target is not impacted should they decide not to accept the offer of therapy. HoBtPCT was noted to be supportive of the policy. Isobel Bartram expressed concern that the policy may be regarded as discriminatory to patients who smoke and recommended that Sandwell PCT should be asked whether an equality impact assessment has been undertaken. The Chair noted that as there is no delay to the treatment pathway, should smoking cessation therapy not be accepted, then the policy cannot be seen to be discriminatory. Isobel Bartram questioned why the Board was being asked to approve the policy, given that it seemed to be a routine operational matter. John Adler advised that the approval at Board level would ensure that the policy is enforced with clinicians; the PCT also treated the policy as requiring Board approval. Richard Kirby agreed with the principles of the policy but asked what the Trust needed to do to practically implement it. Mr O'Donoghue advised that a pilot would be needed to determine the most successful method of implementation. Mr Kirby also suggested that the expectations of the Trust and Sandwell PCT need to be aligned.	

Cllr Thomas remarked that anecdotally many people give up smoking as a result of a medical episode. In Sandwell the demographic data shows that a high proportion of the population smoke, therefore Sandwell Council has targets for smoking cessation, which in turn pressures the healthcare providers in the region to encourage patients to give up smoking. As such it is understandable why Sandwell PCT is keen to implement the policy. Jessamy Kinghorn asked if a similar policy was being implemented elsewhere in the country. She was informed that it is not clear if this is the case. Mr O'Donoghue was asked how the requirements of the policy are to be communicated. He suggested that this detail would be included in the implementation plan for the policy, which is currently held by the PCT. The Chair stressed the importance of communicating any successful outcomes as a result of the implementation of the policy. Gianjeet Hunjan asked what data would be collected to monitor the success of the implementation. Mr O'Donoghue advised that the number of patients due to be referred to smoking cessation clinics would need to be audited. The PCT is however likely to set a standard. Sarindar Sahota was asked to note any discussion around such targets at the Sandwell PCT Board meetings. Tim Atack remarked that the Trust has a big public health responsibility and therefore even though a small subset of patients are impacted by the introduction of the policy, consideration should be given to rolling it out to a wider set of patients. John Adler noted that the PCTs had previously presented to the Trust Board and had been asked what measures the Trust could take to assist with improving heath overall. He agreed to follow this up with the relevant Executive leads in the PCTs. The Trust Board unanimously approved the introduction of the smoking cessation policy.	
ACTION: **Donal O'Donoghue to obtain details of the proposed smoking cessation implementation plan** **ACTION:** **John Adler to follow up with PCTs measures that the Trust could undertake to assist with improving heath overall** **AGREEMENT:** **The Trust Board approved introduction of the smoking cessation policy**	
10 Strategy and Development	
10.1 'Towards 2010' programme: progress report	**SWBTB (10/08) 105** **SWBTB (10/08) 105 (a)** **SWBTB (10/08) 105 (b)** **SWBTB (10/08) 105 (c)**
Richard Kirby presented the monthly progress report for the 'Towards 2010' programme. The report highlights work done to relaunch the transport group for the programme and work to look at appropriate IT solutions in advance of the electronic record being introduced. Tim Atack outlined the different approaches being taken by the	

PCTs in relation to Connecting for Heath; the Trust is far more aligned to the direction being taken by HoBtPCT. John Adler suggested a solution may be to adopt a common front end for the system. Donal O'Donoghue recommended that the concerns be discussed at the partnership board. Sarindar Sahota asked what effect the different approaches would have. He was advised that there is a likelihood of more outpatient and diagnostic appointments being required. Sandwell PCT has adopted the core Connecting for Heath product set, which is different to the set adopted by HOBtPCT, as the standard set is incompatible with the way in which its clinical services are integrated with the rest of Birmingham. The difference in approach causes issues for a joined up 2010 model, although these do not outweigh the benefits of adopting the new products. Mr Adler concluded by reiterating that a common front end would alleviate these issues. Mr Adler reported that the partner organisations and CENTRO are to agree a mapping exercise around transport times and links around the new community facilities and the new acute hospital. The work will be funded by CENTRO and the three main 2010 partners.	
10.2 New acute hospital project: progress report	**SWBTB (10/08) 103** **SWBTB (10/08) 103 (a)** **SWBTB (10/08) 103 (b)**
Graham Seager presented the monthly report on progress with the new acute hospital project. He reminded the Board that it had previously received the Outline Business Case for the new hospital, which has now been sent to the SHA, with some comments having now been received. The presentation of the final OBC is planned for the December meeting of the Trust Board. The Trust has been asked in particular to demonstrate that the 2010 community developments are deliverable within the timescales suggested. The Land Business Case is currently with the SHA and will be considered in November. In terms of the outline planning permissions, the concerns from the Environment Agency have now been resolved and work has also been undertaken on the access element of the application. The transport group is mapping the planned 2010 facilities and travel times for access by public transport, private vehicle, and on foot for those patients in the Trust's catchment area. The finance and affordability work for the scheme is nearing completion and confirms that the project continues to be affordable. The equipment group has undertaken much work, looking at the equipment needed to provide the services from the new hospital. An equipment responsibility matrix will be developed shortly. The Chair asked whether an audit of the Trust's current equipment is planned. Mr Seager advised that much of the Trust's current equipment is nearing its life end, therefore the disposal of a significant amount of equipment is planned. Cllr Thomas noted that compulsory purchase valuations are currently against the depressed market prices, therefore this could provide a positive result in future years when market conditions have recovered.	
11 Performance Management	
11.1 Monthly performance monitoring report	**SWBTB (10/08) 097** **SWBTB (10/08) 097 (a)**
Robert White introduced the monthly performance monitoring report for the period	

covering August 2008.

Delayed transfers of care increased to 3.3% during August, predominantly due to an increase at the Sandwell site. There is a possibility that this target will be impacted over the next few months by the closure of a major nursing home in HoBtPCT, which represents the loss of 1-2 beds per month. Regular updates regarding the situation are being received from HoBtPCT. The situation may be exacerbated by the delayed opening of a care centre in HoBtPCT, although there are plans to open this within the next 2-4 weeks. The facility provides 22 interim care beds and is key to winter plans at City Hospital.

Stroke data has been verified and shown to be correct: only 22% stroke patients spend in excess of 90% of the time of their stay on a stroke unit. There are a number of reasons for this, mainly concerning the pathways of care involved: of the 6-7 days a short stay stroke patient may stay in the hospital, one of these is spent on EAU or MAU; interim beds are being used in the case of delayed discharge; some patients are treated for palliative care rather than being directed to a stroke unit. It is anticipated that many of the issues may be resolved through the Listening into Action process, where the stroke pathways will be reviewed. The Chair remarked that it was reassuring that the clinicians are engaged with the issues. During discussions regarding the LDP, the Trust's commissioners acknowledged a need to look at stroke in the context of appropriate clinical care, suggesting that there may be funding available to address stroke performance.

In terms of cancelled operations, performance is similar to previous months, although there were slightly fewer operations in August. Ophthalmology continues to be the major pressure point for this target.

Robert White reported that the Trust is on track to meet year end infection control trajectories, although two bacteraemia cases were reported in August and three reported in September.

Ambulance turnaround times are now reported against targets set for the proportion of ambulances turned round in excess of 30 minutes and 60 minutes. The Trust is performing well against the 60 minutes target in comparison to other Trusts in the region and satisfactorily against the 30 minutes target. The SHA is currently developing an agreed protocol for measuring and reporting ambulance turnaround times. It is likely that it will be proposed that 90% cases should be handled in 30 minutes or less and any validated case in excess of 60 minutes be treated as a serious incident.

Agency spend has increased above the target of 2%, some of which is attributable to staff costs against which VAT cannot be recouped. The expenditure trends have been shared with divisions and work is underway to determine areas where savings can be made.

The number of PDRs submitted is 3216, representing over 60% of the 2008/09 target now being met.

There is now additional focus on theatre utilisation, specifically late starts and early finishes. Work is planned to address the current poor theatre utilisation rates, which also involves Listening into Action initiatives.

Mr Atack reported that a number of wards have been closed at both City and Sandwell hospitals due to an outbreak of Norovirus. The Trust Board was assured that

limiting the spread of the virus to other wards was well managed. This has resulted in a number of bed capacity issues throughout September, although this is not expected to impact on the Trust's year to date performance. It will impact in the short term on indicators such as cancelled operations and ambulance turnaround times, although the situation will be alleviated to some degree by the imminent opening of five additional acute beds and the appointment of an acute physician from January 2009. There is a possibility that an additional 12-34 beds may be opened from January 09. Additional staff have been recruited to assist with the management of the extra beds.	
11.2 Monthly finance report	**SWBTB (10/08) 098** **SWBTB (10/08) 098 (a)**
The Committee was pleased to hear that all divisions reported an in-month surplus, resulting in an overall surplus of £369k being achieved against a target of £248k, £121k ahead of plan. The year to date surplus was reported to be £1,625k. A year end forecast of £2.5m surplus continues to be anticipated. The slight dip in CIP reported at the previous meeting has now been recovered and the year end target is expected to be met. Capital expenditure has accelerated to bring the year to date expenditure more in line with plan. In order to achieve the required financial year end position, a programme of non-recurrent spend has been agreed. Richard Kirby noted that cash levels have been low for a few successive months. Mr White reported that this trend was driven by the payment of non-NHS trade creditors; the position is a matter of timing rather than any underlying issues with the income and expenditure situation. John Adler drew the Board's attention to the workforce numbers, where the report shows that WTEs are below plan, although pay costs are on budget. The Women and Child Health division is reporting the largest surplus at present, although this is attributable to pay underspend, therefore a specific recruitment plan is underway. Roger Trotman confirmed that at the Finance and Performance Management Committee, it had been agreed that a more meaningful analysis of workforce numbers would be presented, particularly to separate bank and agency expenditure from that associated with substantive positions.	
12 Governance and Operational Management	
12.1 Heath and safety annual report	**SWBTB (10/08) 102**
Colin Holden presented the annual heath and safety report for 2007/08. He advised that the detailed data underpinning the report was presented as part of the annual risk report, received by the Board at the last meeting. Mr Holden reported that the HSE visited in September 2007 and focussed in particular on the processes around stress, sickness and rehabilitation, the outcome of which was a number of recommendations, progress against which will be reviewed in December 2008. Progress with sickness and rehabilitation has been good, although stress	

management still needs to be considered more fully. A stress management risk assessment is due to be completed shortly to determine the position. Gianjeet Hunjan asked if the needlestick injury working party had reported yet. She was advised that it had and work was continuing. As a consequence of this additional focus, every injury caused by incorrect disposal is now flagged as a red incident which will prompt a full review. Rachel Stevens asked whether this monitoring included disposal by drugs users within the hospital grounds or being treated within the hospital. She was informed that this was the case. John Adler noted the good performance against mandatory training targets for conflict resolution and manual handling, which appears to have led to a reduction in violent and aggressive incidents and fewer injuries resulting from incorrect manual handling. Mr Holden reported that a permanent base for heath and safety trainers has now been found at both sites.	
12.2 Use of the Knowledge and Skills Framework	**SWBTB (10/08) 104** **SWBTB (10/08) 104 (a)** **SWBTB (10/08) 104 (b)** **SWBTB (10/08) 104 (c)**
Colin Holden reminded the Trust Board that the Agenda for Change agreement, implemented in 2004, comprised two elements: revised terms and conditions, including pay, and the introduction of the knowledge and skills framework (KSF). Good progress is being made with the introduction of the KSF, although there is still much work to do to ensure it is fully embedded. A director with responsibility for the KSF needs to be identified and a regular report needs to be presented to the Trust Board to update it with progress with embedding into the Trust. There have been a number of concerns expressed regarding the complexity of the KSF, therefore moves are underway to simplify the document. The underpinning principle is that competencies are identified for a particular role at a level appropriate to the seniority or requirements of the job. The individual's performance against the competencies is assessed as pat of the annual PDR process, with a performance development review being agreed to address any gaps. A number of organisational processes are required however, to ensure that the KSF is well implemented, such as a robust appraisal system. Given the recent good performance with holding PDRs, the Trust performs well in terms of the number of PDPs delivered and PDRs performed against the KSF. An example of the e-KSF for the Head of Learning and Development was presented, which is based on six core competencies accompanied by another set of service specific competencies. The Board noted that the process to evaluate a member of staff against the KSF would be administratively burdensome, although the e-KSF has been designed to overcome some of the issues raised with the KSF implementation. Judith Whalley confirmed the staff side view that the use of the current KSF is burdensome and overly complex. Members of staff are required to prepare a portfolio of evidence to demonstrate that they have met the competency levels within the KSF, although some staff find that there is difficulty in selecting appropriate evidence.	

Robert White observed that an individual's progression up the payscale is dependent on successful completion of a gateway review, part of which includes a review against a KSF. Should a review not be completed there is no means of withholding an individual's salary increment, should they not be deemed to have attained the required competencies for the role. Mr Holden was thanked for his update and encouraged to contribute to the wider national debate concerning simplification of the KSF.	
13 Update from the Board Committees	**SWBFC (8/08) 041**
13.1 Finance and Performance Management Committee	
The Trust Board received the minutes of the Finance and Performance Management Committee held on 28 August 2008.	
AGREEMENT: The Trust Board approved the minutes and associated actions from the Finance and Performance Management Committee held on 28 August 2008	
13.2 Audit Committee	
Audit Committee annual report	**SWBTB (10/08) 107** **SWBTB (10/08) 107 (a)**
Gianjeet Hunjan presented the Audit Committee annual report, previously presented and approved at the Audit Committee on 11 September 2008. It was agreed that future reports will coincide with the financial timetable. The report outlined the work undertaken by the Committee from 1 October 2007 to 31 August 2008, including agreeing the Statement on Internal Control and reviewing the Assurance Framework. The Committee will seek assurance in the future on embedding governance arrangements in the Trust. Roger Trotman congratulated Mrs Hunjan on the successful chairship since taking on the role in May 2008. The Trust Board noted the annual report.	
13.3 Annual audit letter	**SWBTB (10/08) 101** **SWBTB (10/08) 101 (a)**
Robert White presented the annual audit letter, previously presented and approved by KPMG at the Audit Committee on 11 September 2008. The letter reported that the external auditors were pleased with the quality and timeliness of paperwork made available to them as part of the year end process. The work reported a lower rate of coding errors than the national average. The Chair questioned the recommendation to ensure that SLAs are signed before the start of the next financial year. She was advised that this refers to completion of both parts of the two stage process to sign SLAs with the main commissioners, including details such as quality standards and trigger points. Heads of Terms were always signed before the start of the year.	

Roger Trotman noted that there is a requirement to accelerate the preparation and submission of accounts for 2008/09. He was assured that the plans were in hand and the ledger would be closed earlier than usual in May. There is work to be undertaken to raise the ALE score for the area related to internal control from 2 to 3. There is optimism that this can be achieved however, given the greater focus on linking the Trust risk register, Assurance Framework and corporate objectives. A more comprehensive evidence capturing system has also been arranged to ensure that the auditor review is more efficient than prior year.	
14 Any other business	**Verbal**
Richard Kirby reported that following the recent bid for South Birmingham Community Ophthalmology work, the Trust has been invited to present its bid during week commencing 6 October 08.	
15 Details of next meeting	**Verbal**
The next meeting is scheduled for Thursday 6 November at 2.30pm in the Anne Gibson Boardroom at City Hospital.	
16 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1 (2) Public Bodies (Admission to Meeting Act 1960).	

Signed ……

Print……

Date ……

Next Meeting: 6 November 2008, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham NHS Trust - Trust Board

2 October 2008 - Sandwell Hospital

Members: Mrs S Davis (SD) [Chair], Cllr B Thomas (BT), Ms I Bartram (IB), Mr R Trotman (RT), Mrs G Hunjan (GH), Dr S Sahota (SS), Mr J Adler (JA), Mr D O'Donoghue (DO), Mr R White (RW), Mrs R Stevens (RS), Mr R Kirby (RK)

In Attendance: Mr T Atack (TA), Ms K Dhami (KD), Mr G Seager (GS), Mr C Holden (CH), Mrs J Kinghorn (JK), Ms J Whalley (JW)

Guests Ms K Barber (KB)

Apologies: Prof D Alderson (DA)

Secretariat: Mr S Grainger-Payne (SPGP)

Last Updated: 31 October 2008

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 055	Monthly Performance Monitoring Report	SWBTB (9/08) 064 SWBTB (9/08) 064 (a)	04-Sep-08	Speak to Mike Harding regarding comparative performance for cancelled operations information being included in future versions of the monthly performance reports	TA	03-Oct-08	~~Comparative data must include cancelled~~ operations to be incorporated into future versions of the performance management report. Information based on data to be provided by the SHA from November. Comparative data now included where appropriate.	Completed Since Last Meeting	
SWBTBACT. 046	Single Equality Scheme	SWBTB (7/08) 057 SWBTB (7/08) 057 (a)	03-Jul-08	Circulate the terms of reference for the subgroups of the Equality and Diversity Steering Group	RS	15-Aug-08	A revised Single Equality Scheme, including the Terms of Reference for the various subgroups will be presented at the November Trust Board meeting. Included as agenda item 11.2	Completed Since Last Meeting	
SWBTBACT. 040	Patient experience report	SWBTB (6/08) 036 SWBTB (6/08) 036 (a) SWBTB (6/08) 036 (b) SWBTB (6/08) 036 (c)	05-Jun-08	Circulate the patient experience action plan when timescales have been assigned to the various actions	RS	03-Jul-08	A full revision together with dates and progress will be presented at the November Trust Board. Included as agenda item 11.9	Completed Since Last Meeting	
SWBTBACT. 004	Nursing workforce strategy	Presentation	03-Apr-08	Present the results of the nursing workforce strategy pilot at the October Board meeting	RS	02-Oct-08	Results not yet ready for publication, so present at November Trust Board meeting. Included as agenda item 11.1	Completed Since Last Meeting	
SWBTBACT. 052	Update on actions from the previous meeting	SWBTB (7/08) 062 (a)	04-Sep-08	Discuss the requirements of the Patient Safety Development role with Sarindar Sahota	RS	02-Oct-08	Suggested that KD may be better placed to discuss with SS. Discussed with SS on 21/10/08	Completed Since Last Meeting	
SWBTBACT. 058	Integrated Risk and Complaints Report	SWBTB (9/08) 071 SWBTB (9/08) 071 (a)	04-Sep-08	Provide a further analysis as to the incidents of case files not being available	KD	06-Nov-08	Included in integrated risk and complaints report presented at the Governance and Risk Management Committee. Update also issued by e-mail by SGP.	Completed Since Last Meeting	
SWBTBACT. 060	Blood Transfusion Policy	SWBTB (10/08) 096 SWBTB (10/08) 096 (a) SWBTB (10/08) 096 (b) SWBTB (10/08) 096 (c)	02-Oct-08	Amend the blood transfusion policy to reflect suggestions made at the meeting	DOD	06-Nov-08	Suggested amendments have been conveyed to the Blood Transfusion Committee and will be incorporated into the next version of the policy	Completed Since Last Meeting	

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 061	Smoking cessation policy	SWBTB (10/08) 095 SWBTB (10/08) 095 (a)	02-Oct-08	Obtain details of the proposed smoking cessation implementation plan	DOD	06-Nov-08	Meeting has been arranged with Sandwell PCT representatives to discuss the smooth implementation of the policy	Completed Since Last Meeting	
SWBTBACT. 062	Smoking cessation policy	SWBTB (10/08) 095 SWBTB (10/08) 095 (a)	02-Oct-08	Follow up with PCTs, measures that the Trust could undertake to assist with improving health overall	JA	31-Dec-08	ACTION NOT YET DUE	Future	
SWBTBACT. 023	2010 programme progress report	Enclosure 5d	03-Apr-08	Present the working assumptions in connection with the future ownership of community hospital sites at a future meeting	RK	03-Jul-08	Initial assessment of this work presented to one of the FT seminars and will now be undertaking further work on the detail which will come back to Trust Board later in 2008/9.	Review next meeting	4-Dec-08
SWBTBACT. 048	Annual complaints report	SWBTB (7/08) 055 SWBTB (7/08) 055 (a)	03-Jul-08	Consider a more appropriate way of providing a comparison of the Trust's performance regarding the number of complaints received with other organisations	KD	04-Sep-08	Standardisation to be incorporated into next quarterly report due in December.	Review next meeting	4-Dec-08
SWBTBACT. 056	Assurance Framework Update	SWBTB (9/08) 072 SWBTB (9/08) 072 (a)	04-Sep-08	Send a reminder to Executives regarding updates to the Assurance Framework to ensure that the correct information is provided for the next update	KD	06-Nov-08	To coincide with the next quarterly update.	Review next meeting	4-Dec-08

Next Meeting: 6 November 2008, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham NHS Trust - Trust Board

2 October 2008 - Sandwell Hospital

Members:	Mrs S Davis (SD) [Chair], Cllr B Thomas (BT), Ms I Bartram (IB), Mr R Trotman (RT), Mrs G Hunjan (GH), Dr S Sahota (SS), Mr J Adler (JA), Mr D O'Donoghue (DO), Mr R White (RW), Mrs R Stevens (RS), Mr R Kirby (RK)
In attendance:	Mr T Atack (TA), Ms K Dhami (KD), Mr G Seager (GS), Mr C Holden (CH), Mrs J Kinghorn (JK), Ms J Whalley (JW)
Guests	Ms K Barber (KB)
Apologies:	Prof D Alderson (DA)
Minutes:	Mr S Grainger-Payne (SPGP)

Last Updated: 31 October 2008

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAG.049	Minutes of the previous meeting	SWBTB (9/08) 093	02-Oct-08	The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held
SWBTBAG.050	Foundation Trust application	SWBTB (10/08) 106 SWBTB (10/08) 106 (a)	02-Oct-08	The Trust Board approved the submission of the application for Foundation Trust
SWBTBAG.051	Blood Transfusion Policy	SWBTB (10/08) 096 SWBTB (10/08) 096 (a) SWBTB (10/08) 096 (b) SWBTB (10/08) 096 (c)	02-Oct-08	Subject to the suggested amendments being made, the Trust Board approved the blood transfusion policy
SWBTBAG.052	Smoking Cessation Policy	SWBTB (10/08) 095 SWBTB (10/08) 095 (a)	02-Oct-08	The Trust Board approved the introduction of the smoking cessation policy
SWBTBAG.053	Finance and Performance Committee	SWBFC (8/08) 041	02-Oct-08	The Trust Board approved the minutes and associated actions from the Finance and Performance Management Committee held on 28 August 2008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Single Tender Action – Locum GP Service
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	6 November 2008

KEY POINTS:

To request authorisation to raise a requisition for £500k to cover a locum GP service, supporting Medicine A division.

The urgent care centre at City Hospital is staffed by approximately 20 GPs who submitted individual invoices for the hours that they work. It is proposed that the total cost is covered by one purchase order so that separate orders do not need to be raised for individual invoices.

These costs are fully funded by HoB tPCT as part of the 2010 urgent care exemplar project.

PURPOSE OF THE REPORT:

◉ **Approval** ○ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to approve the single tender arrangement.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically

IMPACT ASSESSMENT:

FINANCIAL	☑	Value of the call off order to be raised is £500k.
ALE	☐	
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Towards 2010 Programme Progress Report
SPONSORING DIRECTOR:	Richard Kirby, Director of Strategy
AUTHOR:	Jayne Dunn, 2010 Implementation Director
DATE OF MEETING:	6 November 2008

KEY POINTS:

The paper provides a progress report on the work of the Towards 2010 Programme as at the end of October 2008 and includes a copy of the 2010 Programme Director's report to the 2010 Partnership. It covers:

- Progress of confirming 2008/09 targets for exemplar and second stage transition projects and monitoring performance;
- Progress with establishing the Strategic Model of Care Steering Groups

PURPOSE OF THE REPORT:

○ **Approval** ◉ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. NOTE the progress made with the Towards 2010 Programme.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

3.1 Deliver new models of care through the first wave 2010 exemplar projects and begin to deliver new models of care for community-based outpatients in the second wave 2010 exemplar specialties.

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	The 2010 Programme sets the context for future clinical service models.
WORKFORCE	☑	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS

NHS Trust

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TOWARDS 2010 PROGRAMME: PROGRESS REPORT
NOVEMBER 2008

INTRODUCTION

The Towards 2010 Programme is the partnership of S&WBH, HoB tPCT, Sandwell PCT and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. This brief paper provides a progress report for the Trust Board on the work of the Programme as at the end of October 2008.

This report is in two sections:

a) overview of the work of the Towards 2010 Programme;
b) Programme Director's report as presented to the 2010 Partnership and the Boards of Sandwell and HoB PCTs (Appendix 1)

OVERVIEW

This section provides an overview of the work of the Towards 2010 Programme. This work is set out in more detail in the Programme Director's report in Appendix 1 (please note the appendices are not included but are available from Richard Kirby or Jayne Dunn). It is also reviewed and discussed on a monthly basis at the Trust's 2010 Implementation Board meetings. The most significant issues arising are as follows:

Project Targets – A revised set of targets was presented to the 2010 Partnership Board for approval and will be include in next month's progress report.

Project Performance – The 2010 Programme Team continue to work with project leads, IT and information colleagues on the provisions of robust data on an ongoing basis.

Strategic Model of Care Steering Group – The chairs have been agreed for each of the Groups apart from the group for End of Life Care. Chief Executive's have been asked to identify nominations for each group and it is envisaged that the groups will start to meet in November.

RECOMMENDATIONS

The Trust Board is recommended to:

1. NOTE the progress made with the Towards 2010 Programme.

Jayne Dunn
2010 Implementation Director
29th October 2008

APPENDIX 1

Sandwell and the Heart of Birmingham Health and Social Care Community

TOWARDS 2010 PROGRAMME

Report to:	**2010 Partnership Board**
Report of:	**Les Williams, Programme Director**
Subject:	**Programme Director's Report**
Date:	**Monday, 27th October, 2008**

1. Summary and Recommendation

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

The Partnership Board is recommended to:

- Note that the Programme Project Methodology has been agreed by the Strategy Group
- Note the Project Targets 2008/09 have been agreed by the Strategy Group
- Note the content of the remainder of the report.

2. Programme Project Methodology

As discussed previously, the Programme Project Methodology has now been debated with Project Leads and agreed through comments from members of the Strategy Group. This is now therefore fully agreed in accordance with the approach required by the Partnership Board and is attached for information at Appendix 1.

3. Project Targets

As agreed at the last Partnership Board meeting, the schedule of targets proposed was to be agreed at Strategy Group. The revised schedule was agreed at the Strategy Group on Wednesday 22nd October, and is attached at Appendix 2 for final agreement by the Partnership Board.

The Programme Team will shortly begin the process for reviewing with Project Leads the deliverability of the 2009/10 targets, as identified by Version 4.1 of the Activity and Capacity Model.

4. Project Performance

The report indicating the performance of projects to date is attached at Appendix 3. This uses the targets agreed by Strategy Group as reported in Section 3 above. These now include within the target activity levels the pre-existing activity being undertaken in community settings as well as the target activity to transfer or change the provision of new activity during this year.

This means that the target activity for September may look strange in a number of projects. The previously set target levels for April to August have been left as originally set, with the September figure being used as a balancing figure to enable the first six months' actual activity to be set against an appropriate level of target for that period.

The status of projects shown is based on a series of judgements by the Programme Team. These are based on a combination of hard data and judgements about the progress being made by projects. For example, where there is a lack of activity data being provided, but it is felt that there is real progress against plan, the status is not automatically Red. Where neither of these is in place, Red is used.

There remain significant issues in several projects about provision of data and reports on a robust and continuing basis. The Programme Team is meeting with project leads, IT and Information colleagues on 3rd and 4th November to resolve the data issues and tighter performance management will now be applied, based on the agreed targets. Future reports will identify issues which are impeding progress and will indicate the period of time that the issues have been apparent, as well as commenting on action being taken to resolve them.

5. Update on Strategic Model of Care Steering Groups

The Chair of each of the Groups has now been agreed and reported to the Clinical Group, with the exception of End of Life Care. The original proposal was to use the Palliative Care Network Board but the chair has recently left, and the Board is to be restructured. I am therefore pursuing the identification of a chair and an appropriate group to undertake the work with the Commissioning Leads in each of the PCTs.

In addition, the Clinical Group has agreed the format and content of the Clinical Strategies and the Overall Model of Care to guide the initial discussions of the SMOCS Groups.

Chief Executives have been asked to identify nominations for each group and when these are all returned, the meetings will be set up. I anticipate therefore that these will begin in November. I will be meeting with colleagues from the Adults and Communities Directorate of Sandwell MBC to agree the most appropriate method of supporting this work, given that they will not be able to provide representatives for every group.

6. Alignment of LDPs and Programme Requirements

As members will recall, the SHA indicated in its External Review from November last year that there should be greater alignment of LDPs and Programme requirements for development funding across the Programme. This was recently discussed at the Finance Group and it was agreed that Finance Directors in SWBH and the two PCTs will ensure that Project Leads were given the opportunity to raise development issues in projects for the 2009/10 LDP process.

7. Recommendation

The Partnership Board is recommended to:

- Note that the Programme Project Methodology has been agreed by the Strategy Group
- Note the Project Targets 2008/09 have been agreed by the Strategy Group
- Note the content of the remainder of the report.

Les Williams
Programme Director

2008-10-20 – prog dir report - lnw

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Towards 2010 Programme
Acute Hospital Services Development

1.0 Outline Business Case (OBC)

Work continues on plan to develop the Outline Business Case (OBC). A third draft of the OBC has been developed to include:

- A financial assessment of the scheme
- Further detail about how the development fits into the wider *Towards 2010 Programme*
- The case for change, the activity model and workforce implications

The document has been forwarded to the Strategic Health Authority (SHA) for further review and comment.

The project team will be working hard to ensure that we respond to SHA comments within the development of the Submission Draft of the OBC. The final document will show the updated costs for the scheme and will reflect all of the work done to validate the figures supporting the OBC.

The OBC will be presented to the Trust Board and Primary Care Trust (PCT) Boards in December 2008.

2.0 Outline Planning Permission

Outline Planning Permission for the Acute Hospital was approved at SMBC planning committee on 29th October 2008.

3.0 Land Acquisition

The Land Business Case (LBC) has been reviewed by the SHA's Capital Review Group (CRG). The CRG has recommended that the LBC be considered by the SHA Board pending a number of conditions:

- Outline Planning Permission being granted on 29th October 2008
- PCT endorsement of the scheme
- Subsequent approval from the Department of Health (DH)
- A Value for Money Treasury test query being addressed

These conditions are currently being addressed and we anticipate approval at the SHA Board meeting in November.

Steps have also been taken to make contact with the land / property owners. This will help us build a database of information to keep them informed.

.

Graham Seager
Project Director

SWBTB (11/08) 112

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

REPORT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning and Performance Mgt
DATE OF MEETING:	6 November 2008

KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period August – September 2008

PURPOSE OF THE REPORT:

☐ **Approval** ☒ **Noting** ☐ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically. Satisfies compliance with NHS Plan and other locally agreed targets.

IMPACT ASSESSMENT:

FINANCIAL	☑	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☑	
LEGAL	☑	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☑	
RISKS		

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - SEPTEMBER 2008

SWBTB (11/08) 112 (a)

EXECUTIVE SUMMARY

<table>
<tr><th>Note</th><th>Comments</th></tr>
<tr><td rowspan="2">a</td><td>The percentage of cancelled operations increased from 1.0% in August to 1.5% during September, with increases seen across a number of specialties. A number of contributory factors have been identified; principally Bed pressures (which accounted for 50% of the cancellations) , Consultant sickness absence, Equipment failure and Administrative failures.</td></tr>
<tr><td>National annual health check data for 2007 / 08 on cancelled operations has recently been published by the Healthcare Commission. The Trust reported 0.912% cancelled operations during 2007 / 08, this compared with a national average of 0.898%. The threshold for achievement of this indicator was set at 0.8% or less, which in excess of 50% of Trusts failed to achieve.</td></tr>
<tr><td rowspan="2">b</td><td>The level (%) of Delayed Transfers of Care remained similar during September, although actual numbers associated with an NHS delay decreased overall.</td></tr>
<tr><td>The availability of an adequate number of Nursing Home beds in Birmingham has previously been discussed. Although this is not an immediate issue for the Trust, the situation is being closely monitored. The Norman Power Centre is due to be opened by HOBtPCT in mid November which will increase current capacity.</td></tr>
<tr><td>c</td><td>Further, detailed, analysis of the data on Stroke Care, and adjustment to the data query, has improved the percentage of stroke patients who spend in excess of 90% of their time on a stroke unit. An additional indicator has been introduced into the report which expresses the total number of days that stroke patients spent on a stroke unit, expressed as a percentage of total days on any ward.</td></tr>
<tr><td>d</td><td>The percentage of patients waiting in Accident & Emergency for less than 4 hours reduced to 97.0% across the Trust during September, although performance for the first 6 months remained above target (98.30%). The HOBtPCT Walk In Centre, the performance of which has historically been mapped to that of the Trust, is now run by the Independent Sector. Information on the Healthcare Commission website indicates that this is still likely to be the case, but will provide an update later in the year. Performance reported internally, including within this report, is exclusive of any walk-in centre data, which has historically added c.0.2 - 0.3% to the Trust's overall performance against this indicator.</td></tr>
<tr><td>e</td><td>The Trust GUMedicine performance has improved since the beginning of the year and now compares favourably with the SHA average. August Trust data for patients offered an appointment to be seen within 48 hours of contacting the service was 100% (SHA 99.1%) and for patients seen within 48 hours of contacting the service was 86.5% (SHA 87.0%).</td></tr>
<tr><td rowspan="2">f</td><td>Although the Trust overall incidence of C. Diff was within target during September, the number of cases at City Hospital rose sharply, resulting in the decanting of patients and the deep cleaning of several wards. The number of MRSA Bacteraemias increased to 3 during September, with numbers now totaling 6 for the last 3 months, compared with 2 for the first 3 months.</td></tr>
<tr><td>National data available for the first 4 months of the year reports an incidence of MRSA Bacteraemia of 13% below trajectory and an incidence of C. Diff 20% below trajectory, this compares with the Trust's performance for the same period of 75% below trajectory for MRSA Bacteraemia and 49% below trajectory for C. Diff.</td></tr>
<tr><td>g</td><td>RTT data for September indicates that 95.7% of non-admitted patients and 95.0% of admitted patients were treated within 18 weeks of referral. The number of Diagnostic Waits in excess of 6 weeks rose dramatically to 199 at the end of September. 191 of the 199 are attributable to Diagnostic Waits for Myocardial Perfusion Studies in Imaging. The non-operation of the Petten reactor in the Netherlands has had a major impact upon the availability / supply of the radioisotope necessary for this investigation. The reactor is unlikely to be fully operational again before early December. In the meantime the Division have formulated a plan to minimise waits as much as possible, this includes extended day working to ensure the use of available isotope is maximised. An update on the situation and further actions being taken will be discussed at an imminent Divisional Review meeting. Commissioners are aware of the situation.</td></tr>
<tr><td>h</td><td>Activity to date is compared with the contracted activity plan for 2008 / 2009.
<table>
<tr><th></th><th>Sandwell</th><th>City</th><th>Trust</th></tr>
<tr><td>IP Elective</td><td>10.9%</td><td>-6.9%</td><td>-0.5%</td></tr>
<tr><td>Day case</td><td>2.7%</td><td>2.1%</td><td>2.4%</td></tr>
<tr><td>IPE plus DC</td><td>4.2%</td><td>-0.1%</td><td>1.8%</td></tr>
<tr><td>IP Non-Elective</td><td>1.5%</td><td>0.1%</td><td>0.7%</td></tr>
<tr><td>OP New</td><td>7.7%</td><td>14.5%</td><td>11.8%</td></tr>
<tr><td>OP Review</td><td>-0.8%</td><td>-1.9%</td><td>-1.5%</td></tr>
</table>
Overall Elective, Non-Elective and New Outpatient activity during September returned to the levels seen during July, further increasing over performance to date against these elements of the Trust's contract with commissioners.

When activity to date is compared with 2007 / 08 for the corresponding period
<table>
<tr><th></th><th>Sandwell</th><th>City</th><th>Trust</th></tr>
<tr><td>IP Elective</td><td>11.9%</td><td>3.9%</td><td>7.0%</td></tr>
<tr><td>Day case</td><td>5.8%</td><td>9.3%</td><td>7.7%</td></tr>
<tr><td>IPE plus DC</td><td>6.9%</td><td>8.0%</td><td>7.5%</td></tr>
<tr><td>IP Non-Elective</td><td>3.2%</td><td>2.3%</td><td>2.7%</td></tr>
<tr><td>OP New</td><td>13.3%</td><td>15.2%</td><td>14.5%</td></tr>
<tr><td>OP Review</td><td>3.3%</td><td>-0.4%</td><td>1.0%</td></tr>
</table>
Actual performance to date remains well in excess of the corresponding period last year.</td></tr>
<tr><td>i</td><td>A breach of the national maximum 13-week wait for an outpatient appointment was reported at the end of September. The breach occurred in Clinical Immunology and resulted from non-adherence by administrative staff to internal procedures. Actions taken to prevent a future reoccurrence include; staff retraining, staff with dedicated responsibility to monitor / prevent potential breaches and the procurement of an 18-week pathway tool, to be used by staff to monitor, real time, a patients progress. The circumstances relating to the breach have also prompted a comprehensive review of the current systems and processes in place. The Strategic Health Authority has been advised of the circumstances.</td></tr>
<tr><td rowspan="2">j</td><td>The percentage of ambulances being turned around in excess of 30 minutes has reduced over the last 3 months to 9% overall, compared with an SHA mean of 11%. There were 21 recorded instances of delays in excess of 60 minutes, including 1 of 90 minutes, relating to extreme bed pressures, of which the ambulance service were advised of problems beforehand.</td></tr>
<tr><td>The Strategic Health Authority has recently published a report on a review of the turnaround of ambulances within the West Midlands. There are a number of recommendations contained within the report, agreed by Chief Executives, which the various health partners will work together to implement.</td></tr>
<tr><td>k</td><td>A noticeable drop in Nurse Agency expenditure during the month, coupled with the continued reduction of Other Agency Costs reduced the overall agency spend to 1.75% in month.</td></tr>
<tr><td>l</td><td>Sickness Absence increased slightly to 4.68% during August. Sickness Absence for the year to date is 4.36%, which compares favourably with the corresponding period last year, when the level was 4.62%. With the exception of two Divisions, all Divisions have sickness absence reported as less than 6% for the month of August.</td></tr>
<tr><td>m</td><td>The number of PDRs undertaken and reported during September fell to 154, although numbers from the earlier part of the year mean that 67% of staff have received a PDR during 2008/09 to date. Numbers of staff attending both Mandatory Training and Conflict Resolution Training both increased during September, although remain less than the target set for the period.</td></tr>
</table>

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - SEPTEMBER 2008

Exec Lead	NATIONAL INDICATORS			Jul-08 S'well	Jul-08 City	Jul-08 Trust	Aug-08 S'well	Aug-08 City	Aug-08 Trust	Sep-08 S'well	Sep-08 City	Sep-08 Trust	To Date	TARGET YTD	TARGET 08/09	Exec Summary Note	THRESHOLDS			06/07 Outturn	07/08 Outturn	08/09 Projected
RW	Net Income & Expenditure (Surplus / Deficit (-))		£000s	→		351 ▲	→		369 ▲	→		295 ▼	1918	1414	2500		0%	0 - 1%	>1%	3399	6547	
RK	Cancer	2 weeks	%	→		99.8 ▼	→		100 ■	→			99.4	>99	>99		No variation		Any variation	100	97.1	99.5
		31 Days	%	→		100 ■	→		100 ■	→			100	>98	>98		No variation		Any variation	99.9	99.9	100
		62 Days	%	→		100 ■	→		100 ■	→			99.8	>98	>98		No variation		Any variation	99.3	99.7	99.8
TA / MD	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.3 ■	1.0 ■	0.7 ■	0.4 ▼	1.4 ■	1.0 ■	0.8 ■	2.0 ▼	1.5 ■	1.0	<0.8	<0.8	a	<0.8	0.8 - 1.0	>1.0	0.9	0.9	1.0
		28 day breaches	No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0	0	0		3 or less	4 - 6	>6	4	0	0
	Delayed Transfers of Care	Total	%	2.1 ■	3.7 ■	3.0 ■	2.6 ▼	3.8 ▼	3.3 ▼	2.9 ▼	3.7 ▲	3.4 ▼	3.7	<3.0	<3.0	b	<3.0	3.0 - 4.0	>4.0	4.0	2.7	3.7
	Coronary Heart Disease	Thrombolysis (60 minutes)	%	no pts	no pts	no pts	no pts	no pts	no pts				0	80	80		>80	75-80	<75	56.8	50.0	
		Primary Angioplasty (<90 mins)	%	89 ■	100 ■	92 ■	100 ▲	50 ■	86 ▼				82	80	80		>80	75-80	<75	n/a	63.0	85.0
		Rapid Access Chest Pain	%	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	100	100	100		>99	98 - 99	<98	99.7	99.6	100.0
DO'D	Stroke Care	>90% stay on Stroke Unit	%	→		52.6 ■	→		39.0 ■	→			35.5	50	65+	c	55 - 65+	45 - 54	<45	n/a	n/a	
		Average % of stay on Stroke Unit	%	→		79.7	→		81.8	→			73.8	No. Only	No. Only					n/a	n/a	
TA / MD	A/E 4 Hour Waits		%	98.0 ■	99.0 ▲	98.8 ▲	98.6 ▲	99.0 ■	98.8 ■	97.0 ■	97.0 ■	97.0 ■	98.30	=>98	=>98	d	=>98		<98	98.20	98.28	98.20
	GUM 48 Hours	Patients seen within 48 hours	%	→		85.1 ▲	→		86.5 ▲	→		86.9 ■	75.7	95	95	e	No variation	0 - 10% variation	>10% variation	n/a	n/a	81.5
		Patients offered appointment within 48 hou	%	→		100 ■	→		100 ■	→		99.1 ■	96.8	100	100		No variation	0 - 10% variation	>10% variation	35.8	80.7	98.0
RS	Infection Control	C. Diff (aged 2+) - EXTERNAL TARGET	No.	4 ▲	6 ▼	10 ■	5 ▼	5 ▲	10 ■	2 ▲	13 ▼	15 ▼	80	161	317	f	No variation		Any variation	n/a	360	160
		C. Diff (aged 2+) - EXTERNAL TARGET	per 1000 adm	1.42 ▲	1.51 ▼	1.47 ▲	1.89 ▼	1.34 ▲	1.57 ▼	0.68 ▲	3.38 ▼	2.21 ▼	2.03	4.26	4.19		No variation		Any variation	n/a	4.76	2.03
		C. Diff (aged 2+) - INTERNAL TARGET	No.	4 ▲	6 ▼	10 ■	5 ▼	5 ▲	10 ■	2 ▲	13 ▼	15 ▼	80	154	301		No variation		Any variation	n/a	261	160
		C. Diff (aged 2+) - INTERNAL TARGET	per 1000 adm	1.42 ▲	1.51 ▼	1.47 ▲	1.89 ▼	1.34 ▲	1.57 ▼	0.68 ▲	3.38 ▼	2.21 ▼	2.03	4.08	3.98		No variation		Any variation	n/a	3.34	2.03
		MRSA Bacteraemias	No.	0 ■	1 ▼	1 ▼	1 ▼	1 ■	2 ▼	1 ▼	2 ■	3 ▼	8	18	33		No variation		Any variation	61	43	16
		MRSA Bacteraemias	per 1000 bed	0.00 ■	0.07 ▼	0.04 ▼	0.08 ▼	0.07 ■	0.07 ▼	0.08 ■	0.13 ■	0.11 ■	0.05	0.10	0.10		No variation		Any variation	0.16	0.14	0.05
TA	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	→		83 ■	→		84 ▲	→			84	90	90		>/=90	89.0-89.9	<89	90.0	89.0	87.0
DO'D / RS	Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	→			→			100 ■	99.9 ▼	99.9 ▼	99.9	100	100		>99	98 - 99	<98	99.9	99.5	99.9
		Breast Feeding Status Data Complete	%	→			→			100 ■	96.1 ■	97.7 ■	98.3	100	100		>99	98 - 99	<98	98.3	99.8	99.0
		Maternal Smoking Rates	%	→			→			20.8	7.8	13.3	13.8	No. Only	No. Only					13.2	13.1	13.8
		Breast Feeding Initiation Rates	%	→			→			37.9	65.4	53.8	53.2	No. Only	No. Only					52.5	55.0	53.2
TA / MD	RTT Milestones	Admitted Care (RTT <18 weeks)	%	→		95.0 ▲	→		94.9 ▼	→		95.0 ▲	95.0	90	90	g	< YTD target		> YTD target	52.0	90.6	91.0
		Non-Admitted Care (RTT <18 weeks)	%	→		95.2 ■	→		95.4 ▲	→		95.7 ▲	95.7	95	100		< YTD target		> YTD target	n/a	95.5	96.0
	Diagnostic Waits	Number greater than 6 weeks	No.	→		10 ▼	→		22 ▼	→		199 ▼	199	0	0		0-10% variation	10 - 20% variation	>20% variation	996	25	0

Exec Lead	ACTIVITY			S'well	City	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	08/09	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Projected
TA	Spells	Elective IP	No.	508 ▲ ■	742 ■	1250 ■	395 ▼	610 ■	1005 ■	492 ▲	644 ▼	1136 ▲	6745	6776	13669	h		No Variatio	0 - 2% Variatio	>2% Variatio	13887	13395	13604
		Elective DC	No.	1918 ■	2469 ▲	4387 ■	1704 ■	1985 ■	3689 ■	2036 ■	2332 ■	4368 ■	25093	24510	48285			No Variatio	0 - 2% Variatio	>2% Variatio	45831	46304	49434
		Total Elective	No.	2426 ▲	3211 ■	5637 ■	2099 ■	2595 ■	4694 ■	2528 ■	2976 ■	5504 ■	31838	31286	61954			No Variatio	0 - 2% Variatio	>2% Variatio	59718	59699	63038
		Non-Elective - Short Stay	No.	480 ■	453 ▼	933 ▼	534 ▲	440 ▼	974 ▲	523 ▲	360 ▼	883 ▼	6104	5945	11949			No Variatio	0 - 2% Variatio	>2% Variatio	12414	11575	12264
		Non-Elective - Other	No.	1903 ▼	2900 ▲	4803 ▲	1788 ■	2796 ▼	4584 ■	2013 ▼	2863 ▲	4876 ■	27718	27641	55538			No Variatio	0 - 2% Variatio	>2% Variatio	52662	55163	55692
		Total Non-Elective	No.	2383 ▼	3353 ▲	5736 ▲	2322 ■	3236 ■	5558 ■	2536 ■	3223 ■	5759 ■	33822	33586	67487			No Variatio	0 - 2% Variatio	>2% Variatio	65076	66738	67956
	Outpatients	New	No.	4827 ▲	8742 ▲	#### ▲	4635 ■	6824 ▼	#### ▼	5219 ▲	8288 ▲	#### ▲	75216	67252	131870			No Variatio	0 - 2% Variatio	>2% Variatio	127449	131941	147482
		Review	No.	#### ■	#### ▲	#### ■	#### ■	#### ■	#### ■	#### ■	#### ■	#### ■	185483	188260	369288			No Variatio	0 - 2% Variatio	>2% Variatio	370970	361113	363835
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	7113 ■	9253 ■	#### ■	6890 ■	8847 ▲	#### ■	6988 ▲	8322 ▼	#### ■	97801	98402	193188			No Variatio	0 - 2% Variatio	>2% Variatio	200561	195093	192030
	A/E Attendances	Type II (BMEC)	No.	→	2624 ▼	2624 ▼	→	2413 ▼	2413 ▼	→	2746 ■	2746 ■	15417	17098	32743			No Variatio	0 - 2% Variatio	>2% Variatio	31373	29803	29523
	CLINICAL QUALITY																						
TA	Readmission Rates	(Within 28 days of discharge)	%	10.9	11.7	11.4	13.2	10.7	11.8				11.2	No. Only	No. Only						10.1	n/a	11.0
		(Within 14 days of discharge)		5.0	6.3	5.8	3.9	5.9	5.1				5.1	No. Only	No. Only						n/a	n/a	5.0
RS	Infection Control	Savings Lives Compliance	%	→		98.0 ■	→		98.0 ■	→		98.0 ■	98.0	>95	>95		< YTD target		> YTD target		n/a	n/a	98.0
		Phlebitis Rate	%	0.6	0.4		0.7	0.5		0.2	0.4			<5	<5		< YTD target		> YTD target		n/a	1.77	0.5
		Phlebitis Compliance	%	87	81		86	84		86	89			>95	>95		>95%	75-95%	<75%		n/a	78	86
KD	Incident Reporting	Internally Reported Clinical Red Incidents	No.	→		11	→		11	→		3	53	No. Only	No. Only						37	137	100
		Internally Reported Non-Clinical Red Incide	No.	→		1	→		1	→		6	17	No. Only	No. Only						53	34	30
RS	Hip Fracture	Operations within 48 hours of admission	%	66.7 ■	78.9 ▼	73.0 ▼	75.0 ■	81.8 ▲	77.8 ▲	84.6 ▲	100 ▲	89.5 ▲	80.3	74	77		No variation	0 - 10% variation	>10% variation		63.6	70.1	85
DO'D	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	→ (April 2008)		97.2	→ (May 2008)		96.5	→ (June 2008)		91.4	95.3	Rate Only	Rate Only						101.1	100.2	
		Peer (SHA) HSMR	HSMR	→ (April 2008)		101.2	→ (May 2008)		94.1	→ (June 2008)		94.8	97.2	Rate Only	Rate Only						110.7	106.1	
	PATIENT EXPERIENCE																						
KD	Complaints	Number Received	No.	→			→			→			172	No. Only	No. Only						673	697	688
		Response within 25 days	%	→			→			→			84	85	85		80%+	70 - 79%	<70%		77.4	81.2	84
	Thank You Letters		No.	→			→			→			529	No. Only	No. Only						6026	3491	2116
TA	Elective Access Contact Centre	Number of Calls Received	No.	→		####	→		####	→		####	105681	No. Only	No. Only						n/a	n/a	222000
		Average Length of Queue	mins	→		3.28 ▼	→		2.00 ■	→		1.53 ▲	1.53	2.0	0.5		No variation	0 - 10% variation	>10% variation		n/a	n/a	0.75
		Maximum Length of Queue	mins	→		34.5 ▼	→		23.2 ▲	→		24.4 ▼	24.4	9.0	6.0		No variation	0 - 10% variation	>10% variation		n/a	n/a	15.0
TA	Telephone Exchange			→			→			→				No. Only	No. Only						n/a	n/a	

Exec Lead	PATIENT ACCESS & EFFICIENCY			S'well	City	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	08/09	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Projected
TA	Admitted Care	RTT maximum IP wait	Weeks	→		15	→		18	→		17	17	11	8		< YTD target		> YTD target	18 weeks max	17 weeks max	8 weeks max
		RTT (IP Waits greater than 8 weeks)	No.	→		94	→		181	→		172	172	60	0		< YTD target		> YTD target	n/a	191	0
		Inpatients >26 weeks	No.	→		0	→		0	→		0	0	0	0		0		>0	1	0	0
		Revascularisation >13 weeks	No.	→		0	→		0	→		0	0	0	0		0		>0	0	0	0
	Length of Stay	Average Length of Stay	Days	5.9	4.7	5.2	4.9	4.2	4.5				5.1	5.0	5.0		No Variation	0 - 5% Variation	>5% Variation	5.7	5.0	5.0
		All Patients with LOS > 14 days	No.	127	160	287	135	168	303	135	162	297	297	No. Only	No. Only					n/a	345	300
		All Patients with LOS > 28 days	No.	60	69	129	65	101	166	77	92	169	169	No. Only	No. Only					190	174	160
		Minimal Stay Rate (Electives (IP/DC) <2 da	%	90.1	91.8	91.1	92.1	89.8	90.9	91.2	91.3	91.2	91.2	91.4	92.0		No Variatio	0 - 5% Variatio	>5% Variatio	88.3	90.5	92.0
	Admissions	Day of Surgery (IP Elective Surgery)	%	76.8	82.0	79.7	82.1	81.3	81.7	74.5	85.0	79.8	79.0	80.0	82		No Variatio	0 - 5% Variatio	>5% Variatio	63.2	76.5	82.0
		Day of Surgery (IP Non-Elective Surgery)	%	67.7	68.4	68.1	65.3	68.1	66.9	61.3	71.0	66.5	68.5	No. Only	No. Only					n/a	68.3	70.0
		With no Procedure (Elective Surgery)	%	11.5	12.7	12.3	10.7	9.8	10.2				11.1	No. Only	No. Only					10.6	n/a	10.5
		Per Bed (Elective)	No.	4.85	5.33	5.11	5.56	5.72	5.65	5.26	5.08	5.16	5.30	5.35	5.90		No Variatio	0 - 5% Variatio	>5% Variatio	4.66	4.87	5.30
	Discharges	Pt's Social Care Delay	No.	4	4	8	4	17	21	10	10	20	20	<18	<18	b	No Variatio	0 - 10% Variatio	>10% Variatio			
		Pt.'s NHS & NHS plus S.C. Delay	No.	2	6	8	6	6	12	3	3	6	6	<10	<10		No Variatio	0 - 10% Variatio	>10% Variatio			
	Beds	Occupied Bed Days	No.	####	####	####	####	####	####	####	####	####	168237	169464	338000		No Variatio	0 - 5% Variatio	>5% Variatio	378060	348676	335553
		Occupancy Rate	%	88.3	88.0	88.1	87.6	88.4	88.0	89.3	88.5	88.9	89.8	86.5 - 89.5	86.5 - 89.5		86.5 - 89.5	85.5-86.4 or	<85.5 or	88.6	90.8	89.0
		Open at month end (total)	No.	460	564	1024	445	566	1011	464	563	1027	1027	1033	1017		No Variatio	0 - 2% Variatio	>2% Variatio	1097	1065	1017
		Open at month end (exc Obstetrics)	No.	439	527	966	424	529	953	443	526	969	969	975	975		No Variatio	0 - 2% Variatio	>2% Variatio	1039	1007	975
	Day Case Rates	All Procedures	%	78.6	76.3	77.3	80.9	76.1	78.3	80.1	77.7	78.8	78.3	78.5	80.0		No Variatio	0 - 5% Variatio	>5% Variatio	76.0	76.9	80.0
		BMEC Procedures	%	→	80.6	80.6	→	79.2	79.2	→	80.6	80.6	80.0	79.0	80.0		No Variatio	0 - 5% Variatio	>5% Variatio	71.5	77.2	80.0
		Basket of 25 procedures	%	68.8	79.9	75.5	76.7	78.4	77.8	71.6	82.7	78.2	77.8	78.5	80.0		No Variatio	0 - 5% Variatio	>5% Variatio	75.2	78.0	80.0
		Quality Metrics (Specified Procedures)	%	49.2	74.6	61.4	58.5	66.7	62.5	48.5	75.7	59.9	62.3	67.00	69.08		No Variatio	0 - 5% Variatio	>5% Variatio	n/a	61.29	70.0
	Non-Admitted Care	RTT maximum OP wait	Weeks	→		12	→		12	→		13	13	5	5		< YTD target		> YTD target	9 weeks max	10 weeks max	5 weeks max
		RTT (OP Waits greater than 5 weeks)	No.			2091			2381			2023	2023	0	0		< YTD target		> YTD target	n/a	1409	750
		New : Review Rate	Ratio	2.56	2.35	2.43	2.26	2.51	2.41	2.44	2.46	2.45	2.47	2.48	2.30		No Variatio	0 - 5% Variatio	>5% Variatio	2.91	2.74	2.47
		DNA Rate - New Referrals	%	10.8	11.9	11.5	10.9	13.3	12.4	10.9	13.6	12.5	11.5	10.2	9.0		No Variatio	0 - 5% Variatio	>5% Variatio	10.8	10.9	11.0
		DNA Rate - Reviews	%	12.0	14.5	13.6	11.7	14.4	13.4	12.1	13.8	13.1	13.5	11.6	9.0		No Variatio	0 - 5% Variatio	>5% Variatio	12.8	13.5	13.0
		Outpatients >13 weeks	No.	→		0	→		0	→		1	1	0	0	i	0		>0	4	0	1
	Diagnostics	Imaging Waits >6 weeks	No.	→		5	→		0	→		191	191	0	0	g	0 - 10%	10 - 15%	>15%	185	18	0
		Pathology >6 weeks	No.	→		0	→		0	→		0	0	0	0		0 - 10%	10 - 15%	>15%	n/a	0	0
		Audiology Waits >6 weeks	No.	→		5	→		22	→		7	7	0	0		0 - 10%	10 - 15%	>15%	60	3	0
		Cardiology Waits >6 weeks	No.	→		0	→		0	→		0	0	0	0		0 - 10%	10 - 15%	>15%	137	0	0
		Neurophysiology Waits >6 weeks	No.	→		0	→		0	→		1	1	0	0		0 - 10%	10 - 15%	>15%	218	0	0
		Respiratory Physiology Waits >6 weeks	No.	→		0	→		0	→		0	0	0	0		0 - 10%	10 - 15%	>15%	12	4	0
		Endoscopy Waits >6 weeks	No.	→		0	→		0	→		0	0	0	0		0 - 10%	10 - 15%	>15%	106	0	0
		Ophthalmic Science Waits >6 weeks	No.	→		0	→		0	→		0	0	0	0		0 - 10%	10 - 15%	>15%	278	0	0
		Urodynamics Waits >6 weeks	No.	→		0	→		0	→		0	0	0	0		0 - 10%	10 - 15%	>15%	0	0	0
		Orthotics Waits >6 weeks	No.	→		n/a	→		n/a	→		129	129	0	0		0 - 10%	10 - 15%	>15%	1854	67	0
	Pathology	Cervical Cytology Turnaround	Weeks	3.1	1.8		3.3	1.8					1.8 - 3.3	<4.0	<4.0		<4.0	4.0-6.0	>6.0	1.7 - 4.0	1.5 - 2.9	1.8 - 3.3
	Ambulance Turnaround	In Excess of 30 minutes	%	13	10	11	11	8	10	10	9	9	9	<10	<10	j	<10	10 - 12.5	>12.5	n/a	29.1	9.0
		(West Midlands average)	%	→		11	→		9	→		11	11							n/a	31.1	9.0
		In Excess of 60 minutes	No.	6	1	7	6	2	8	19	2	21	21	0	0		0	1 - 5	>5	n/a	n/a	0

Exec Lead	FINANCE & FINANCIAL EFFICIENCY			S'well	City	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	08/09	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Projected
RW	Gross Margin		£000s	→		2361 ▲	→		2373 ▲	→		2299 ▼	14032	13686	27137		0%	0 - 1%	>1%	26429	33250	
RW	CIP		£000s	→		696 ▼	→		734 ▲	→		729 ▼	6140	6151	11030		0 - 2.5%	2.5 - 7.5%	>7.5%	19679	14027	
RW	In Year Monthly Run Rate		%	→		50.0 ▲	→		48.8 ▼	→		19.9 ▼	35.60	0	0		NO or a +	0 - 5% variation	>5% variation	329	45	
TA	Income / WTE		£s	→		5062 ▲	→		5003 ▼	→		4993 ▼	4972	4861	4861		No variation	0 - 5% variation	>5% variation	5460	4924	
TA	Income / Open Bed		£s	→		#### ▲	→		#### ▲	→		#### ▼	30394	30158	30158		No variation	0 - 5% variation	>5% variation	24774	29065	
TA	Income per Spell	Total Income	£s	→		2640 ■	→		2897 ■	→		2638 ■	2698	2808	2808		No Variatio	0 - 4% Variatio	>4% Variatio	2635	2740	
TA	Income per Spell	Clinical Income	£s	→		2332 ■	→		2591 ■	→		2342 ■	2401	2510	2510		No Variatio	0 - 4% Variatio	>4% Variatio	2317	2449	
TA	Income per Spell	Non-Clinical Income	£s	→		308 ▼	→		306 ▼	→		296 ■	297	298	298		No Variatio	0 - 4% Variatio	>4% Variatio	318	291	
TA	Cost per Spell	Total Cost	£s	→		2609 ▲	→		2861 ■	→		2612 ■	2668	2709	2709		No Variatio	0 - 4% Variatio	>4% Variatio	n/a	2643	
TA	Cost per Spell	Total Pay Cost	£s	→		1714 ■	→		2000 ■	→		1745 ■	1771	1737	1737		No Variatio	0 - 4% Variatio	>4% Variatio	1772	1737	
TA	Cost per Spell	Medical Pay Cost	£s	→		507 ■	→		580 ■	→		522 ■	530	517	517		No Variatio	0 - 4% Variatio	>4% Variatio	543	517	
TA	Cost per Spell	Nursing Pay Cost (including Bank)	£s	→		592 ▲	→		701 ■	→		625 ■	619	615	615		No Variatio	0 - 4% Variatio	>4% Variatio	609	615	
TA	Cost per Spell	Non-Pay Cost	£s	→		895 ■	→		860 ▲	→		866 ▼	898	929	929		No Variatio	0 - 4% Variatio	>4% Variatio	n/a	906	
TA	Cost per Spell	Mean Drug Cost / IP Spell	£s	→		102 ■	→		105 ▼	→		98 ■	106	97	97		No Variatio	0 - 4% Variatio	>4% Variatio	n/a	95	
TA	Cost per Spell	Mean Drug Cost / Occupied Bed Day	£s	→		41 ▼	→		39 ▲	→		40 ▼	41	35	35		No Variatio	0 - 4% Variatio	>4% Variatio	n/a	35	
	WORKFORCE																					
TA	WTE in Post	Total	No.	→		5932 ▲	→		5936 ■	→		5951 ▼	5951	6129	6082		No Variatio	0 - 1% Variatio	>1% Variatio	6000	5875	
TA	WTE in Post	Medical and Dental	No.	→		745 ▲	→		745 ■	→		753 ▼	753	770	761		No Variatio	0 - 1% Variatio	>1% Variatio	822	736	
TA	WTE in Post	M'ment, Admin. & HCAs	No.	→		1795 ▲	→		1805 ▼	→		1812 ▲	1812	1893	1867		No Variatio	0 - 1% Variatio	>1% Variatio	1806	1765	
TA	WTE in Post	Nursing & Midwifery (excluding Bank)	No.	→		2243 ▼	→		2241 ▼	→		2240 ▼	2240	2524	2528		No Variatio	0 - 1% Variatio	>1% Variatio	2481	2255	
TA	WTE in Post	Scientific and Technical	No.	→		897 ▼	→		900 ▼	→		902 ■	902	941	926		No Variatio	0 - 1% Variatio	>1% Variatio	891	869	
TA	WTE in Post	Bank Staff	No.	→		252	→		242	→		238	238	No. Only	No. Only					n/a	250	
TA	WTE in Post	Gross Salary Bill	£000s	→		#### ▼	→		#### ■	→		#### ▲	116258	116353	231000		No Variatio	0 - 1% Variatio	>1% Variatio	220244	219667	
TA	Bank & Agency	Nurse Bank Fill Rate	%	→		84.9	→		83.7	→		81.2	84.8	No. Only	No. Only	k				n/a	87.6	85.0
TA	Bank & Agency	Nurse Bank Shifts covered	No.	→		5654 ■	→		5862 ▼	→		5587 ▲	33880	30918	61836	k	0 - 2.5% Variatio	2.5 - 5.0%	>5.0% Variatio	67330	68707	67760
TA	Bank & Agency	Nurse Agency Shifts covered	No.	→		402 ▲	→		276 ▲	→		336 ▼	2457	2486	4972	k	0 - 5% Variatio	5 - 10% Variatio	>10% Variatio	2879	5524	4914
TA	Bank & Agency	Nurse Bank AND Agency Shifts covered	No.	→		6056 ■	→		6138 ▼	→		5923 ▲	36337	33404	66808	k	0 - 2.5% Variatio	2.5 - 5.0%	>5.0% Variatio	70209	74231	72674
TA	Bank & Agency	Nurse Bank Costs	£000s	→		583 ▲	→		537 ■	→		687 ■	3472	3141	6282	k	0 - 2.5% Variatio	2.5 - 5.0%	>5.0% Variatio	6883	6980	6944
TA	Bank & Agency	Nurse Agency Costs	£000s	→		55 ▲	→		105 ■	→		33 ■	375	485	970	k	0 - 5% Variatio	5 - 10% Variatio	>10% Variatio	474	1078	750
KD	Bank & Agency	Medical Agency Costs	£000s	→		166 ▼	→		127 ▲	→		156 ▼	766	583	1166	k	0 - 5% Variatio	5 - 10% Variatio	>10% Variatio	693	1296	1532
TA	Bank & Agency	Other Agency Costs	£000s	→		321 ▼	→		220 ▲	→		155 ▲	1226	690	1379	k	0 - 5% Variatio	5 - 10% Variatio	>10% Variatio	1661	2223	2452
KD	Bank & Agency	Medical Locum Costs	£000s	→		260 ▲	→		187 ■	→		218 ■	1421	1100	2200	k	0 - 2.5% Variatio	2.5 - 5.0%	>5.0% Variatio	2566	2445	2842
TA/KD	Bank & Agency	Agency Spend cf. Total Pay Spend	%	→		2.79 ■	→		2.20 ■	→		1.75 ■	2.04	<2	<2	k	<2	2 - 2.5	>2.5	1.50	2.15	1.95
CH	Sickness Absence	Long Term	%	→		3.38 ■	→		3.68 ▼	→			3.27	<3.00	<3.00	l	<3.0	3.0-3.35	>3.35	2.50	3.52	3.45
CH	Sickness Absence	Short Term	%	→		1.10 ▼	→		1.00 ▲	→			1.09	<1.25	<1.25	l	<1.25	1.25-1.40	>1.40	2.17	1.26	1.15
CH	Sickness Absence	Total	%	→		4.48 ▼	→		4.68 ▼	→			4.36	<4.25	<4.25	l	<4.25	4.25-4.75	>4.75	4.67	4.78	4.60
CH	Recruitment & Retention	Permission to Recruit	wte	→		56	→		74	→		60	509	No. Only	No. Only					n/a	1143	1018
CH	Recruitment & Retention	New Starters	wte	→		39	→		285	→		114	645	No. Only	No. Only					n/a	855	1250
CH	Recruitment & Retention	Leavers	wte	→		62	→		265	→		104	615	No. Only	No. Only					n/a	1004	1230
CH	Recruitment & Retention	Inductions	No.	→		75	→		76	→		92	484	No. Only	No. Only					n/a	442	1000
CH	Learning & Developme	PDRs (includes Junior Med staff)	No.	→		1135 ▲	→		1107 ▼	→		154 ■	3568	2670	5341	m	0-5% variation	5 - 15% variation	>15% variation	n/a	1963	4800
CH	Learning & Developme	Mandatory Training	No.	→		265 ▼	→		248 ▼	→		450 ■	1843	2581	5163	m	0-5% variation	5 - 15% variation	>15% variation	4313	2770	3500
CH	Learning & Developme	Conflict Resolution Training	No.	→		73 ▼	→		61 ▼	→		109 ▲	477	1000	2000	m	0-5% variation	5 - 15% variation	>15% variation	1441	1712	1200

Exec Lead	STRATEGY			S'well	City	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	08/09	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Projected
RK	Referral Rates (Target for 08/09 derived from 07/08 actuals profiled by month, according to 'working' days within period)	Total By Site	No.	→		#### ▲	→		#### ▼	→			73906	63000	147784		No Variatio	0 - 2% Variatio	>2% Variatio	138580	151755	160000
		Total GP Referrals	No.	→		7988 ■	→		6594 ■	→			38716	40764	95622		No Variatio	0 - 2% Variatio	>2% Variatio	98476	95857	100000
		Total Other Referrals	No.	→		7766 ▲	→		7354 ▼	→			35190	22237	52162		No Variatio	0 - 2% Variatio	>2% Variatio	40104	55898	60000
		By PCT - Heart of B'ham	No.	→		4511 ▲	→		3804 ▼	→			20525	17354	40708		No Variatio	0 - 2% Variatio	>2% Variatio	40394	41628	44000
		By PCT - Sandwell	No.	→		7643 ▲	→		6987 ▼	→			36296	31896	74820		No Variatio	0 - 2% Variatio	>2% Variatio	72580	77592	78000
		By PCT - Other	No.	→		3600 ▲	→		3157 ▼	→			17085	13751	32256		No Variatio	0 - 2% Variatio	>2% Variatio	25606	32535	38000
		Conversion (all referrals) to New OP Att'd	%	→		86.1	→		82.2	→			83.5	No. Only	No. Only					91.5	87.0	85.0
	THEATRE UTILISATION																					
TA	Sitrep Declared Late **Cancellations** by Specialty	General Surgery	No.	3	2	5 ▼	2	3	5 ■	5	6	11 ■	53	30	60	a	0-5% variation	5 - 15% variation	>15% variation	n/a	75	
		Urology	No.	0	3	3 ▼	0	10	10 ■	3	11	14 ▼	43	24	48		0-5% variation	5 - 15% variation	>15% variation	n/a	67	
		Vascular Surgery	No.	0	0	0 ■	0	0	0 ■	0	4	4 ■	4	1	1		0-5% variation	5 - 15% variation	>15% variation	n/a	1	
		Trauma & Orthopaedics	No.	0	1	1 ▲	1	0	1 ■	6	9	15 ■	33	36	72		0-5% variation	5 - 15% variation	>15% variation	n/a	100	
		ENT	No.	0	2	2 ■	0	2	2 ■	0	0	0 ■	11	8	15		0-5% variation	5 - 15% variation	>15% variation	n/a	19	
		Ophthalmology	No.	6	18	24 ▼	0	15	15 ▲	0	21	21 ▼	102	54	108		0-5% variation	5 - 15% variation	>15% variation	n/a	139	
		Oral Surgery	No.	0	0	0 ■	0	0	0 ■	0	0	0 ■	4	4	8		0-5% variation	5 - 15% variation	>15% variation	n/a	10	
		Cardiology	No.	0	0	0 ■	1	1	2 ■	2	4	6 ■	11	11	21		0-5% variation	5 - 15% variation	>15% variation	n/a	28	
		Gynaecology	No.	1	5	6 ■	1	5	6 ■	6	3	9 ■	36	27	54		0-5% variation	5 - 15% variation	>15% variation	n/a	69	
		Plastic Surgery	No.	0	2	2 ■	0	0	0 ■	0	0	0 ■	9	6	12		0-5% variation	5 - 15% variation	>15% variation	n/a	17	
		TOTAL	No.	10	33	43 ■	5	36	41 ▲	22	58	80 ▼	306	200	399		0-5% variation	5 - 15% variation	>15% variation	n/a	525	585

Theatre Location	Late Starts (%)	Early Finishes (%)	Session Util'on (%)	No. of Patients	Pts / Session	Late Starts (%)	Early Finishes (%)	Session Util'on (%)	No. of Patients	Pts / Session	Late Starts (%)	Early Finishes (%)	Session Util'on (%)	No. of Patients	Pts / Session
Theatre Sessions: City (Main Spine)	37	47	87	306	1.4	43	54	85	276	1.5	38	50	83	314	1.4
City (BTC)	42	60	80	699	3.3	30	62	78	474	3.2	32	64	77	553	3.1
City (BMEC)	36	54	85	580	3.3	36	53	82	511	3.2	37	47	87	612	3.4
Sandwell (Main Theatres)	52	40	90	457	2.4	64	42	85	279	2.3	45	44	90	421	2.2
Sandwell (SDU)	49	64	77	485	4.4	41	59	82	460	4.6	42	60	80	546	4.4
TRUST	43	53	85	2527	2.8	42	54	82	2000	2.8	38	53	83	2446	2.7

Thresholds, applied to targets opposite
GREEN = up to 5.0% deviation
AMBER = 5.1 to 15.0% deviation
RED = greater than 15.0% deviation

Targets		
Late Starts / Early Finishes	Session Util'on	Pts / Session
<31 / <36	>89	1.7
<31 / <36	>89	3.9
<31 / <36	>89	3.7
<31 / <36	>89	2.5
<31 / <36	>89	4.9
<31 / <36	>89	3.1

07/08 Outturn (Nov - March data only)				
Late Starts (%)	Early Finishes (%)	Session Utilisation (%)	No. of Patients	Patients / Session
41	53	83	1518	1.5
41	59	85	2763	3.4
42	51	82	2539	3.2
42	47	93	1309	2.2
44	69	78	1710	4.3
42	55	84	9839	2.7

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Financial Performance – Month 6
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	6 November 2008

KEY POINTS:

The report is provided to update the Trust Board on financial performance for the period to 30th September 2008.

In-month surplus is £295k against a target of £246k; £49k ahead of plan.

Year to date surplus is £1,918k, £504k ahead of plan.

In-month WTEs are 131 below plan.

Cash balance is £4.2m below plan at 30th September.

PURPOSE OF THE REPORT:

○ **Approval** ◉ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To receive and note the monthly finance report.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

4.1- Deliver the financial plan including achieving a financial surplus of at least £2.5m and a CIP of £11m.

IMPACT ASSESSMENT:

FINANCIAL	☑	Trust has a target surplus for the year of £2.5m in line with requirement to repay the residue of its working capital loan.
ALE	☐	
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2008

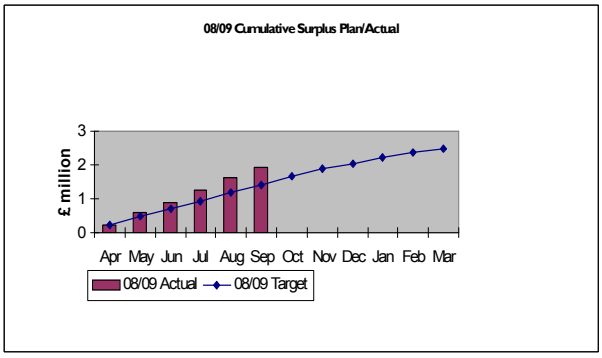
EXECUTIVE SUMMARY

- **At the end of September, the Trust had an actual surplus of £1,918k, £504k ahead of plan.**
- **In month surplus is £295k against a target of £246k, £49k ahead of plan.**
- **In-month WTE's 131 below plan.**
- **Cash balance is £4.2m below plan at 30th September but expected to return to planned levels by the year end.**
- **A significant number of operational divisions have posted in month deficits, primarily linked to lower levels of activity for August (the latest available fully coded data) although early available information for September indicates a significant upturn in activity. Reserves and miscellaneous divisions has an improved position in month largely resulting from the agreement of over performance figures which lowers the need for provisions for data challenges.**
- **Although year to date patient activity continues to show over performance there was a significant downturn in August which has resulted in a weakening of the financial performance of some divisions. Early September information suggests that this downturn has been reversed and indications from PCTs also supports the view that activity levels for the remainder of the year are expected to be above plan.**
- **CIP performance remains in line with planned levels.**

Key Financial Performance Indicators

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	49	504	>Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	27	346	>Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	-174	95	<Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	-174	-1,020	<Plan	<1% above plan	>1% above plan
WTEs Actual v Plan	131	178	<Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000	-4,249	-4,249	>=Plan	>=95% of plan	<95% of plan
CIP Actual v Plan £000	0	-3	>97½% of Plan	>=92½% of plan	<92½% of plan

Note: positive variances are favourable, negative variances unfavourable



2008/2009 Summary Income & Expenditure Performance at September 2008	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	312,966	26,088	26,376	288	156,434	157,629	1,195	314,566
Other Income	37,853	3,248	3,335	87	19,432	19,508	76	37,953
Operating Expenses	(323,774)	(27,064)	(27,412)	(348)	(162,180)	(163,105)	(925)	(325,774)
EBITDA	27,045	2,272	2,299	27	13,686	14,032	346	26,745
Interest Receivable	1,164	119	141	22	598	756	158	1,464
Depreciation & Amortisation	(16,343)	(1,362)	(1,362)	0	(8,171)	(8,171)	0	(16,343)
PDC Dividend	(9,258)	(771)	(771)	0	(4,629)	(4,629)	0	(9,258)
Interest Payable	(108)	(12)	(12)	0	(70)	(70)	0	(108)
Net Surplus/(Deficit)	**2,500**	**246**	**295**	**49**	**1,414**	**1,918**	**504**	**2,500**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2008

External Perspective

• Sandwell PCT has reported an under spend up to 31st August of £3.695m which is £779k ahead of plan. Their forecast outturn remains at a £7m surplus which is in line with their control total and reflects the decision to release further reserves to support priority developments. Significant over performance is reported for major providers, including Sandwell & West Birmingham Hospitals and these high levels of performance are forecast to continue over the remainder of the year.

•Heart of Birmingham tPCT has a control total surplus of £9.68m against which it is currently expecting to deliver an £11m surplus, the variation mainly being the result of prescription underspends. Expenditure against its main commissioning contracts, including Sandwell & West Birmingham, is forecast to be in line with plan although there are some emerging over performances which are expected to be contained within the PCT's contingency sum.

•On a national basis, there is still significant upward pressure in the system and all organisations within the West Midlands StHA have been issued with control total positions which must be achieved within a margin of £100k. Going forward, the NHS is expecting to significantly reduce its underspend over the next two years and forward planning control totals have been issued at StHA level.

Performance of Major Commissioners

• Fully coded activity data is available up to 31st August and this, and its related income, is incorporated into the financial position reported this month.

•There has been a significant downturn in activity during August. In part, this is predictable with holidays and theatre closures and is built into activity profiles but the downturn has been greater than expected.

•Early indications for September (although this is not based on fully costed data) are that there has been a significant upturn in activity. Both the Trust and its major commissioners anticipate a return to previous trends.

•Agreement of activity data via the CBSA has led to a more certain income position, at least for the early months of the year. This lowers the need for provisions for data challenges by PCTs.

•Major variations from SLA activity targets are shown in the adjacent table.

Year to Date Key Activity Performance
Peformance Against SLA

Activity Up To August	Sandwell PCT	Heart of Birmingham PCT	Overall
Admitted Care			
Elective	3.31%	-6.33%	-2.70%
Non Elective	-2.29%	3.43%	0.01%
Day Case	3.61%	-2.80%	1.78%
Excess Bed Days	13.86%	0.35%	7.22%
Out-Patients			
New	9.46%	1.61%	9.20%
Follow Ups	-3.11%	-8.23%	-2.79%

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2008

Divisional Performance

• Overall performance in month has deteriorated in a number of clinical divisions, particularly Medicine A, Medicine B, Surgery A and Pathology although the in month deficit recorded for Pathology is of a technical nature rather than a real change in performance.

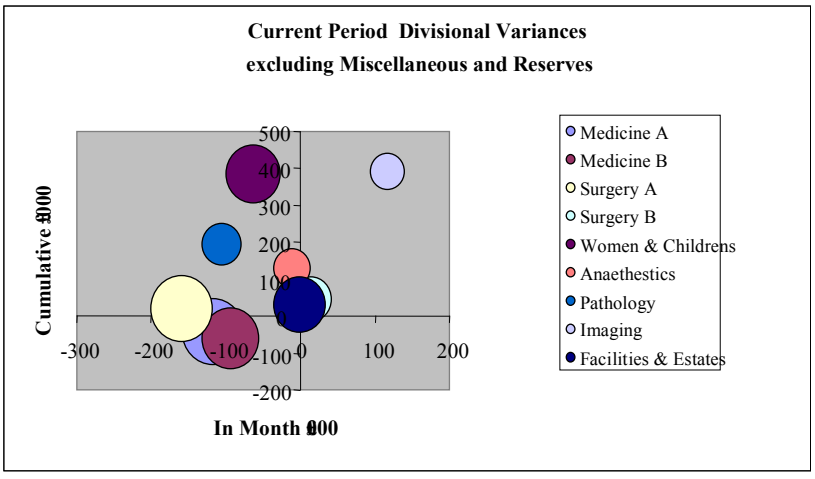
•On a year to date basis, both Medicine A and Medicine B now have small deficits.

•Although still recording a sizeable year to date deficit, the position reported within Reserves and Miscellaneous has improved as provision for data challenges and doubtful debts has been reduced with the finalisation of activity data via the CBSA. However, the reported position for the area still reflects a relatively prudent position on income as well as some provision for uncertain expenditure items.

•Much of the downturn in performance in month can be attributed to lower levels of activity and income (although it should be noted that this relates to August performance) coupled with closure of capacity due to infection control restrictions, the result being that reductions in income were not matched with similar reductions in expenditure. Early information for September does suggest a significant upturn in activity and income which suggests that the poor current period performance is an exceptional position rather than the beginning of a trend. Nevertheless, ongoing performance will need to continue to be closely monitored and corrective action taken if improvements are not witnessed.

•Levels of non pay expenditure continue to rise. Pay expenditure has exceeded plan by £174k in month and, taking substantive and bank expenditure together, nursing costs have exceeded budget in month by £128k, the first time this has happened since April. Non pay expenditure has also exceeded budget in month by £174k, primarily on medical equipment and consumables. For the year to date, non pay expenditure is over £1m greater than budget although it should be noted that £0.6m of this relates to miscellaneous and reserves.

•Although net actual wte numbers have increased by 72 in month, overall numbers remain significantly lower than planned. Savings from vacant posts are being offset by expenditure on agency staff and payments which do not generate wte equivalents (e.g. waiting list initiative work).



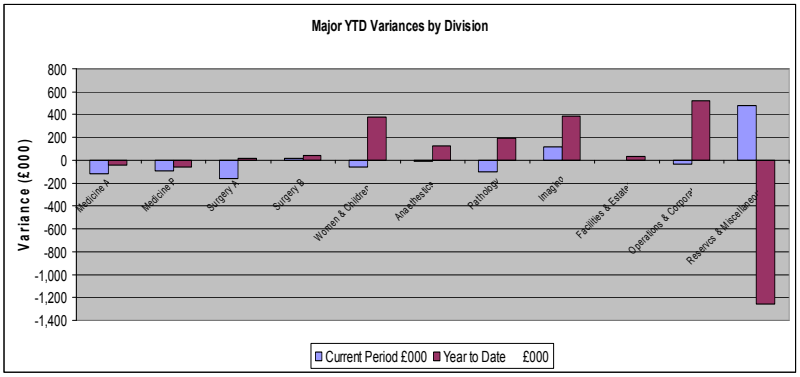
The tables adjacent and overleaf show a more widespread distribution of performance than has been seen in earlier months. Most operational divisions have posted in month deficits and both Medicine Divisions now have small year to date deficits. Imaging continues to generate significant in month and year to date surpluses. The in month deficit in Pathology relates to the transfer of budget to contribute to capital expenditure and the underlying position remains healthy.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

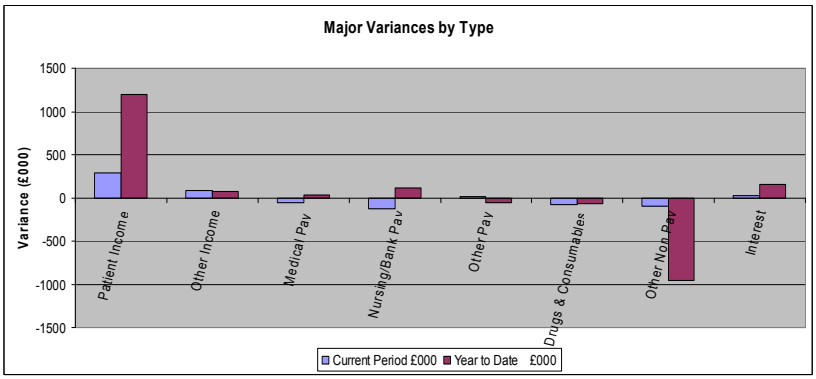
Financial Performance Report – September 2008

Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine A	-116	-44
Medicine B	-93	-63
Surgery A	-158	20
Surgery B	15	44
Women & Childrens	-62	382
Anaethestics	-11	128
Pathology	-105	192
Imaging	117	389
Facilities & Estates	0	30
Operations & Corporate	-36	523
Reservcs & Miscellaneous	476	-1,255



The tables below illustrate that income, pay and interest are all are performing better than plan for the year to date. The only area where actual performance is worse than plan is other non pay and much of this relates to Reserves and Miscellaneous where provisions are being made for uncertain expenditure as well as ongoing challenges to patient related income.

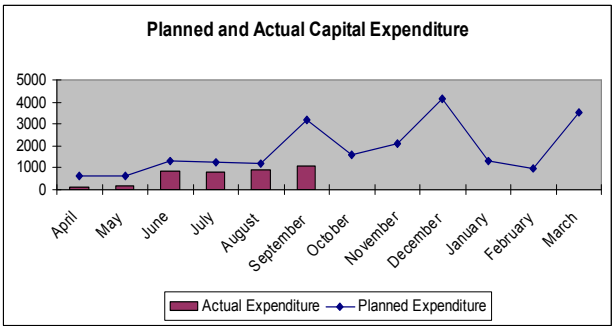
Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	288	1195
Other Income	87	76
Medical Pay	-59	38
Nursing/Bank Pay	-128	117
Other Pay	13	-60
Drugs & Consumables	-74	-62
Other Non Pay	-100	-958
Interest	22	158



Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Year to date expenditure by September has risen to £3,958k, an increase in month of £1,066k, mainly related to pathology reconfiguration, IT and statutory standards.

•Additional expenditure has been processed by the Capital Projects Office, particularly in relation to reconfiguration projects, and this will be manifested in future financial performance. The Board approved Blood Tracking investment is now proposed as a capital transaction as opposed the provision of managed-service.



Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2008

Paybill & Workforce

• Overall workforce numbers (wte's) are around 131 below plan for September (52 fewer under plan than in August), primarily continuing to be within administration & estates, scientific & therapeutic and management.

•Paybill (including agency staff) is £174k above budgeted levels for the month, the result of a combination of increased wte numbers, continuing high levels of bank and agency staff and payments not generating wte equivalents.

•Excluding the cost of agency staff, the paybill would be £158k below budget in month and £2,003k year to date.

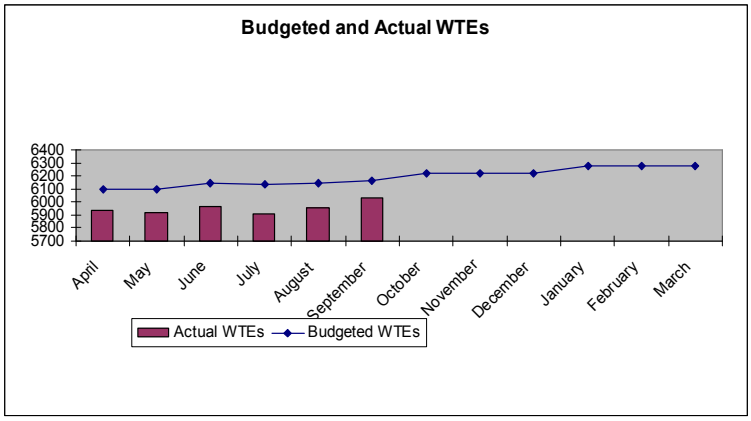
•Agency spend in month was £344k with the monthly average for the year £395k. The biggest users of agency staff to date continue to be Surgery A (mainly in theatres), Medicine B (primarily within A&E) and Finance (Internal Audit).

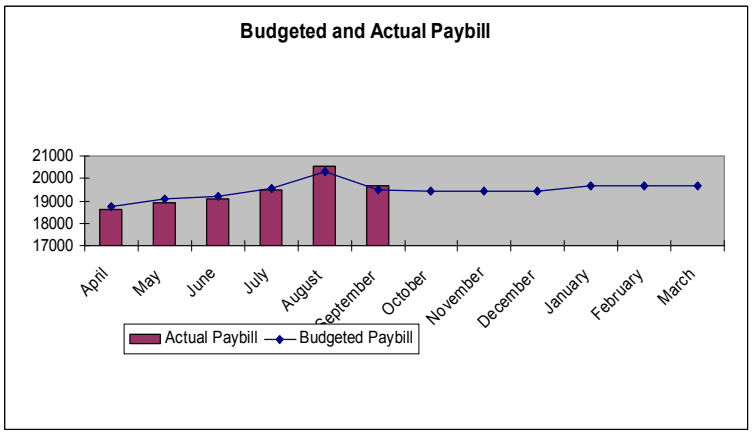
•In terms of divisional performance, the most significant contributors to the wte shortfall are:

▪Finance

▪Pathology (scientific staff)

▪Workforce





Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2008

Balance Sheet

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

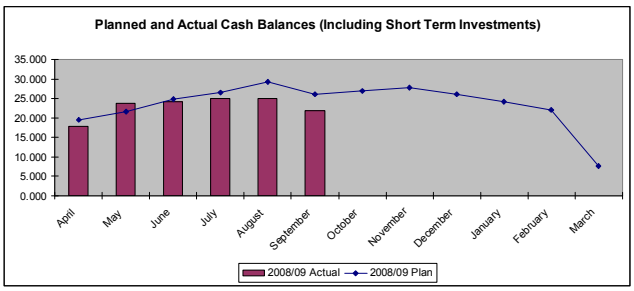
•Changes in fixed asset values are largely a consequence of the estimated value of indexation of existing assets at 1st April 2008 along with depreciation charged between April and September. New capital expenditure in 2008/2009 remains fairly low although significant progress has been made on some major schemes including the City neo natal redevelopment and pathology reconfiguration.

•Variation from planned cash balances has remained broadly steady in month although this still leaves cash balances around £4m lower than originally planned. The primary cause of this is higher than expected payments to creditors. In part this is a reflection of increased budgets since the start of the year as well as general increases in prices. The cash budget will be reassessed in the light of changed income and expenditure budgets and actual experience in the first six months of the year.

•Debtor and accrued income balances have increased slightly in month. The £2.3m impairment related debtor with Sandwell PCT was cleared on 1st October as part of the circular cash flow exercise.

Sandwell & West Birmingham Hospitals NHS Trust
BALANCE SHEET

		Opening Balance as at March 2008 £000	Balance as at September 2008 £000	Forecast at March 2009 £000
Fixed Assets	Intangible Assets	373	320	325
	Tangible Assets	274,392	280,811	285,524
	Investments	0	0	0
Current Assets	Stocks and Work in Progress	3,649	3,499	3,550
	Debtors and Accrued Income	19,508	20,553	16,500
	Investments	0	0	0
	Cash	8,285	24,232	7,614
Current Liabilities	Creditors and Accrued Expenditure Falling Due In Less Than 1 Year	(27,172)	(40,010)	(25,399)
	Loan Repayments Due in Less Than 1 Year	(2,500)	(1,250)	0
Long Term Liabilities	Creditors Falling Due in More Than 1 Year	0	0	0
Provisions for Liabilities and Charges		(5,571)	(4,641)	(3,750)
		270,964	283,514	284,364
Financed By				
Taxpayers Equity	Public Dividend Capital	162,296	162,296	163,396
	Revaluation Reserve	83,147	93,779	93,779
	Donated Asset Reserve	2,669	2,669	2,500
	Government Grant Reserve	2,163	2,163	1,500
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	11,631	13,549	14,131
		270,964	283,514	284,364



Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2008

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	8.6%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	102.5%	5
Return on Assets	Surplus before dividends over average assets employed	2.4%	3
I&E Surplus Margin	I&E Surplus as % of total income	1.1%	3
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	5.3	1
Overall Rating			**2.7**

Risk Ratings

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

•Currently, the only significant weak area is the liquid ratio which will only be improved by the introduction of a working capital facility under FT status or sizeable net inflows of cash from another source.

Forecast Outturn and Forward Look

•The forecast outturn position for the Trust currently remains at £2.5m which is in line with its target required to repay the residue of the working capital loan.

•It is expected that patient related income will return to its previous buoyant levels and both Trust and PCT forecasts suggest that this performance will be maintained over the remainder of the year.

•Pay expenditure has continued to rise in month and on a year to date basis has almost returned to budgeted levels. This is compared with underspends approaching £0.5m at M4. It should be noted that significant volatility exists in expenditure levels with current levels of bank and agency spend at around 5% of total pay expenditure. WTE numbers are still significantly below budgeted levels although there have been significant upward movements in actual staff employed over the last two months. Savings from vacant posts are being more than utilised on agency staff and additional non wte generating payments. Whilst this is not at the moment something which will prevent the Trust achieving its financial plan, it is something which will have to be carefully monitored and controlled for the future.

•To date, although non pay appears to be a major downward pressure on bottom line performance, much of this actually relates to reserves and miscellaneous rather than operational areas. Although there is some pressure on operational budgets, particularly manifested in medical consumables, energy and hotel costs, to date, these are not causing major problems. However, national inflationary pressures being felt across the whole economy are also affecting the NHS. The overall movement in the Health Service Cost Index (HSCI) for the past 12 months has now reached 5.53% compared with increases in previous years averaging only 1-2%. Particularly noticeable increases include electricity (68%), oil (66%), clothing and uniforms (19%) and catering provisions (13%). The Consumer Prices Index (CPI) rose to 5.2% in September compared with 4.7% in August. However, the general opinion is that inflationary pressures have reached or are close to their peak and expectations are that inflation rates, however they are measured, will fall dramatically over the next few months. Indeed, there are already significant examples, including fuel and energy, of significant recent downward movements.

•Future predictions of energy costs are more positive this month and there has been a downward movement of £147k in projected costs to the year end. To reduce risk and the Trust's exposure to the continued volatility of the gas market, 25% of October's consumption has been secured at a locked in price. The Trust commenced a new electricity contract on 1st October secured through PASA agreement. At the moment, pressure on oil and gas prices is downwards with a barrel of oil falling as low as $75 and wholesale gas prices negative on 11th and 12th October. Electricity prices currently continue to rise. It is highly likely that there will continue to be significant volatility in energy markets over the coming months although the increasing pressures of actual or near recession in the global economy is likely to continue current downward pressure on prices.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2008

Forecast Outturn and Forward Look (Continued)

• The NHS Operating Framework for 2009/2010 is expected some time in the autumn. The Pre Budget report is also expected at the same time and this will clarify the position regarding the current projection of 6% growth in the NHS. It is expected that the tariff uplift for 2009/10 for NHS trusts will be 5.3% gross and 2.3% net of an assumed 3% efficiency gain. This level of uplift is assumed to deal with current cost pressures including rises in energy prices as well as pay pressures from AfC incremental drift and other settlements as well as national pay awards. A 3% efficiency gain represents cost reductions of approximately £10.5m to the Trust in addition to savings required as a result of the Towards 2010 programme. Work is currently underway as part of the 2009/2010 financial planning process to identify divisional CIPs necessary to deliver this level of saving for the Trust.

Conclusions

Overall, the Trust has delivered a bottom line year to date surplus of £1,918,000 which is £504,000 ahead of plan for the 6 months to 30th September. This remains a positive position in spite of the downturn in activity in August.

In month and on an overall Trust wide basis, income over performance is broadly matched by over spending against both pay and non pay budgets although non pay expenditure continues to reflect a prudent approach to potential cost pressures.

Although capital expenditure continues to be lower than plan, over £1m of expenditure was incurred in month and further spend, particularly in respect of major reconfiguration schemes, is being processed and will impact on the position over the next couple of months. Contingency plans are being developed to ensure that capital resources are effectively utilised including a switch in the Blood Tracking investment from leasing to outright purchase.

Cash balances remain over £4m below planned levels although it is still expected that these will return to around planned levels by the year end.

Recommendations

The Finance & Performance Management Committee is asked to:

i. NOTE the contents of the report

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Annual Plan 2008/9: Corporate Objectives Progress Report Q2
SPONSORING DIRECTOR:	Richard Kirby, Director of Strategy
AUTHOR:	Richard Kirby, Director of Strategy
DATE OF MEETING:	6 November 2008

KEY POINTS:

The Trust's Annual Plan for 2008/9 set 25 corporate objectives for the year to ensure that we make progress towards our six longer-term strategic objectives. An overview of progress with these objectives is presented to the Trust Board quarterly. This report presents the position as at Quarter 2.

At Q2 the Trust was on track to achieve the majority of corporate objectives with twenty rated "green", four rated "amber" and only one rated "red". More detail on the position for each objective is set out in the report.

PURPOSE OF THE REPORT:

○ **Approval** ◉ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. NOTE the progress made on the corporate objectives as at Q2.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

The report sets out an overview of progress against the corporate objectives for 2008/9.

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		The risk to delivery of particular objectives are highlighted in the report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ANNUAL PLAN 2008/9
CORPORATE OBJECTIVES PROGRESS REPORT (QUARTER TWO)

INTRODUCTION

The Trust's Annual Plan for 2008/9 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 Two is set out in the table that accompanies this report. An overview of the Q2 RAG assessment for each objective compared with the Q1 assessment is set out in the table below.

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
1. Accessible and Responsive Care				
1.1 Continue to achieve national and local access targets.	3	3		
1.2 Successfully deliver our Patient Experience Action Plan.	3	3		
1.3 Develop and begin to deliver a Single Equality Scheme	3	3		
2. High Quality Care				
2.1 Continue to reduce hospital infection rates	3	3		
2.2. Develop our patient safety culture and systems	3	3		
2.3 Develop and deliver Maternity Development Plan	2	3		
2.4 Deliver improvements in the quality of nursing care	3	3		
2.5 Deliver interim service reconfigurations	3	3		
2.6 Take on Sandwell / Walsall breast screening service	3	3		
2.7 Deliver improvements in cancer and stroke	2	3		
2.8 Agree plan to ensure EWTD compliance	3	3		
3. Care Closer to Home				
3.1 Deliver new models of care through exemplar projects	2	2		
3.2 Deliver community-based dermatology service for BEN	2	3		
4. Good Use of Resources				
4.1 Deliver financial plan including £2.5m surplus	3	3		
4.2 Improve productivity through DC rates and LOS	3	3		
4.3 Deliver service improvement programme	3	3		
5. 21st Century Facilities				
5.1 Produce and secure agreement to new hospital OBC	2	3		
5.2 Deliver land acquisition strategy	2	2		

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
6. An Effective NHS FT				
6.1 Achieve Healthcare Commission Healthcheck standards	3	3		
6.2 Ensure staff receive appraisals and mandatory training	2	2		
6.3 Achieve NHS FT status	2	1		
6.4 Improve clinical administration and communications	3	3		
6.5 Develop marketing and business development activity	2	2		
6.6 Improve staff engagement through Listening into Action	3	3		
6.7 Ensure effective emergency preparedness	3	3		

The Trust is on target to achieve the majority of our objectives for 2008/9 with 20 rated "green" (80%). A number of the objectives rated "amber" at the end of Q1 are now rated "green" showing progress with action plans in those areas.

Only one objective is rated "red" at Q2. Although the Trust submitted our application for NHS Foundation Trust status in October as planned, further work has been necessary to ensure that the assumptions in the Integrated Business Plan and Long-Term Financial Plan are fully consistent with the latest position set out in the new hospital Outline Business Case. This has extended the timetable for proceeding to the Monitor assessment stage of the process.

Four objectives are rated as "amber" at Q2.

- Deliver new models of care through exemplar projects: many of the exemplar project are now making steady progress but some are taking longer than expected due to the complexity of service redesign envisaged.

- Deliver land acquisition strategy: although now proceeding to plan (with the Land Business Case approved by the Trust Board in October) the timetable for this exercise has been revised since the original objective was set at the start of the year

- Ensure staff receive appraisals and mandatory training: good progress has been made on appraisals but further work is being undertaken on mandatory training.

- Develop marketing and business development activity: this work is now well underway but has taken longer to establish than originally planned due to delays in recruitment of key staff.

CONCLUSION AND RECOMMENDATIONS

This report and the accompany table has presented an overview of the position on our corporate objectives for 2008/9 at the end of Q2. The Trust Board is recommended to:

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

Richard Kirby
30th October 2008

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
TRUST OBJECTIVES 2008/9: 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 2008/9 financial plan and progress with national access targets) or through specific monthly reports (e.g. 'Towards 2010' 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 throughout the last year, using a traffic-light based system at the following Board meetings:

- Q1 position reported to September Board meeting;
- Q2 position reported to November Board meeting;
- Q3 position reported to February Board meeting;
- Q4 position reported to May 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 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter Two (September 2008)**	**Red / Amber / Green Assessment**
0.	***Accessible and Responsive Care***				
1.1	Continue to achieve national and local access targets (18 weeks, cancer, A&E and GUM) TA	• 18 week referral to treatment target achieved by December 2008 • Cancer targets (2 week, 31 day and 62 day) achieved by March 2009 • A&E 4 hour wait target achieved by March 2009 • GUM target (48 hours) achieved by March 2009 • Accelerated waiting times agreed in the LDP delivered by March 2009. 75% of IP waits within 6 weeks and 90% within 8, 75% of OP waits within 4 weeks and 90% within 5; 75% of diagnostic waits within 4 weeks and 90% within 6.	Incorporated within description of success factors.	On track to meet the December target of 90%/95% admitted/non-admitted. September position was 95%/96% with the targets met for all specialities. Cancer on target. MDT support team expansion agreed at SIRG to meet new targets Recruitment of additional staff commenced. Procurement of Somerset IT system. Definitions for new Cancer waits are awaited. A&E on track 98.3% YTD GUM position is improving monthly with the YTD patients seen/offered appointments within 48-hours at 75%/97%	**3**
1.2	Successfully deliver our Patient Experience Action Plan in response to patient survey results.	• Patient Experience Action Plan agreed for 2008/9 • Actions delivered as set out in plan • Improvement in key areas of	By September 2008 In line with plan.	The Patient Experience Action Plan has been agreed and the Patient Experience Group established. The actions are on target and the next quarterly	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter Two (September 2008)**	**Red / Amber / Green Assessment**
	RS/JK	2008 patient survey results		report will be presented to the November trust board.	
1.3	Develop and begin to deliver a Single Equality Scheme for the Trust. RS	• Single Equality Scheme agreed • Actions delivered as set out in plan.	By June Trust Board By March 2009	The SES has been approved by the Trust Board. The Equality and Diversity Steering Group and its subgroups have been established. A quarterly progress report will be presented to the Board in November.	**3**
2.	***High Quality Care***				
1.0	Continue to reduce hospital infection rates achieving national and local targets for MRSA and *clostridium difficile* including introducing MRSA screening in line with national guidance. RS	• Achievement of targets for MRSA and clostridium difficile by March 2009 • Introduction of MRSA screening for electives from April 2008	By March 2009	The Trust is currently achieving its targets for reducing MRSA and C Diff. Screening of elective inpatients for MRSA has been introduced as planned.	**3**
1.0	Develop and begin delivery of a plan to enhance the safety culture and systems of the Trust KD	• Patient Safety Plan agreed • Actions delivered as set out in plan	By July 2008 By March 2009	Actions progressing in line with plan, including: • Review completed of all open NPSA alerts; updates provided and action plans developed to ensure compliance. • Integrated incidents and complaints report introduced.	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter Two (September 2008)**	**Red / Amber / Green Assessment**
				• 'Being Open' training session held for clinicians. • Patient safety questionnaire about roles, responsibilities and accountability issued. • Review of risk management training completed. Initial training needs analysis carried out and Trust-wide discussions held. TNA to be finalised.	
1.0	Develop and begin to deliver Maternity Development Plan in the light of local reviews and national guidance. DOD	• Development Plan agreed for 2008/9 • Actions delivered as set out in plan • Improvements on measures used in Healthcare Commission assessment by March 2009	As set out in the plan.	The integrated development plan has been prepared. A series of staff conversations have taken place through LiA. The new Clinical Director is now in post and is undertaking his assessment of the next steps needed to develop this service.	**3**
1.0	Deliver plans to improve the quality and consistency of nursing care RS	• Implementation of the Nursing Workforce Strategy • Implementation of the Ward Performance Review and Accreditation systems • Improved performance on key indicators for quality of nursing care	By March 2009 By March 2009 By March 2009	Recruitment to the first cohort of trainee Assistant Practitioners has commenced in line with workforce strategy. The ward review tool has been revised and second round of reviews is due to commence in November. The key indicators show consistent performance at this stage.	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter Two (September 2008)**	**Red / Amber / Green Assessment**
1.0	Deliver service reconfiguration changes in neo-natal services, surgery and pathology. RK	• Neo-Natal reconfiguration completed by Autumn 2008 • Pathology reconfiguration completed by Winter 20008 • Surgery implementation plan agreed by June 2008 • Surgical reconfiguration implemented in line with plan	• Neonatal – Sept 08 • Pathology – Dec 08 • Emergency General Surgery – Dec 08 • T&O – April 09	• New neo-natal unit at City opened in September as planned. • Pathology on track – capital scheme o complete December 08. • Surgery – emergency general surgery now due February 09 and T&O May 09. Plan in place to ensure delivery.	**3**
2.6	Take on the Walsall and Sandwell breast screening service as part of a larger Walsall / Sandwell / City breast screening service. TA	• Service operational from April 2008 • Service maintains high performance on QA performance indicators		Service launched as planned on 1st April.	**3**
3.6	Deliver improvements in national clinical priorities of cancer (Cancer Reform Strategy) and stroke (Stroke Strategy). Cancer: RK Stroke: DOD	• Cancer: agreement of Trust Cancer Strategy and delivery of actions in line with plan • Stroke: agreement and delivery of plan to implement national stroke strategy	• Trust Cancer Strategy document – Nov 2008 • Timetable for stroke plan to be confirmed.	Cancer Strategy reviewed in draft through cancer meetings and at OMB. To be presented to Trust board in December 08. Stroke. LiA events taken place as planned. Actions arising from these identified and being implemented throughout the rest of 2008/9.	**3**
3.6	Agree a clear plan to ensure EWTD (48 hr) compliance by August 2009, including continued development of Hospital at Night.	• EWTD plan agreed. • Actions delivered in line with plan.	To have at least 50% of all junior doctors EWTD compliant by 6 August 2008.	The Trust achieved 61% compliance with EWTD at 6th August 2008.	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter Two (September 2008)**	**Red / Amber / Green Assessment**
	DOD / KD		To have at least 75% of all junior doctors EWTD compliant by 6 February 2009. To have all junior doctors EWTD compliant by 1 August 2009.	Work continuing to prepare for the August 2009 deadline. This has included strengthening the Trust's leadership of this activity following the appointment the Assistant Director of Nursing – Strategy. A further event is planned for December to continue our planning	
3.	***Care Closer to Home***				
2.0	Deliver new models of care through the first wave 2010 exemplar projects (urgent care, intermediate care, dermatology and diabetes) and begin to deliver new models of care for community-based outpatients in the second wave 2010 exemplar specialties (cardiology, orthopaedics, rheumatology, ophthalmology, respiratory, gynaecology). TA / RK	• Significant volumes of outpatient activity delivered in line with new models of care in exemplar specialities • Clear plans agreed for next stages of community development • Increased numbers of patients treated through UCCs at City and Sandwell in 2008/9 compared with 2007/8 • Agreed models of care successfully implemented at Rowley and Sheldon.	• Second wave 2010 exemplar projects targets for 2008/09 as per Towards 2010 Programme • Speciality review of Towards 2010 outpatient assumptions to be complete by Oct 08	A range of outpatients now being delivered from Aston HC. Trust is developing plan to make greater use of this facility for approval by HoB. First wave of 2010 projects continue to deliver (urgent care centres, diabetes, dermatology and rehabilitation beds at Rowley and Sandwell) although some schemes slightly behind on activity levels. Second stage projects continuing planning. Review of future outpatient plans at specialty level completed for October.	**2**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter Two (September 2008)**	**Red / Amber / Green Assessment**
2.0	Successfully deliver a community-based dermatology service for Birmingham North and East PCT. RK	• BEN service launched and achieving expected levels of activity • BEN PCT and GPs satisfied with service	May 2008 Review October 2008	Service now launched and delivering expected levels of activity. Work to be undertaken in second half of the year to assess PCT and GP satisfaction with progress.	**3**
4	***Good Use of Resources***				
5.0	Deliver the financial plan including achieving a financial surplus of at least £2.5m and a CIP of £11m. RW	• Financial plan delivered • £2.5m surplus by March 2009 • £11m CIP delivered by March 2009	Monitored monthly, final assessment at yearend	The surplus position is ahead of plan although this year it is important that the surplus is kept as close to pre-planned levels as possible. The CIP is rated "Green" in terms of year to date and forecast positions.	**3**
5.0	Further improve productivity by improving day case rates and reducing average hospital; length of stay. TA	• Day case rate higher than 2007/8 outturn aiming for 80% by March 2009 • LDP day case incentive scheme targets achieved • Average hospital LOS lower than 2007/8 outturn aiming for 4.5 days by March 2009	Targets hit by March 2009	Schemes progressing to plan. SGH/Rowley has reduced beds by 30 as per plan. City maternity have closed 16 beds. 4 new acute physicians to start, 2 at SGH in October, 2 at City in January. HoB interim care beds opening in November will reduce City LoS. LOS fell to 4.5 days in August. Day case rate rose to 78.8%.	**3**
5.0	Deliver the next stages of the Trust's Service Improvement Programme. RK	• Service improvement priorities for 2008/9 agreed • Demonstrable improvements in areas prioritised	By July 2008 By March 2009.	Service improvement team have continued to deliver the agreed plan completing work with ante-natal clinics and commencing the Listening into	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter Two (September 2008)**	**Red / Amber / Green Assessment**
				Action Medical Records project.	
5	***21st Century Facilities***				
5.0	Produce and secure agreement to the Outline Business Case for the new acute hospital. GS	• New hospital OBC approved by Trust Board • New hospital OBC approved by SHA and DoH	December 2008 March 2009	Production of outline business case currently on track. The complexity of the case means there remains a number of significant risks to be	**3**
5.0	Agree and begin to implement land acquisition for the new hospital. GS	• Land acquisition strategy agreed by Trust Board • Strategy delivered in line with plan	Start procurement October 2008	Land Business Case approved by Trust Board in October and due for SHA approval in early November.	**2**
5	***An Effective NHS FT***				
5.0	Continue to achieve Healthcare Commission Healthcheck standards. KD	• Maintain and if possible improve the Trust's ratings in the Annual Healthcheck	Achieve compliance with core standards declared as non-compliant – C7e by July 2008 and C8b by August 2008. Review evidence to support continued compliance with the core standards in November.	Action plans developed to achieve compliance with the core standards previously declared as 'not met' have been implemented. Interim self-assessment planned for November with the findings scheduled to be presented to the G&RMC.	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter Two (September 2008)**	**Red / Amber / Green Assessment**
5.1	Ensure that all staff received appropriate mandatory training and receive an annual appraisal. CH	• Significant increase in staff undertaking mandatory training and receiving annual appraisals.	By March 2009	Approx 93% of staff have had an appraisal in the last 17 months, this is a significant improvement. Mandatory Training remains problematic. Improvement plans are being developed.	**2**
6.3	Achieve NHS Foundation Trust status. RK	• FT application approved by Trust Board • Secretary of State approves Trust to apply to Monitor for FT status • Authorised as an FT	By October 2008 By January 2009 By April 2009 (earliest)	Trust Board approved application at its October meeting. Subsequent feedback from the SHA has required some further work resulting in a delay to the likely date for SoS approval to go to Monitor.	**1**
6.4	Using the Trust's new patient information systems improve clinical administration and clinical communications. TA	• Agree plan to improve clinical administration and communication • Improvement in processes leading to reduced OP DNAs and cancellations and quicker communication with GPs		Expansion of new functionality continues to plan. Q1 saw new SGH A&E system go-live and Q2 saw order comms go live at SGH. Q3 will see maternity go live and new faster CfH infrastructure. Work is progressing to improve the OP bookings processes, to date this has increased clinic fill rates.	**3**
6.5	Develop further our approach to marketing and business development activity. RK / JK	• Marketing Strategy approved by Trust Board • Programme of business development and marketing	Marketing strategy revised by end August To be included in Marketing Strategy	Marketing strategy presented to FT Seminar and to OMB. Final version to be completed by end of October. Action plan for 2008/9 being delivered and	**2**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter Two (September 2008)**	**Red / Amber / Green Assessment**
		activity delivered as agreed • Trust at least retains market share for main commissioners	Data reported monthly to OMB	progress reported to FMB. Trust's recent new outpatient market share was stable for all commissioners in Q2.	
6.6	Improve staff engagement through implementation of the "Listening into Action" programme CH	• Staff engagement process successfully delivered • Improved staff engagement demonstrated through staff survey results		All LiA activity on target. Additional funding received from SHA. New facilitator to commence mid November Staff survey currently live	**3**
6.7	Ensure effective emergency preparedness. TA	• Emergency response plans agreed and tested as appropriate		Heatwave Plan updated and implemented in July. Major Incident Plan has been revised and was approved at September OMB Training has been undertaken at City ED about CBRN and a revised procedure for City decontamination has been introduced	**3**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Update on progress against Nursing Workforce Strategy
SPONSORING DIRECTOR:	Rachel Stevens, Chief Nurse
AUTHOR:	Rachel Stevens, Chief Nurse
DATE OF MEETING:	6 November 2008

KEY POINTS:

This report provides the Trust Board with an update on progress against the themes within the strategy.

PURPOSE OF THE REPORT:

○ **Approval** ◉ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the contents of this report.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

2.4 Deliver plans to improve the quality and consistency of nursing.

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☐	
WORKFORCE	☑	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Update On Progress Against Nursing Workforce Strategy

1. Introduction

The Trust Board were made aware of the new Nursing workforce strategy by the Chief Nurse in March 2008. This was essentially a collection of best practice ideas and solutions to workforce issues in nursing that should be introduced prior to any significant investment in new monies into nursing budgets.

This report provides the Trust Board with an update on progress against the themes within the strategy.

2. Context

Ward staffing will always be a point of concern in every hospital as it is simply not possible to staff for all eventualities and there is no standard way of calculating whether staffing levels are acceptable or otherwise within general wards. This means that perceptions of poor staffing often go unchallenged.

The previous report to Trust Board outlined a range of measures that could be taken to improve perceptions around staffing at ward level. These included improvements in rostering, shift patterns, absence management, recruitment, new role development and others.

Within the Trust there has been considerable progress towards getting some of the basics around staffing issues in place, but this is not likely to have had any real significant difference yet on actual staffing levels in all but a handful of wards.

More importantly significant progress has been made around the culture of our wards, especially around enabling and motivating staff to take control of their areas and make a difference for themselves and their patients. This has been through work such as Optimal Wards, Ward Reviews, PEAT visits, Productive Wards, Matron Development Programme and Leadership Conferences.

3. Planning for the Future

The new hospital will require a different type of nursing workforce. With fewer in-patient beds and increased services in the community, patient acuity within the hospital will be greater. The following key principles will apply to the nursing workforce (generic wards):

- Pre-registration student nurses and nurses during the transition period from novice practitioner to skilled practitioner will need a higher level of technical competency.
- Competent support roles will be required to support registered nurses with basic care needs and less advanced technical skills.

- Administration and facilities support roles will be essential to enable registered nurses to maximise the time spent with patients.
- Greater assessment and intervention skills for registered nurses will be required.
- Enhanced ability with caring for patients with mental impairment; diseases of old age and obesity will almost certainly be required.
- Skills currently considered advanced eg. Non-medical prescribing, nurse led discharge, transcribing, initial assessment and diagnostic orders will become the normality.

The themes described in this report are the start of a journey towards developing a nursing workforce fit for our new hospital.

4. The Strategy Themes

Within the strategy presented to the Trust Board in March the following areas were described as areas where improvement and development within the nursing workforce could and should take place:

- Improving numbers on a shift
- Workload organisation
- New role development
- Support roles
- Flexible workforce
- Planning for winter and holidays
- Recruitment

The original intention had been to identify four pilot areas and work with them to test out whether the ideas within the above themes would make a difference to staff perception regarding staffing levels. Four pilot areas were identified, these were D16, D7, P5 and L3. Each of these wards were “challenged” in one way or another and all felt that poor staffing levels contributed to poor performance.

In addition to identifying pilot wards, a number of corporate work streams were commenced to enable changes to happen around nursing workforce corporately.

Shortly after the pilot wards had been identified, the LiA staff conversations happened. A very strongly voiced theme at the conversations was around ward staffing levels. It was felt that the staffing projects could benefit from an LiA approach and Optimal Wards: Happy Staff, Happy Patients was born!

5. Optimal Wards: Happy Staff, Happy Patients.

The same four wards were used as pilots but the LiA methodology was used to engage staff in the process. Many of the staff were cynical about the process and did not attend the conversations without some degree of “persuasion”! However, after several conversations and significant encouragement all of the four wards have made progress.

Generally the themes that the wards wanted to focus on changing were around:

- Staffing organisation and working smarter.
- The environment.
- Ward identity and being proud to work there.
- Improved patient care.
- Enhancing the patient experience.

The projects have been running for around 5 months now and some of the changes seen include:

- Ward missions, visions and values agreed.
- Environmental improvements.
- Trials of new shift patterns.
- Staff social events and meetings to improve communications.
- Annual leave and sickness absence management improvements.
- Patient information developments.
- Meet and greet standards.
- New ward clerk uniforms.
- Patient mobility ID.
- Reviewing the patients day.

The four wards also led a Sharing into Action event where ideas were shared with other wards and new wards were enrolled on the project.

The single biggest change observed in the pilot areas has been the change in attitude and behaviour of staff. There is a general feeling of optimism around these wards that wasn't there before and staff are quick to volunteer to do things.

Next steps with Optimal wards:
Additional conversations with the original optimal wards have been set up for early November to focus specifically on staffing issues.

Five additional new wards have come on stream in November and wards identified for the Productive Ward Project have also become part of this project – making a total of fifteen wards. The ultimate aim is to have "Optimised" all trust wards in 18 months.

6. Improving the Numbers

Corporately there has been a considerable amount of work done with Matrons and Ward Managers to change their thinking around rostering and shift patterns. The result of which is a number of wards now using a middle shift, eg 11am – 7pm, to manage the busy time of the day and early evening. There is also a move towards an increase in recruitment of part time HCA posts rather than the traditional full time posts. As long as hours continue to be worked over five days, this practice reduces shift overlap and allows hours to be reinvested into busy times of the day.

In addition, two of the Optimal Wards are using late twilight shifts (6pm – midnight) and dawn shifts (6am- midday) to avoid staff working throughout the small hours of the night

where there is often a lull in activity. This also increases the number of staff around when the ward is busy settling patients for the night and waking patients in the morning.

A review of annual leave management on the Optimal Wards showed a variance of staff on annual leave each week of between 0-7 staff. Most wards have no annual leave policy. This has now been asked for as part of the ward review process.

The Optimal Wards and ward reviews demonstrated that very few Ward Managers held any information regarding sickness absence trends. Once again as part of the ward review process, best practice has been shared across the Trust and we hope to see an improvement in local systems to identify sickness absence trends with the next round of ward reviews.

Workload Organisation

Much of this section of the strategy was aimed at improving leadership capability so that current out dated ward practices could be changed effectively.

The Trust Matrons have been undertaking a bespoke Matron Development Programme which will culminate in the Matron's Den later this year. The aim of the programme is to create a Senior Nursing Team with shared vision and values; to develop both individual and team capability; to give Matrons specific skills to help them do their jobs better and to provide shadowing and observation opportunities. Having a stronger senior nursing team within the Trust will lead to more robust ward management and therefore a greater ability to improve staffing issues.

There has been a second nurse leadership conference concentrating on improving basic care and "myth busting". Again, this was intended to challenge ward leaders to think about what nurses spend their time doing and maximising time spent with patients.

The autumn conference this year has been converted into a Ward Team challenge event where ward teams from across the Trust will compete against each other on scenario based ward problems and issues. The aim is to develop team capability in a safe and fun environment where some of the scenarios will relate to staffing issues.

An LiA session has been planned for early December to work with ward leaders on the development of their roles. We know that currently capability is variable and we need to move towards more modern roles and models of ward management which include medical staff and therapists as part of the management team.

In addition to leadership development a corporate Visitor week was held to try to bring some control back to visiting hours and allow nursing staff to organise their work accordingly. This is likely to be repeated twice a year and audited in between times.

The Optimal wards work has identified a number of "myths" and unnecessary obstructions which impact on workload which we are currently addressing Trust wide. For example:

- HCAs not being allowed to do a whole range of tasks which are commonplace elsewhere.

- Absence of some advanced skills which would reduce wasted time, eg nurses being able to transcribe drug and nurse led discharge.
- Newly qualified nurses not being able to do a number of key clinical tasks on qualification, eg give IV drugs and basic phlebotomy.

New Role Development

A corporate wide piece of work has been undertaken by the ADN Workforce to establish how many of our HCAs have NVQ's as a starting point for developing band 3 and 4 roles within the nursing workforce.

The conclusion was that out of a total of 500 HCAs around 30% did not have a level 2 NVQ in care. This is now being established as the expected minimum standard within the Trust and a big catch up exercise is underway, working with the L+D staff. Clearly, if staff have been with the Trust for some time and can demonstrate through competency assessment that they are already working at a theoretical and practical level afforded by a NVQ level 2 then they will not be required to undertake the programme. A HCA Policy is currently going through the approval and staff side routes to establish NVQ 2 as the minimum standard expected of our HCAs (within a specific timescale of commencing within the Trust) and there will be a requirement for this to be stated as part of our recruitment process.

The same piece of work has identified how many band 3 HCAs we have in the Trust, what roles they are undertaking and with what qualifications. The conclusion was that this is very inconsistent. Competencies and new job descriptions for band 3 HCAs and for band 4 Assistant Practitioners are being developed by a HCA task and finish group led by the ADN Workforce. This will allow the incorporation of such roles into our nursing workforce safely and of a standard that can be measured and monitored. The educational requirements for these posts are likely to be at NVQ 3 and foundation degree respectfully.

The recruitment for a foundation degree programme has commenced. This will lead to our first Assistant Practitioners in Care and will allow wards to be less reliant on registered nurses to do more basic tasks as well as giving a route into care for school leavers who will not have the academic qualifications to undertake a degree based professional qualification.

Support Workers

The introduction of Ward Service Officers at City will save around 15 hours per day per ward of nursing time to re invest into other aspects of patient care. The Ward Service Officer roles are being introduced throughout the Autumn and will manage the whole meal service and equipment cleaning at ward level.

The volunteer database has been "cleaned up" so that we know how many active volunteers we actually have. This was disappointingly very low and as such a recruitment drive for more volunteers has been undertaken and will be repeated several times a year. The current drive has secured around 20 new volunteers who will be focussed on supporting ward service officers and nursing staff in feeding patients and ensuring patients are drinking throughout the day – this builds on the red tray system for

identifying patients who need assistance with meals and the new blue beaker system which identifies patients who need encouragement with drinking.

Young people who have volunteered have been appointed as way finders. We are also seeking “occupational” volunteers for two of the Optimal wards because the staff struggle to keep elderly, often demented and physically challenged patients stimulated throughout the day. These volunteers would play games with patients, undertake hand massages and manicures, do crosswords and talk to patients.

We are commencing discussions with the local universities about the content of student nurse training and looking at the preceptorship period after qualification to ensure that when students qualify that they are able to practice and that they are supported to do so.

Flexible Workforce

A complete review of the nursing bank is being undertaken with the intention of:

- Improving controls and ensuring bank staff are used where they are most required.
- Standardising pay rates.
- Establish flexible workers as part of our workforce and valuing them accordingly.

A Minimum Staffing levels Policy has also been introduced which gives the Trust a flexible response to critical staffing levels by detailing priorities; the bank response; the non clinical nursing resource that can be called upon and operational changes required in such an eventuality.

Planning for Winter and holidays

Most of this work has been led within the medical divisions and is really about conscious over recruitment of staff ahead of the winter months and main summer holidays. The reality is that it takes a long time to recruit staff and over establishment never really happens with the level of turnover there is within nursing. However this approach minimises the number of vacancies that wards are carrying going into winter and the Trust is in a far better position this year with regard to staff in post than it was at the same time last year.

Recruitment

The speed of recruitment within the trust has definitely improved and therefore had a positive effect on staffing at ward level. However there is a view amongst senior nurses that we need to position ourselves more positively in the market and work harder to attract staff. To this end an Open day is currently being planned for December.

Ward Reviews

There has been one full round of reviews undertaken this year and the results were reported to the Trust Board in early summer. The next round is due to start in November with a revised tool and an accreditation process also included. We are hoping to see improvements in many of the clinical elements but also in the management of resources

and workload. The results will be reported to the Trust Board in the New Year once completed.

Conclusion

Although there has not been a systematic approach to improving staffing levels a significant amount of work has been undertaken and a climate that supports change is beginning to emerge. Ward Managers are certainly beginning to understand that investment in increased staffing will only take place when it can be demonstrated that existing resources are managed well through:

- Excellent sickness management.
- Low turnover
- Effective PDR systems
- Effective rostering and shift patterns that match work demands.
- Effective annual leave management
- No ritualistic practices.
- Effective workload management eg handovers etc
- New role development and modern working practices
- Excellent recruitment
- Good supporting structures.

The ongoing work of the Optimal Wards project, with some focussed work on staffing issues, should further develop this culture.

Rachel Stevens

Chief nurse

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Single Equality Scheme (SES) Progress Update
SPONSORING DIRECTOR:	Rachel Stevens, Chief Nurse
AUTHOR:	Sheila Peacock, Assistant Director of Nursing - Patient Experience and Performance
DATE OF MEETING:	6 November 2008

KEY POINTS:

The report is intended to share with the Trust Board the progress achieved since the approval of the Single Equality Scheme in July 2008.
The SES action plan has been further developed to monitor and measure progress of the 4 Equality and Diversity sub-groups:

- Workforce Monitoring
- Independent Living
- Service and Policy Assessment
- Patient Experience

All of the groups have been established with enclosed terms of reference.
A designated team for Equality and Diversity has been recruited.
The action plan has been redesigned into work programmes for the working groups with key outcomes stated.
The website has been launched and publishing duties have been achieved.

PURPOSE OF THE REPORT:

To seek approval for the amended SES and action plan and Terms of Reference for the groups.
To provide the Trust Board with an update on progress in relation to achieving its obligations under the equality legislation and objectives.

✓ Approval

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to approve the revised SES action plan and Terms of Reference.

The Trust Board is also recommended to note the progress to date.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

The action plan aligns with the Trust Strategic Objectives
No 4 Respond to our patients
No 5 Improve quality and standards of care
No 7 Promote education, training and research
HCC core standards
Essence of Care standards

IMPACT ASSESSMENT:

FINANCIAL	☑	None known currently although may be some as the action plan is implemented.
ALE	☐	
CLINICAL	☐	
WORKFORCE	☑	Appointing Head of E&D, Diversity Adviser and Impact Assessment Coordinator.
LEGAL	☑	Equality legislation.
EQUALITY & DIVERSITY	☑	SES (single equality scheme)
COMMUNICATIONS	☑	Public dates for publishing and access to information under equality legislation.
PPI	☑	Consultation and engagement active as required under public duties of equality legislation.
RISKS		

Trust Board Update Report November 08

IMPLEMENTATION OF THE SINGLE EQUALITY SCHEME

1.0 Introduction

This report is designed to inform members of the Trust Board of the progress achieved since the approval of the Single Equality Scheme (SES) in July 2008.

The latest version of the SES is attached (SWBTB (11/08) 126 (b)).

2.0 Implementation Process

In order to achieve the ambitious plan for the next 3 years a business plan was developed and approved by SIRG to obtain resources to enable the recruitment of a designated E&D team. Successful recruitment has led to the appointment of Head of Equality & Diversity, Diversity Adviser and Impact Assessment Coordinator, who will commence employment in November. The team will be responsible for the operational management and coordination of the SES and will work closely with the subgroups and key departmental leads.

3.0 Reporting and Monitoring Framework

To ensure a robust reporting and monitoring process an Equality & Diversity Steering Group has been established, with four sub-groups to address key themes outlined in the SES action plan (included within the SES). The following groups have been launched and meet quarterly, providing ongoing progress reports:

- Workforce Monitoring Group
- Independent Living Group
- Service and Policy Assessment Group
- Patient Experience Group

Terms of reference and membership of these groups are attached (SWBTB (11/08) 126 (c)).

Monitoring of the work of the four sub-groups is coordinated via the Equality and Diversity Steering Group and detailed in the SES action plan.

4.0 Action Plans

The current action plans have been redesigned to clearly demonstrate outcomes for each key theme. They are now segregated and linked to the sub-groups. The action plan will be RAG rated and a quarterly report received by the E&D steering group from each sub-group.

5.0 External communication

There have been three key pieces of external communication with the Trust with regard to E&D within the last 12 months. These being:

- Comment from 'Equality Works' re the proposed SES (18th June 2008)
- Equality and Human Rights Commission letter (19th March 2008)
- Healthcare Commission request (25th September 2008)

These communications have helped to direct and prioritise E&D work to date, which is summarised below and which should assure the Trust Board that the Trust has taken on board the external views of expert bodies within our work programme.

5.1 Equality Works

Equality Works were asked by the Trust to give expert commentary on the SES prior to Trust Board submission in July. Most of their advice related to supplementary work required in addition and in support of the SES. These comments have been passed on to the sub-groups and discussed at their initial meetings and actions required have now been incorporated into the SES action plan.

5.2 Equality & Human Rights Commission

The Trust was asked to respond to a number of concerns raised by the EHRC regarding E&D in respect to the interim reconfiguration plans. The response to the EHRC was shared with the Trust Board. Subsequent to this response, more work has been completed to ensure that commitments made by the Trust within the response have been delivered. The Trust now provides internet access for impact assessments, policies, workforce monitoring and the SES.

A commitment was made to the EHRC to include within the Trust annual report detail of Trust employment monitoring data. On reflection, this is not achievable due to the volume of data available and so readers are now directed to the internet site where the data is published.

5.3 Healthcare Commission

The Healthcare Commission wrote to the Trust requesting information supporting our publishing duties in relation to race, disability and gender. We were able to provide them with most of the information they required through the E&D website. However, this request prompted a wider discussion about reporting of workforce equality monitoring data at the E&D Steering Group. As a result it has been agreed that monitoring data will be available in real time via the internet and reported via the workforce sub-group quarterly rather than the familiar annual report which only relates to the previous 12 months. Along with detail of action planned as a result of workforce monitoring this

should provide both the Trust Board and the public with more meaningful information.

6.0 Public Consultation

In order to comply with equality legislation, consultation and public engagement is a crucial element of our public duties. The Head of Communication is developing a Consultation strategy and guidelines to support staff across the organisation. This will be presented in the next quarterly report.

The Independent Living Group is increasing its membership from the voluntary sector and project working groups are lobbying for more disabled representatives. The Head of Communication, in conjunction with the Head of Equality & Diversity will maintain a community engagement register and database for teams to access in support of public consultation and involvement.

7.0 Workforce Monitoring Group

In addition to the comments above re workforce monitoring information, the group have been focusing attention on training needs and publication duties.

Learning & Development are currently reviewing the content of the staff induction programme to ensure that sufficient information is provided for new employees about their role in relation to Equality & Diversity. For existing employees the Trust has delivered diversity training for several years but attendance is extremely poor. Staff release and conflicting priorities to attend training is leading L&D to explore alternative solutions of open learning and IT packages.

An Equality & Diversity webpage designated to Workforce is now available on the Trust Internet site; this will house information leaflets and any training materials.

In November SES master classes will be launched for executive leads, senior managers and matrons. This will provide an advanced 2-day learning set to facilitate the strategic implementation of the Trust's SES. It is intended that once the E&D team are in place they will assume the provision of impact assessment training for all managers.

8.0 Independent Living Group

This group is now established and is currently seeking wider membership from the community groups.

9.0 Service and Policy Assessment Group

Work is underway with divisional management teams to produce a realistic service impact assessment work programme. There will then be an updated programme attached to the SES and published on the website. From

November E&D has been integrated into the Trust performance and governance process. Divisional and ward reviews will set targets for completion of impact assessments and training of staff.

The Policy Register has been updated and is included in the SES.

10.0 Patient Experience Group

It was decided to incorporate the above group into the E&D reporting structure as a significant amount of the work on Patient Experience has an E&D theme. However, there are also parts of the Patient Experience action plan that have no relevance to E&D and for this reason a separate report has been produced to inform the Trust Board of progress against the Patient Experience action plan.

With regard to E&D and Patient Experience, the main issues currently are around the new meal service at City site; producing the E&D website, reviewing the interpreting service and patient information.

11.0 Conclusion

Considerable progress has been achieved since the development of the Single Equality Scheme which has enabled the Trust to meet compliance of the Healthcare Commission core standards for E&D. However, there are areas that need further work and which are detailed below. These form part of the SES action plan.

12.0 Further Work Areas

- Equality is integrated into procurement contracts
- IT systems are improved to capture all equality strands for staff and patients. The patient system is extended to capture patients who are from hard to reach groups such as asylum seekers and migrant communities
- Local population demography is captured and compared with service user and employment monitoring information
- Patient Information is translated into multiple languages or alternative media formats in order to provide material for non English reading patients or individuals with learning disabilities

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Embracing Our Diverse Communities
Single Equality Scheme
NOVEMBER UPDATE

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Embracing Our Diverse Communities
Single Equality Scheme

PROFILE	
REFERENCE NUMBER:	
VERSION:	Final
STATUS:	Approved
ACCOUNTABLE DIRECTOR:	Chief Nurse
AUTHOR:	Assistant Director of Nursing – Patient Experience
DATE OF LAST REVIEW/ ORIGIN DATE:	
DATE OF THIS REVIEW:	November 2008
APPROVED BY:	Trust Board
DATE OF APPROVAL:	July 2008
IMPLEMENTATION DATE:	July 2008
DATE NEXT REVIEW DUE:	July 2011
REVIEW BODY:	
CATEGORISATION:	
DATE OF EQUALITY IMPACT ASSESSMENT:	March 2008
APPLICATION:	
PRINCIPAL TARGET AUDIENCE:	Staff & Public
ASSOCIATED TRUST DOCUMENTS:	Current Equality & Diversity Policies

Embracing Our Diverse Communities
Single Equality Scheme

Contents **Page No.**

FOREWORD BY TRUST CHIEF EXECUTIVE

I welcome the introduction of our new Single Equality Scheme into Sandwell and West Birmingham Hospitals NHS Trust. We serve a diverse population over a large area and have extensive experience of promoting equality for patients and staff across the organisation. The Trust is committed to providing equal employment and advancement for all individuals.

The process of developing this new scheme has provided the Trust with an opportunity to re-examine all our equality policies and practices and capture under one umbrella the equality pathway that addresses the needs of all our diverse communities.

The Single Equality Scheme sets out how as an organisation we will meet our obligations under the equality legislation over the next three years, but more importantly, how we will make a real and positive difference to the lives of all who are affected by what we do. It sets out our commitment to achieving equality and our determination to ensure that our policies and practices meet the needs of all service users as well as those of our staff.

The success of the scheme requires commitment and leadership at all levels and that we hold ourselves accountable for our delivery; only then can we make the differences we want all to see.

John Adler
Chief Executive

WIDESPREAD CONSULTATION

This Consultation Document issued by Sandwell & West Birmingham Hospitals NHS Trust will replace our current schemes and combines our existing Equality and Diversity Schemes into a Single Equality Scheme. It contains the Trust's response to the statutory general and specific duties enshrined in the Equality Act (2006), the Disability Discrimination Act (2005) and the Race Relations (Amendment) Act (2000). It also embraces other equal opportunities legislation including sexual orientation, religion and belief, age, race, disability and gender. This document supersedes our Equality and Diversity Strategy.

One of the Trust's core values is to be open and accountable about what we do. We hope that publication of this consultation will stimulate consideration and discussion of the issues and our plans to address them.

We would welcome comments on all aspects of this document, in particular your opinions on the action plans. Should you want to join any of our sub groups or contribute to elements of our work then please contact our Communications Department.

DOCUMENT TRANSLATION AVAILABILITY

This document is available in other formats and languages upon request.

Amharic ይሄንን ማስታወቂያ በሌላ ቋንቋ እንዲሰጠዎት ከፈለጉ አባክዎን እኛን ያነጋግሩን። ዝርዝር አድራሻችን ከዚህ በታች እንደሚከተለው ነው።

Arabic إذا أردت هذه المعلومات بلغة أخرى، رجاءً اتصل بنا. ستجد فيما يلي بيانات الاتصال الخاصة بنا.

Bengali আপনি যদি এই তথ্যাবলি অন্য কোন ভাষায় চান তবে অনুগ্রহ করে আমাদের সাথে যোগাযোগ করুন। আমাদের বিস্তারিত নীচে দেওয়া আছে

Chinese 如果您希望获得以另一种语言提供的本信息，请联系我们。我们的详细联系方式如下。

Chinese (traditional) 如果你想得到本資訊的其他語言版本，請聯繫我們。我們的聯繫詳情如下。

Czech V případě zájmu o stejné informace podané v jiném jazyce nás prosím kontaktujte. Naše kontaktní údaje jsou uvedeny níže.

Farsi Afghan اگر شما این معلومات را به کدام زبان دیگر میخواهید، لطفا با ما به تماس شوید. تفصیلات ما قرار ذیل میباشد.

French Si vous désirez avoir accès à ces informations dans une autre langue, veuillez nous contacter. Vous trouverez nos coordonnées ci-dessous.

Gujarati જો આપને આ માહિતી અન્ય ભાષામાં જોઈતી હોય તો, કૃપા કરી અમારો સંપર્ક કરો. અમારી માહિતી આ મુજબ છે.

Hindi यदि आप यह जानकारी किसी दूसरी भाषा में लेनी चाहें तो कृपया हमसे संपर्क करें। हमसे संपर्क करने की जानकारी नीचे दी गई है।

Hindko اگر تسی کسی دوئی زباناں یچ اے معلومات چاہنڑیں او، تے میربانی کر کے اساں نال رابطہ کرو. اساں نیاں تفصیلاں تلاں دیتاں ہوئیاں نیں.

Japanese この情報を他の言語で必要な場合、お問い合わせ下さい。連絡先は以下のとおりです。

Kurdish Sorani ئەگەر ئەم زانیاریانەت بە زمانێکی دیکە دەوێت، ئەوا پەیوەندیمان پێوە بکە. ناونیشانمان ئەمەی خوارەوەیە.

Lingali Soko olingi mayebisi oyo na monoko (langue) mosusu nde okoki kobenga biso mpo na kosenga yango. Numéro mpe esika na biso ekomami awa na nse.

Mirpuri اگر تساں ہے معلومات کسے ہوری زبان وچ چاہنڑیں او، تے میربانی کری تے ساڈے نال رابطہ کرو. ساڈیاں تفصیلاں تلے دیتاں نیں.

Pashto که داسي دغه معلوماتو په کومه بله ژبه غواړئ، لطفا زمونږ سره په تماس کې شئ. زمونږ معلومات په لاندې دول دي.

Polish	Aby otrzymać niniejsze informacje w innym języku, prosimy o kontakt. Dane kontaktowe podano poniżej.
Portuguese	Se desejar esta informação noutra língua, por favor contacte-nos. Encontrará em seguida os nossos dados de contacto.
Punjabi	ਜੇ ਤੁਸੀਂ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿੱਚ ਲੈਣੀ ਚਾਹੋ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰੋ। ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰਨ ਦੀ ਜਾਣਕਾਰੀ ਹੇਠਾਂ ਦਿੱਤੀ ਗਈ ਹੈ।
Romanian	În cazul în care doriți să primiți aceste informații într-o altă limbă, vă rugăm să luați legătura cu noi. Iată datele noastre de contract.
Russian	Если Вы желаете получить эту информацию на другом языке, пожалуйста, свяжитесь с нами. Наши контактные данные указаны ниже.
Shona	Kana muchada ruzivo urwu mune chimwe chirudzi, tapota tiziviseyi. Kuti tinobatika seyi kwakapihwa pazasi.
Slovak	Kontaktujte nás v prípade, že máte záujem o túto informáciu v inom jazyku. Naše kontaktné údaje sú priložené.
Somali	Haddii aad ku doonayso macluumaadkan luuqad kale, fadlan nala soo xariir. Faahfaahintayadu way soo socotaa.
Swahili	Kama utapenda kupata habari hizi katika lugha nyingine, tafadhali wasiliana nasi. Maelezo yetu yatafuatilia.
Thai	หากคุณต้องการข้อมูลนี้เป็นภาษาอื่น กรุณาติดต่อเราตามรายละเอียดด้านล่างนี้
Tigrinya	ነዚ ሓበሬታ'ዚ ብካልእ ቋንቋ ክዋሃበኩም እንድሕር ደሊኹም ብኽብረትኩም ነዓና ኣዘራርቡና። ዝርዝር ኣድራሻና ካብ'ዚ ትሕቲ'ሉ ከምዝቕጽሎ ኢዩ።
Turkish	Bu bilgiyi başka bir dilde almak istiyorsanız lütfen bizimle irtibat kurun. İrtibat bilgilerimiz aşağıdadır.
Twi	Sɛ wo pɛ saa nsɛmfua weyi wɔ kasa foforɔ mu a, yepaakyew frɛ yɛn. Baabi a wo bɛnya yɛn didiso.
Urdu	اگر آپ کو یہ معلومات کسی اور زبان میں چاہیے، تو برائے مہربانی ہم سے رابطہ کریں۔ تفصیلات نیچے دی گئی ہیں۔
Vietnamese	Nếu bạn muốn nhận thông tin này bằng ngôn ngữ khác, hãy liên hệ với chúng tôi theo địa chỉ dưới đây.

0121 507 5303
Equality@swbh.nhs.uk
We look forward to hearing your views.

TRUST VISION

"The Trust will help improve the health and well being of people in Sandwell, West Birmingham and surrounding areas, working with our partners to provide the highest quality healthcare in hospital and closer to home."

OUR VALUES

Alongside our vision, we have also identified values that will underpin all we do. We believe these values will be vital to the successful delivery of health care in the future.

Our Values	**What this means**
Caring and Compassionate	- We care for patients, their carers and relatives as they would want us to. - We treat all patients with dignity and respect.
Accessible and Responsive	- Our services are accessible to all. - We identify and respond to the diverse needs of the patients and communities that we serve. - We involve patients in decisions about their care.
Professional and Knowledgeable	- We demonstrate high levels of competence and professionalism in all we do. - We provide safe, high-quality services. - We pursue opportunities for innovation in the way we provide services.
Open and Accountable	- We are open about what we do. - We are accountable to patients and local people for the decisions we take and the services we provide.

Adopting these core values embeds the principles and legal requirements of the Equality and Diversity Schemes.

INTRODUCTION

1.1 Sandwell & West Birmingham Hospitals NHS Trust (SWBH) is currently operating across three hospital sites, City Hospital, Sandwell Hospital and Rowley Regis Hospital. The Trust has a workforce of 6,000 staff, with an income in excess of £325 million. The Trust has been recognised through the Investors in People and Improving Working Lives campaigns to be an excellent employer and service provider.

1.2 One of the Trust's key objectives is to deliver high quality services that are accessible, responsive and appropriate to meet the needs of different groups and individuals. SWBH is working hard to ensure that all communities have equal access to Trust services and career/job opportunities. We strive to actively consult with the public and staff, and are currently in the middle of several public consultations. Information on how patients and the public have been involved in consultation on this Scheme is set out in Section 2.4-2.7. Section 7 sets out how patients and the public will be involved in the ongoing implementation of the scheme.

2.0 Single Equality Scheme

2.1 All public sector services have a legal duty to combat inequality. Equality is about treating individuals fairly. Diversity is about the recognition and valuing of differences for the benefit of the individual and organisation. Equality and diversity are not interchangeable, but are interdependent.

2.2 The Trust welcomes the duty to comply with various pieces of legislation covering equality and diversity issues (Appendix 1). The Trust has decided to develop a Single Equality Scheme (SES) which will encompass the current duties of the race, disability and gender equality schemes whilst also addressing duties in relation to age, religion or beliefs and sexual orientation.

2.3 This Single Equality Scheme replaces the Trust's three previous and separate Schemes (the Race Equality Scheme 2005-2008, the Disability Equality Scheme 2006-2009 and the Gender Equality Scheme 2006-2009). It combines these Schemes into a single document containing the Trust's response to the statutory general and specific duties enshrined in the Equality Act (2006), the Disability Discrimination Act (2005) and the Race Relations (Amendment) Act (2000). It also embraces other equal opportunities legislation including sexual orientation, religion and belief, age, race, disability and gender. This document supersedes our Equality and Diversity Strategy.

2.4 The Single Equality Scheme is very much a living document and feedback, review and discussion will constantly influence its direction and development.

The Trust has carried out a public consultation on this Scheme. A summary of the results of this consultation is included in Appendix 2.

The Trust has previously consulted with disabled people and with employee networks in the development of the Disability Equality Scheme 2006 -2009.

The Trust recognises the need for ongoing consultation and involvement of employees, patients and the public in the implementation of the scheme. Sections 6 and 7 outline how stakeholders will be involved and consulted in the implementation of the Scheme.

3.0 Aims of the Single Equality Scheme

3.1 To meet the legislative and policy drivers incumbent upon the Trust and ensure that equality and fairness are embedded in all areas of service delivery, employment, planning and decision-making.

3.2 To provide a caring environment in which each patient's individuality, preferences and dignity are respected. Where we fail to meet individual needs, their views are heard and where possible we try to immediately rectify the problem.

3.3 To ensure that patients and their families have equality of access and can voice their opinions on how we can develop our services.

3.4 To provide a framework for staff to ensure that current and potential employees are treated fairly, with respect and dignity. Where we fail to meet staff needs, we listen to their views and where possible we try to rectify the problem immediately.

4.0 Single Equality Scheme Principles

4.1 Reduce health inequalities and improve health outcomes for patients.

4.2 Ensure equal access to services, and through effective review provide an improved more appropriate service for our diverse patients.

4.3 Ensure that consideration of diversity and equality issues are mainstream and embedded in day to day practices across the Trust.

4.4 Address Trust polices and practices which may be discriminatory.

4.5 Provide a framework for a coordinated approach to meeting legal duties for all key strands of equality.

4.6 Raise staff awareness and understanding of these issues.

4.7 Integrate with Trust's values especially delivering healthcare that is accessible and responsive

These principles link with the Trust's vision and values and the requirements of the Standards for Better Health Framework. and other NHS policy drivers – See Appendix 1 for an overview of the legal framework and NHS policy drivers.

5.0 How the Trust will implement the Single Equality Scheme

5.1 To ensure compliance with our legal duties and organisational intent to eradicate discrimination, the Trust has identified actions and will monitor achievements of actions outlined in this document through the Divisional performance management and governance processes. This will ensure that the requirements of the Single Equality Scheme are integrated into service delivery and policy implementation.

6.0 The Framework for Delivery

6.1 **Equality and Diversity Steering Group**.

Leadership is crucial to the success of the Single Equality Scheme, therefore an Equality and Diversity Steering Group chaired by an Executive Lead has been established, to ensure that overall standards, targets and objectives are met. Senior managers and clinicians will join with PPI forum representatives shortly to be replaced by Local Involvement Networks (LINKS), trade union delegates and voluntary sector nominees, to work in partnership, advising on aspects of environmental and service delivery design. They will monitor the overall effectiveness of the scheme.

The purpose of the Steering group is:

- To set the strategic direction for equality and diversity in line with the Trust's Single Equality Scheme.
- To raise the profile of equality and diversity across the Trust's sites/functions and services.
- To ensure the work undertaken by the Single Equality Scheme is monitored, progressed and appropriately reported.
- To produce the annual Single Equality Scheme Report

The Equality Steering Group is chaired by the Chief Nurse and provides quarterly and annual reports to the Trust Board. The membership of the group will be reviewed at the inaugural meeting and other stakeholders may be co-opted onto the group or to form sub-groups as required for the delivery of the work.

6.2 Our action plans have been developed to take account of the Trust's legal responsibilities and due to the various challenges, four sub groups have been established:-

- Workforce Monitoring Group
- Independent Living Group
- Service and Policy Assessment Group
- Patient Experience Group

6.3 **Workforce Group:** will manage the data collection and analysis, associated action plans relating to all elements of workforce employment and training, ensuring their findings are published and easily accessible to the public.

This group is responsible for monitoring the training and development of all Trust employees and new inductees in both equality and diversity awareness and undertaking relevant impact assessments.

They will be host agents to evidence folders with examples of good practice.

6.4 **Service and Policy Assessment Group:** will monitor the completion of impact assessment of policies and services in accordance with the legal duties. They will review the priority order of assessment and review associated action plans.

They will ensure the publication of findings and compile an evidence folder of good practice; keeping a register of all managers responsible for undertaking assessments who have completed impact assessment training.

6.5 To address the legal requirements of public involvement in line with Disability Discrimination Act 2005 and Section 11 of the Health and Social Care Act two partnership groups have been established:

6.6 **The Independent Living Group:** will monitor the environmental elements of hospitalization, access to services and quality of care delivery for disabled and diverse groups. The membership of this group will be made up of disabled people with an interest in the Trust's work. They will be linking with the Patient Environmental Action Team (PEAT) inspection teams and Patient Experience Group to ensure a coordinated approach to service improvement. This group will also provide consultation input into the equality impact assessment process.

6.7 **Patient Experience Group:** will receive the results of user feedback from surveys, focus groups, complaints and PALS concerns. They will review quality information provide through the Essence of Care audits and PEAT action plans. The patient experience work program for service improvement will link to the Saving Lives campaign.

By integrating work streams this forum will be able to identify key themes to address sub standard care issues and exchange best practices. Equality of care is embedded in the philosophy of improving all patients' experience. Many patient focus groups exist and this forum will monitor their progress through reports from Head of Communications who leads on capturing patient views and opinions. This group will co-ordinate public consultations e.g. with equality groups as part of the impact assessment process.

7.0 Involvement & Consultation of Stakeholders

7.1 The Trust recognizes the importance of consultation in all aspects of the development and implementation of its responsibilities for equality. Involvement and consultation will give diverse groups a meaningful voice in the provision of their care, ensure higher satisfaction with service levels and help make best use of resources. The Head of Communications is the Trust lead for coordinating public consultation and seeking public opinion.

7.2 As described above, the sub groups who report to the Trust Equality and Diversity Steering Group, include members of the public, including disabled people , who will provide valuable insight into our progress and approaches.

7.3 The Trust and its recognised trade unions are committed to building an environment and workforce characterized by dignity and mutual respect, in which diversity is valued and reflects the community we serve and the delegates we have on our groups.

7.4 The past effects of institutional discrimination are recognized and all staff, regardless of role, seek to guarantee equality of opportunity for all. Everyone who works in the NHS, or applies to work in the NHS, should be treated fairly and valued equally.

7.5 The Trust is also committed to developing a culture in which all forms of discrimination are considered unacceptable, ensuring that:

- medical need and patients' wishes are the priorities in determining equality of access to care
- there is equality of opportunity for staff to develop to the best of their ability

8.0 Public Access to Information

8.1 Under current equality legislation Trusts are required to publish information which reflects how the organisation has embedded the principles of a Single Equality Scheme into and across the Trust. This is ongoing and a new Equality and Diversity webpage has been created to improve access.

8.2 The Webpage displays staff monitoring data, our current equality schemes and our progress in completing impact assessments on our policies. We are in the process of reviewing service impact assessments and monitoring existing policies. We will produce an annual equality and diversity report and newsletters to ensure individuals who cannot access online information are catered for.

8.3 The Trust is committed to ensuring that information provided is user friendly, and is available at the right time and accessible. We are currently updating an Equality and Diversity ward resource pack, and exploring many forms of media to deliver information and are developing our multilingual services. We continuously monitor

and improve communication through user groups and reading panels; working with communities to gain knowledge and exchange ideas.

9.0 Meeting our specific duties as an employer

9.1 Employment duties contained in equalities legislation require the Trust to monitor a range of workforce matters.

The Trust introduced the Electronic Staff Record system from April 2007. This system collects personal data on all of its employees, the purpose of which is to monitor whether the Trust's jobs and development opportunities are equally open to staff and that we encourage applicants from the community that we serve. Monitoring will also enable the trust to see whether there are any differences in employment practice, training, disciplinary and grievance etc. and to take action (including positive action) to address any inequalities or discrimination, as appropriate.

In relation to employment, the Trust collects a range of employment data which:

Monitors the disability, ethnicity and gender of:

- staff in post and
- applicants for jobs, promotion and training.

Monitors:

- training,
- grievances,
- disciplinary procedures,
- performance appraisal,
- dismissals and other reasons for leaving, including redundancy and retirement

in relation to age, disability, ethnicity and gender.

This information will be published annually on the Trust's website.

The Trust needs to undertake an equal pay audit, which is included in the Action Plan.

10.0 Equality Impact Assessments

10.1 The Trust provides an extensive number of services to the people of West Birmingham and Sandwell. It is a legal requirement to conduct equality impact assessments of those services/functions and associated operational

policies/procedures; in order to determine that we are meeting the public duties to promote equality.

In addition to this, the Trust is committed to progressing through the levels of the Healthcare Standards 2006/07, under which we are required to engage in impact/needs/requirements assessments on those services/policies that have been assessed for relevance to the promotion of equality. For this purpose, the Trust EIA process is extended across the areas of race, gender, disability, age, sexuality, religion and belief.

Equality Impact Assessment [EIA] is a way of determining the extent to which policies, procedures, practices and services impact upon individuals and groups in relation to one or more of the equality categories (race/ethnicity, disability, gender, age, sexuality, religion or belief, transgender and transsexual people). If the policy, procedure, practice or service is found to have an adverse impact, the author/s or service developers must consider all other alternatives, which may more effectively achieve the promotion of equality of opportunity. This may include the development of specific measures to mitigate the adverse impact. EIA is also an opportunity to identify opportunities to promote equality and improve services and employment for all.

10.2 The Trust is required to assess all its policies, strategies, functions and services for relevance and impact, usually within a three year cycle, and publish its findings.

The Trust will identify its functions and policies which it has assessed as being relevant to the general duties to promote equality. This list will form the basis for impact assessment and the Trust will publish a schedule of the EIAs that will be undertaken during the period of this Equality Scheme. This list will be included as Appendix 3.

The Trust has already completed some EIAs on policies and these are recorded on the Trust's internet page. The Trust recognises that EIAs on services / functions are a priority for the Trust. The Trust has invested resources to appoint a lead for this important work, who will co-ordinate the Trust's approach, maintain a register of EIAs and contribute to training and development of managers.

10.3 For new policies, an equality impact assessment should be carried out by the policy author, as part of the policy development process. The procedure for this is set out in the Trust's Policy on Policy Development and in the Trust's EIA Toolkit.

All new policies and functions should include also arrangements for equality monitoring the effectiveness of the policy.

10.4 For existing policies and functions, an equality impact assessment should be undertaken by responsible managers, where there is a change or when the policy, service etc, is formally reviewed or renewed. An assessment should usually be carried out on all policies every three years. The procedure for this is set out in the Trust's EIA Toolkit.

Equality impact assessments may be carried out sooner than 3 years where there are significant changes, (including reviews, restructures, withdrawal or introduction of services) or where there is evidence of inequality e.g. from complaints, public concern or equality monitoring information.

10.5 Where negative impact is identified, or where policies or functions may not be appropriately ensuring equality, an action plan will be drawn up and any remedial action prioritised to address any adverse impact.

Where there is limited information available to assess for negative impact, action plans may be drawn up to put equality monitoring systems in place to monitor the impact of the policy or function on different groups.

10.6 The Trust will consult on the likely impact of its new and proposed policies and its existing functions, strategies and services, as part of the EIA process. This may involve consultation with employee networks and/or external stakeholders, including the Independent Living Group and the Patient Experience Group – see Section 6.5.

10.7 The results of impact assessments will be published on the Trust's website and in the annual Equality and Diversity report.

10.8 Executive and Divisional Directors have overall responsibility for ensuring that the above processes are delivered as agreed with their Divisional Management Teams who will be responsible for undertaking the practical work required..

The Trust has developed an assessment tool to assist managers in being consistent in their assessments – the Trust's EIA Toolkit.

The Service and Policy Assessment Group and Equality Lead will oversee progress on EIA and report to the Equality and Diversity Steering Group and the Trust Board.

As described in 6.1 above, the new Equality and Diversity Lead will advise and support managers through this process.

The Head of Communications will manage and co-ordinate public consultations and patient and public engagement to support the EIA process – See Section 7.0

The Human Resources and Learning and Development teams will ensure the rollout and continuation of EIA workshops and training in order to complete both parts of the EIA process and all Trust Managers should ensure they undertake the EIA training provided. However, in the first instance, the priority for such training will be given to identified leads.

11.0 Procurement

11.1 The Trust has various contracts with other private, voluntary and statutory organisations for goods, works, services and employment services. Procurement is a key way for the Trust to exercise its influence in the community and to discharge its public duties and promote equality. It is important to ensure that organisations and partners providing services on our behalf are complying with equality legislation and with SWBH policies and procedures.

Contractors (or partners) carrying out public functions on behalf of the Trust are, by extension, required to work in accordance with the public duties placed on the Trust.

11.2 The Trust will take steps to ensure that its equality and diversity commitments are carried out by organisations that are engaged through a contract or service level agreement. An equality compliance clause is written in into all our contracts. Legally we are required to do this for all our contracts.

Through the Trust Procurement Group and Divisional Finance Teams we will seek to ensure compliance with equality legislation and to identify where positive action can be taken to promote equality. This will be reflected in the Trust's Procurement Strategy.

Contractors will be required to demonstrate they meet equality requirements as part of the tendering process. The Trust will seek to include equality clauses in all new contracts and in all existing contracts over time.

For new contracts, equality clauses will be introduced in the tendering and negotiation stage and equality objectives and targets may be included in contract management arrangements. This may include a requirement to carry out an impact assessment, set or meet equality targets or objectives or provide equality information as part of the work.

For existing contracts, equality clauses should be introduced when the contract is formally reviewed or in the event of significant change to the contract terms. This may be reviewed if there is evidence of inequality in relation to the contract e.g. from complaints, public concern or equality monitoring information.

11.3 The Trust Procurement Group and Divisional Finance Teams will monitor equality in contracts on behalf of the Trust.

12.0 Equality Monitoring in services

12.1 The Trust recognises there is a need to further develop the information it has available to support the implementation of the Single Equality Scheme.

The Trust is engaged in ongoing work to harness patient and staff demographic data and to ensure this is provided in a meaningful format to support the work of the subgroups and the EIA process. This work is described in the action plan.

13.0 Training staff in equality and diversity

13.1 The Trust is currently reviewing its statutory and mandatory training programmes. Our objective for 2008 is to improve uptake and provide more on line training opportunities for all staff to help them better understand and manage diversity and equality.

13.2 Since the publication of the equality impact assessment training toolkit in 2007, the Trust intends to make this training available for all managers of services and introduce monitoring through the Divisional performance review system to ensure its implementation.

13.3 Details of these and other training initiatives designed to promote equality and diversity can be found on the Learning and Development WebPages. The Workforce Directorate will monitor staff applications and attendance on training in accordance with the equality legislation categories.

14.0 Reviewing and monitoring the Single Equality Scheme

14.1 As described in Section 6.0 an Equality and Diversity Steering Group has been formed with specific subgroups related to addressing the action plans of the scheme.

14.2 The subgroups are a combination of members of the public and employees. These groups will produce and receive quarterly reports. An annual review report will be submitted to the Trust Board which draws together all the subgroup activities and service developments. The scheme will be reviewed every three years but continually monitored and updated when appropriate.

14.3 Information about the role of the Equality Steering Group and the subgroups are set out in section 6.0, above.

15.0 Conclusion

15.1 Working with others in partnership is a pervasive theme of this document. The Trust recognises the importance and contribution it can make to eradicate inequality. Bringing this work together under the Single Equality Scheme makes clear the sheer size of the challenges ahead. Views and comments on both the general themes and specific actions would be very welcome.

APPENDIX 1

Legal Framework

This is the Trust's first Single Equality Scheme and will replace all existing schemes. It will form the basis of our Equality and Diversity Strategy. The scheme will be reviewed every three years unless new legislation or information warrants earlier review. The scheme will be continually monitored and an annual equality and diversity report produced which will be presented to the Trust Board and available to the public on line or in other appropriate formats.

The Government response following the Stephen Lawrence Inquiry report in 1999 has been a commitment to work towards the eradication of "institutional racism" within public bodies. Since then a variety of new legislation and national guidance has been published to bring about equality which is listed below.

Equal Opportunity Legislation

- Equal Pay Act 1970
- Sex Discrimination Act 1975
- The Race Relations Act 1976 and Amendment Act 2000
- Disability Discrimination Act 1995 and 2005
- Human Rights Act 1998
- Civil Partnership 2005
- Equality Act 2006
- Gender Duty 2007

European Directives

- Employment Equality (Religion or Belief) Regulations 2003
- Employment Equality (Sexual Orientation) Regulations2003
- Employment Equality (Age) Regulations 2006

NHS Guidance

Several guidelines and national directives developed for the NHS will also influence the context of the Trust approach to tackling the equality and diversity issues. These include:

- The NHS Plan
- Standards for Better Health
- Equality Performance Framework
- National Service Frameworks
- Improving Working Lives
- NHS Knowledge and Skills Framework
- The Vital Connection-An Equalities framework for NHS
- Investing For Health Strategy

PUBLIC DUTIES

The Race Relations Act 1976 and Amendment Act 2000

Section 20 of the Race Relations Act makes it unlawful for a service provider to discriminate on racial grounds against a person who seeks to obtain goods, facilities or services by them:-

Refusing to provide any of the above; or

Not providing goods, facilities or services of the same quality, in the same manner and on the same terms as is normal to other members of the public.

General duty

- eliminate unlawful racial discrimination
- promote equality of opportunity
- promote good relations between people of different race
- ensure all service users, their carers and relatives are treated with sensitivity, respect and dignity, regardless of their age, disability, gender, sexuality or religious belief.

Specific duty

Prepare and publish a Race Equality Scheme which sets out both functions and policies that are relevant to meeting the general duties, including the action required to meet the duty in areas of both policy and service delivery. Monitor employment procedures and practices.

Specific Employment Duty

Under the RRA (2000) the Trust is required to monitor the following by racial groups:

- Staff in post
- Applications for employment training and promotion
- Staff who receive training
- Staff who benefit or suffer detriment as a result of the performance assessment procedures
- Staff involved in grievance procedures
- Staff subject to disciplinary procedures
- Staff who cease employment in the Trust

Disability Discrimination Act 1995 and 2005

The Disability Discrimination Act (DDA) makes it unlawful to discriminate against people with disabilities (or have had a disability) in several areas including access to facilities, goods and services and employment. The duties apply to the Trust both as an employer and a service provider. This has implications for the following areas:

- recruitment and retention policies and procedures
- learning and development
- planning and development of services
- services outsourced to private contractors

General duty (section 49a)

- promote equality of opportunity between disabled people and other people eliminate unlawful discrimination
- eliminate harassment of people with disabilities that is related to their disability
- promote positive attitudes towards people with disability
- encourage participation of disabled people in public life
- take steps to take account of people with disabilities, even where that involves treating people with disabilities more favourably than others

Specific duty

To develop a disability equality scheme which outlines how the Trust will meet the requirements of the general duties?

Equality Act 2006 and Gender Equality Scheme

The Gender Equality duty which came into force on the 6th April 2007 is the most dramatic change to the sex equality legislation for 30years. This will deliver real change and practical improvements in the lives of women, men and transsexual people by ensuring public authorities tackle gender in equality and meet their different needs. In order to meet general and specific duties the Trust needs to systematically collect and analyse information on the use of services and see if there are any unintentional barriers that need removing.

General duty

- eliminate discrimination or harassment that is unlawful under the Sex Discrimination Act (1976) and the Equal Pay Act (1970)

- promote equality of opportunity between men and women

Specific Duty

Prepare and produce a Gender Equality Scheme demonstrating how they will meet the general duties.

Include objectives on how to address the causes of gender pay gap. Impact assess current and proposed policies and practices on gender equality.

APPENDIX 2

Involvement and Consultation on the Single Equality Scheme

Paper by Jessamy Kinghorn, Head of Communications and Engagement

---

Consultation on the Single Equality Scheme took place during April and May 2008 with responses received into mid-June.

1. Production of the document

The Scheme was made available electronically and in hard copy in PDF and word format and in large font. It was included on the Trust's Equality and Diversity page on the Internet and Intranet. An offer to translate the document into any of 31 languages was included in the front of the document in those languages. These languages were selected using Birmingham City Council and Sandwell MBC information on most commonly spoken languages and information on requests for interpreters within the Trust during 2007. The languages on offer are listed below. There were no requests for translations.

Amharic	**Farsi Afghan**	**Kurdish**	**Punjabi**	**Thai**
Arabic	**French**	**Sorani**	**Romanian**	**Tigrinya**
Bengali	**Gujarati**	**Lingali**	**Russian**	**Turkish**
Chinese	**Hindi**	**Mirpuri**	**Shona**	**Twi**
Chinese	**Hindko**	**Pashto**	**Slovak**	**Urdu**
(traditional)	**Japanese**	**Polish**	**Somali**	**Vietnamese**
Czech		**Portuguese**	**Swahili**	

2. Activities to distribute the Scheme and engage in consultation included:

The Scheme was presented to the PPI Forum in April and hard copies made available for members.

An email was sent to all staff together with information in Team Brief in April. Key meetings were attended by the Chief Nurses where discussions about the Scheme were held and the draft document distributed.

Information was sent to organisations involved in recent consultations conducted by Sandwell and West Birmingham Hospitals NHS Trust and to organisations listed with Sandwell Council of Voluntary Organisations and Birmingham Voluntary Service Council (online databases).

Key organisations included:

The Birmingham and Sandwell Overview and Scrutiny Committees, Birmingham Race Action Partnership, Race Equality Sandwell, Sandwell Council of Voluntary Organisations, Birmingham Voluntary Service Council and the Participation Team at Sandwell Council along with a number of Councillors at Sandwell MBC and Birmingham City Council.

Examples of other organisations include:

Sandwell Visually Impaired; BID services for deaf people; RNID; SCOPE; Dial UK; Age Concern; Bangladeshi Women's Project; African Caribbean Health Improvement Service; Autism West Midlands; Sandwell Cares; Birmingham Carers Association; Sandwell Irish Society; Huntington's Disease Association; Oak Tree Centre; Cerebral Palsy Midlands; The Lighthouse Project; Sandwell Parents for Disabled Children; Spurgeons; Sandwell Womens Agency Network (SWAN); Sandwell Young Carers; Service User Reference Group; Al - Islah Community Trust; Queen Alexandra College; Birmingham Talking Newspaper Association; Birmingham Disability Resource Centre; Direct Enquiries (working with Arthritis Care); deafPLUS; the Stoke Association; Remploy; Enable Light (International Institute of Deaf Services); National Youth Advocacy Service; Asylum Support and Immigration Resource Team; Birmingham Refugee Youth Sport; Black Country Urban Industrial Mission; Cameroon Children and Women Project in the UK; Central Africa Refugee Link West Midlands; Caring and Sharing Post adoption service; Centrepoint Christian Church; Changing Our Lives (services for people with learning disabilities); St Francis of Assisi Church; Confederation of Bangladeshi Organisations; Guru Nanak Community Centre & Gurdwara; Leonicks House; Murray Hall Community Trust; OSCAR (Organisation for Sickle Cell Anaemia Research & Thalassaemia Support); Birmingham & the Black Country ICAS; Sandwell Advocacy; Sandwell African Caribbean Mental Health Foundation; Sandwell Community Information and Participation Service; Sant Nirankari Mission; Sandwell Forum for Voluntary Youth Organisations; Sandwell MIND; Sandwell Neurological Alliance; Sandwell University of the Third Age U3A; Sandwell Welfare Trust; Sandwell Women's Aid; Sandwell Womens Agency Network; Smethwick Pakistani Muslim Association (SPMA); Smart Spenders; Victim Support; Friendship, Care and Housing; African Caribbean Resource Centre; Meals on Wheels

Organisations were invited to read and comment on the Single Equality Scheme and action plans. A response form was sent with the Single Equality Scheme.

Organisations were also approached regarding help and advice they could offer in reaching a relevant and appropriately wide audience.

A number of these key organisations were written to twice and followed up by telephone.

Following contact with some organisations that received the Single Equality Scheme from sources other than the Trust, we know that members of Sandwell Council distributed the Single Equality Scheme to organisations and contacts on their databases inviting them to respond to us. However, we had no formal notification from the Council that they have done this.

A temporary member of staff was hired to issue electronic and hard copy documents to organisations on the Trust's consultation databases. There was some concern as to how effectively this duty was carried out and follow up contact was made with some key organisations to ensure they had copies of the document.

Responses were received by phone, email, in post and in person, for example at meetings where the document was presented and a meeting with a member of the public at his request. The number of responses was limited but some were very thorough and most were positive.

Responses were received from key organisations including Race Equality Sandwell, Birmingham Race Action Partnership and Sandwell Visually Impaired. Most responses were from individuals although many are known to be from organisations such as the LINks.

The main themes raised were around:

- Membership of the sub-groups
- How we will address the religious and cultural needs
- How we will ensure each of the strands has equal profile and is not diluted by being pulled into a single scheme
- Being proactive in involving disabled people

Responses were analysed by the Assistant Director of Nursing - Patient Experience incorporated into the final report. An external, independent expert is also involved in finalising the document following the consultation.

APPENDIX 3

Equality Impact Assessment - Recent Policies

Equality Impact Assessment [EIA] is a way of determining the extent to which policies, procedures, practices and services impact upon individuals and groups in relation to one or more of the equality categories (gender, age, sexuality, religion or belief, disability, transgender and transsexual people). If the policy, procedure, practice or service is found to have an adverse impact, the author/s or service developers must consider all other alternatives, which may more effectively achieve the promotion of equality of opportunity. This may include the development of specific measures to mitigate the adverse impact.

LIST OF NEW OR REVISED POLICIES APPROVED BY THE OPERATIONAL MANAGEMENT BOARD OR GOVERNANCE BOARD, HAVING BEEN INITIALLY EQUALITY IMPACT ASSESSED

SEPTEMBER 2008

POLICY TITLE	DATE OF IMPLEMENTATION
1. Missing Patient Policy	18/09/2007
2. Mental Capacity Policy	05/10/2007
3. Falls policy	19/10/2007
4. Grievance and Disputes Procedure	30/10/2007
5. Transfer Policy for Children and young adults	07/11/2007
6. Restraint and control policy	14/11/2007
7. Infection Control; Blood and Body Fluid Spillage Policy	28/11/2007
8. Infection Control; Creutzfeldt-Jacob Disease (CJD); infection control	28/11/2007
9. Infection Control; Hand Hygiene Guidelines for Staff	28/11/2007
10. Infection Control; Central venous catheters; infection control	29/11/2007
11. Infection Control; Gram Negative; infection control	29/11/2007
12. Infection Control; Infection Control in Paediatrics	29/11/2007
13. Infection Control; Infection Control Policy	29/11/2007
14. Infection Control; Linen Segregation; infection control	29/11/2007
15. Infection Control; Meningococcal; Infection Control Guidelines	29/11/2007
16. Infection Control; SARS, Severe Acute Respiratory Syndrome; Infection control	29/11/2007
17. Infection Control; Splenectomy; Policy for prevention of infection	29/11/2007
18. Infection Control; Tuberculosis; infection control	29/11/2007
19. Infection Control; Varicella zoster virus; chickenpox, shingles; infection control	29/11/2007
20. Infection Control; Viral Haemorrhagic Fevers; infection control	29/11/2007
21. Infection Control; Asepsis; Infection control priniciples	30/11/2007
22. Infection Control; A-Z Communicable Infections	30/11/2007

POLICY TITLE	DATE OF IMPLEMENTATION
23. Infection Control; Blood borne Viruses, Infection control	30/11/2007
24. Infection Control; Building/Upgrade works, infection control	30/11/2007
25. Infection Control; Flexible endoscope	30/11/2007
26. Infection Control; Infected Bodies; infection control	30/11/2007
27. Infection Control; Infection Control Committee	30/11/2007
28. Infection Control; Infection Control in Theatres	30/11/2007
29. Infection Control; Pathology specimens; infection control	30/11/2007
30. Infection Control; Outbreak Plan	03/12/2007
31. Infection Control; Protective Clothing	03/12/2007
32. Infection Control; Sharps, clinical and infectious waste; infection control	03/12/2007
33. Infection Control; Specimen collection	03/12/2007
34. NICE Guidance Policy	09/12/2007
35. Disciplinary Policy	11/12/2007
36. First Aid Policy	11/12/2007
37. Investigatory Guidance	11/12/2007
38. Personal Development Review (PDR)	11/12/2007
39. Display Screen Equipment (DSE)	12/12/2007
40. Blood Contamination / Needlesticks Incidents	13/12/2007
41. External Visits Policy	13/12/2007
42. Medicines Management Policy	13/12/2007
43. National Reports	13/12/2007
44. Controlled Drugs Policy	17/12/2007
45. Dignity at Work Policy	19/12/2007
46. Slips, Trips and Falls	03/01/2008
47. Violence and Aggression Policy	03/01/2008
48. Discharge Policy	04/01/2008
49. Lone Worker Policy	04/01/2008
50. Moving and Handling Policy	04/01/2008
51. Security Policy	04/01/2008
52. Stress at Work Policy	04/01/2008
53. Transfer of patients	04/01/2008
54. Criminal Records Disclosure Policy	08/01/2008
55. Recruitment and Selection Procedure	10/01/2008
56. Resuscitation Policy	22/01/2008
57. Domestic Abuse	28/01/2008
58. Healthcare Records Management	30/01/2008
59. Vulnerable adults	30/01/2008
60. Incident and Hazard Reporting Policy	31/01/2008
61. PALS Operational Guidelines	31/01/2008
62. Patient identification Wristband Policy	31/01/2008
63. Emergency Care Plan in children (DNAR)	01/02/2008
64. Medical Devices Competency	01/02/2008

POLICY TITLE	DATE OF IMPLEMENTATION
65. Being Open	04/02/2008
66. Complaint, claim support for staff	04/02/2008
67. Complaints Handling Policy	04/02/2008
68. Blood Transfusion (new ref num is pt care/09)	05/02/2008
69. Complementary Therapy in Cancer Services	05/02/2008
70. Consent for Examination or Treatment Policy	05/02/2008
71. Induction and Mandatory training Policy	05/02/2008
72. Medical Staff Induction Policy	05/02/2008
73. Infection Control Service	07/02/2008
74. Recruitment Medical Staff	07/02/2008
75. Uniform and Dress Code Policy	08/02/2008
76. Infection Control; Decontamination-Equipment; infection control	11/02/2008
77. Infection Control; Infestations; Human and Environmental	11/02/2008
78. Antimicrobial Therapy	14/02/2008
79. Research & Development Policy	04/03/2008
80. Professional Registration Procedure	10/03/2008
81. Infection Control; Decontamination-Environment; infection control	19/03/2008
82. Infection Control; Suspected Communicable infections	12/04/2008
83. Infection control; Taking peripheral blood culture guidelines	12/04/2008
84. Adverse Events, investigation	17/04/2008
85. Alcohol/Drug Misuse Policy	17/04/2008
86. Hospital Cleaning Policy	25/04/2008
87. Non Medical Prescribing Policy new number Pt Care/019	23/06/2008
88. Long Service Awards Policy	30/06/2008
89. Retirement Policy	30/06/2008
90. Infection Control; C Difficile	21/07/2008
91. Infection Control; Diarrhoea	21/07/2008
92. Infection Control; Gram Positive; infection control	21/07/2008
93. Infection Control; Isolation	21/07/2008
94. Infection Control; MRSA	21/07/2008
95. Syringe Driver Policy (also in clin guidelines database)	04/08/2008
96. Food Hygiene Policy	08/08/2008
97. New and expectant mothers (Health & Safety for staff)	08/08/2008
98. Waste Management Policy	08/08/2008
99. Sickness Absence Policy	26/08/2008
100. Thromboprophylaxis in medical inpatients	08/09/2008
100. Thromboprophylaxis in surgical inpatients	08/09/2008
101. Staffing levels nursing	24/09/2008
102. Waiting list policy Admitted	25/09/2008
103. Waiting List Policy Non admitted	25/09/2008
104. Information Governance policy	30/09/2008

TRUST POLICIES ON INTRANET AS AT OCTOBER 2008

	Existing policies prioritised for an initial Impact Assessment

1.	Adverse Events, investigation	SWBH
2.	Agenda for Change, Review and Appeals Procedure	SWBH
3.	Alcohol/Drug Misuse Policy	SWBH
4.	Antimicrobial Therapy	SWBH
5.	Armed Police; Policy on Deployment	SWBH
6.	Asbestos Management Policy	SWBH
7.	Bathing; policy on management of safe bathing	SWBH
8.	Bed Rails; policy for safe use	SWBH
9.	Being Open	SWBH
10.	Bleep Policy for Junior Doctors	SWBH
11.	Blood Contamination / Needlesticks Incidents	SWBH
12.	Blood Transfusion (new ref num is pt care/09)	SWBH
13.	Bomb Threat Procedure	SWBH
14.	Breaking Bad News	Sandwell
15.	Breaking Bad News - Child Development Centre	Sandwell
16.	Business Continuity Plan	SWBH
17.	Capability Procedure	SWBH
18.	Car Parking Policy including Wheel Clamping	SWBH
19.	Carriage/Administration of Paediatric Emergency Medicines	Sandwell
20.	Casenotes; alerting clinicians	SWBH
21.	Casenotes; organisation and maintenance	SWBH
22.	Child Abuse; Guidelines for Medical and Nursing Management	SWBH
23.	Child Development Centre; Operational Policy	Sandwell
24.	Child Development Centre; Physical Handling of Children	Sandwell
25.	Child Protection, guidelines for staff	SWBH
26.	Children attending A&E dept	Sandwell
27.	Childrens Community Care Nursing Operational Policy	SWBH
28.	Claims Policy	SWBH
29.	Clinic Waiting Times in Children's OPD	Sandwell
30.	Clinical Audit Policy	SWBH
31.	Clinical Guideline Development Policy	SWBH
32.	Clinical techniques	SWBH
33.	Communications Policy in Learning & Development	SWBH
34.	Company Representatives on Trust Premises	SWBH
35.	Complaint, claim support for staff	SWBH
36.	Complaints Handling Policy	SWBH
37.	Complementary Therapy in Cancer Services	SWBH
38.	Confiscation of Illegal Drugs	SWBH
39.	Consent for Examination or Treatment Policy	SWBH

40.	Consent for postmortem	Sandwell
41.	Consultant Appraisal Policy	Sandwell
42.	Contractors; Management Policy	SWBH
43.	Controlled Drugs Policy	SWBH
44.	Copyright Policy	SWBH
45.	Coroner Requests; Policy for dealing with Requests from HM Coroner	SWBH
46.	COSHH Policy	SWBH
47.	Counselling, Guidance Notes	SWBH
48.	Criminal Records Disclosure Policy	SWBH
49.	Data Quality Policy	SWBH
50.	Dignity and Privacy for Patients	SWBH
51.	Dignity at Work Policy	SWBH
52.	Discharge Lounge Operational Policy	Sandwell
53.	Discharge Policy	SWBH
54.	Discharge Policy consultant mandated nurse led	SWBH
55.	Discharge Summary Procedure; Children's	Sandwell
56.	Disciplinary Policy	SWBH
57.	Disciplinary Procedure for Medical Staff	SWBH
58.	Display Screen Equipment (DSE)	SWBH
59.	Doctors' Absence Policy	SWBH
60.	Domestic Abuse	SWBH
61.	Dysphagia Policy & Procedures	Sandwell
62.	Elective Clinical Sessions - Cancellation or Reduction	SWBH
63.	Electrical Appliances; Inspection and Testing	SWBH
64.	Emergency Care Plan in children (DNAR)	SWBH
65.	Employees Leaving; procedure to monitor reasons	SWBH
66.	Energy Policy	Sandwell
67.	Enteral feeding - this is a clinical guideline and is in the guideline database, for sake of the categorisation this guideline has been put in this policies database (for my reference only)	SWBH
68.	Environmental Management Policy	SWBH
69.	Equal Opportunities at Work Policy	SWBH
70.	Equipment and Aids for Children	Sandwell
71.	Evacuation Plan	SWBH
72.	Expenses Policy	SWBH
73.	External Visits Policy	SWBH
74.	Falls policy	SWBH
75.	Family Leave Policy	SWBH
76.	Fire Policy	SWBH
77.	First Aid Policy	SWBH
78.	Flexible Working Policy	SWBH
79.	Food Hygiene Policy	SWBH
80.	Fraud and Corruption Policy	SWBH

81.	Genito-Urinary Medicine; Service and Referral Criteria	Sandwell
82.	Glove Policy	SWBH
83.	Grievance and Disputes Procedure	SWBH
84.	Health and Safety Policy	SWBH
85.	Healthcare Records Management	SWBH
86.	Healthcare Records; Access for Patients Policy	Sandwell
87.	Heatwave Plan	SWBH
88.	Hip and Knee Procedures Same Day admission (see details in guideline database)	SWBH
89.	Hospital Cleaning Policy	SWBH
90.	Hospitality Policy	SWBH
91.	Identification of Responsible Professional	SWBH
92.	Incident and Hazard Reporting Policy	SWBH
93.	Induction and Mandatory training Policy	SWBH
94.	Infection Control Service	SWBH
95.	Infection Control; Asepsis; Infection control priniciples	SWBH
96.	Infection Control; A-Z Communicable Infections	SWBH
97.	Infection Control; Blood and Body Fluid Spillage Policy	SWBH
98.	Infection Control; Blood borne Viruses, Infection control	SWBH
99.	Infection Control; Building/Upgrade works, infection control	SWBH
100.	Infection Control; C Difficile	SWBH
101.	Infection Control; Central venous catheters; infection control	SWBH
102.	Infection Control; Creutzfeldt-Jacob Disease (CJD); infection control	SWBH
103.	Infection Control; Decontamination-Environment; infection control	SWBH
104.	Infection Control; Decontamination-Equipment; infection control	SWBH
105.	Infection Control; Diarrhoea	SWBH
106.	Infection Control; Flexible endoscope	SWBH
107.	Infection Control; Gram Negative; infection control	SWBH
108.	Infection Control; Gram Positive; infection control	SWBH
109.	Infection Control; Hand Hygiene Guidelines for Staff	SWBH
110.	Infection Control; Infected Bodies; infection control	SWBH
111.	Infection Control; Infection Control Committee	SWBH
112.	Infection Control; Infection Control in Paediatrics	SWBH
113.	Infection Control; Infection Control in Theatres	SWBH
114.	Infection Control; Infection Control Policy	SWBH
115.	Infection Control; Infestations; Human and Environmental; Infection control	SWBH
116.	Infection Control; Isolation	SWBH
117.	Infection Control; Linen Segregation; infection control	SWBH
118.	Infection Control; Meningococcal; Infection Control Guidelines	SWBH
119.	Infection Control; MRSA	SWBH
120.	Infection Control; Outbreak Plan	SWBH
121.	Infection Control; Pathology specimens; infection control	SWBH
122.	Infection Control; Protective Clothing	SWBH

123. Infection Control; SARS, Severe Acute Respiratory Syndrome; Infection control	SWBH
124. Infection Control; Sharps, clinical and infectious waste; infection control	SWBH
125. Infection Control; Specimen collection	SWBH
126. Infection Control; Splenectomy; Policy for prevention of infection	SWBH
127. Infection Control; Suspected Communicable infections	SWBH
128. Infection control; Taking peripheral blood culture guidelines	SWBH
129. Infection Control; Tuberculosis; infection control	SWBH
130. Infection Control; Varicella zoster virus; chickenpox, shingles; infection control	SWBH
131. Infection Control; Viral Haemorrhagic Fevers; infection control	SWBH
132. Influenza Pandemic Contingency Plan	SWBH
133. Information Governance policy	SWBH
134. Information Security Policy	SWBH
135. Intellectual Property; Managing Protocol	SWBH
136. Interpreting Services	SWBH
137. Investigatory Guidance	SWBH
138. IT User Policy	SWBH
139. IV Medicines Policy	SWBH
140. Late Cancellation Policy	SWBH
141. Lone Worker Policy	SWBH
142. Long Service Awards Policy	SWBH
143. Lost and Found Property	SWBH
144. Lung Cancer Nurse; operational policy	Sandwell
145. Lymphoedema; operational policy for the management of patients	Sandwell
146. Macmillan Cancer Information Support Service	Sandwell
147. Macmillan Colorectal Nurse Specialist; operational policy	Sandwell
148. Macmillan Palliative Care Referral Form	SWBH
149. Macmillan Team; operational policy	Sandwell
150. Major Incident Procedure-CITY Hospital	City
151. Major Incident Procedure-SANDWELL	Sandwell
152. Mass Casualty Plan	SWBH
153. Mattresses; pressure relieving mattresses to Nursing Homes	SWBH
154. Media Relations Management Policy	Sandwell
155. Medical Devices Competency	SWBH
156. Medical Devices Policy	SWBH
157. Medical Staff Induction Policy	SWBH
158. Medicines Management Policy	SWBH
159. Medicines Reconciliation Policy	SWBH
160. Mental Capacity Policy	SWBH
161. Mental Health Act Policy	SWBH
162. Missing Patient Policy	SWBH
163. Mobile Communications Policy	Sandwell
164. Mobile Telephone Policy	SWBH
165. Moving and Handling Policy	SWBH

166. Multidisciplinary Team-Cancer; operational policy	Sandwell
167. Multidisciplinary Team-Colorectal; operational policy	Sandwell
168. Multidisciplinary Team-Gynaeoncology; operational policy	Sandwell
169. Multidisciplinary Team-Upper GI; operational policy	Sandwell
170. Named Nurse Allocation; Children's Services	Sandwell
171. Named Nurse Policy	Sandwell
172. National Reports	SWBH
173. New and expectant mothers (Health & Safety for staff)	SWBH
174. NICE Guidance Policy	SWBH
175. Non Medical Prescribing Policy new number Pt Care/019	SWBH
176. Nursing Staff Cover in Children's Services	Sandwell
177. Occupational Health & Safety Operational Policy	Sandwell
178. Organisational Change, Redeployment and Redundancy Policy	SWBH
179. Organs / Tissues Retention Policy	SWBH
180. Out-Patients Clinic Appointment; Children's	Sandwell
181. Overseas Visitor Policy	SWBH
182. Oxygen Therapy at Home; Children's	Sandwell
183. Paediatric Samples; Collection and Transport	Sandwell
184. PALS Operational Guidelines	SWBH
185. Patient identification Wristband Policy	SWBH
186. Patient Information Policy	SWBH
187. Personal Development Review (PDR)	SWBH
188. Personal Protective Equipment	SWBH
189. Pest Control Policy	SWBH
190. Photographic and video consent policy	SWBH
191. Point of Care Testing Guidelines	SWBH
192. Policies; Development, Approval and Management	SWBH
193. Prescribing unlicensed medicines	SWBH
194. Prison Winson Green and City Hospital; Standing arrangements	SWBH
195. Professional Registration Procedure	SWBH
196. Pt Held Community Childrens Nursing Records Policy	SWBH
197. Race Equality Scheme	SWBH
198. Recruitment and Retention Premia	SWBH
199. Recruitment and Selection of Ex-Offenders	SWBH
200. Recruitment and Selection Procedure	SWBH
201. Recruitment Medical Staff	SWBH
202. Red Identification Bracelet Policy	SWBH
203. Removal and Associated Expenses Procedure	SWBH
204. Repetitive Work Policy	SWBH
205. Research & Development Policy	SWBH
206. Respite Care for Children with Special Needs	Sandwell
207. Respite Policy for Children	Sandwell
208. Restraint and control policy	SWBH

209. Resuscitation Policy	SWBH
210. Resuscitation; DNAR	SWBH
211. Retirement Policy	SWBH
212. Risk Assessment and Register Policy	SWBH
213. Risk Management Strategy	SWBH
214. Safeguarding/Child Protection-Guidelines for staff	SWBH
215. Safety Reporting in Research	SWBH
216. Secondment Policy	SWBH
217. Security Policy	SWBH
218. Self Referral of Haematology and Oncology Patients	SWBH
219. Sickness Absence Policy	SWBH
220. Slips, Trips and Falls	SWBH
221. Smoking Policy	SWBH
222. Staffing levels nursing	SWBH
223. Standing Financial Orders/Instructions	SWBH
224. STEP Procedure	SWBH
225. Stress at Work Policy	SWBH
226. Study Leave Policy; non medical	SWBH
227. Supervision of Non-Professionally Qualified Staff in Clinical Areas	Sandwell
228. Supply of Temporary Staff	SWBH
229. Syringe Driver Policy (also in clin guidelines database)	SWBH
230. Theatre Utilisation Policy	SWBH
231. Thromboprophylaxis in medical inpatients - see details in clinical guidelines database	SWBH
232. Thromboprophylaxis in surgical inpatients - see details in clinical guidelines database	SWBH
233. Transfer of patients	SWBH
234. Transfer Policy for Children and young adults	SWBH
235. Travel Expenses Policy	SWBH
236. Uniform and Dress Code Policy	SWBH
237. Violence and Aggression Policy	SWBH
238. Visitors Policy	SWBH
239. Visually Impaired; Registration Form	SWBH
240. Vulnerable adults	SWBH
241. Waiting list policy Admitted	SWBH
242. Waiting List Policy Non admitted	SWBH
243. Waste Management Policy	SWBH
244. Weather Conditions; Policy for Staff Attendance	SWBH
245. Whistleblowing Policy	SWBH
246. Work Permit Policy	SWBH
247. Working at Heights Policy	SWBH
248. X-Ray Service for Rowley Regis	Sandwell
249. Young worker Policy	SWBH

UNDER REVIEW

Service & Functions Impact Assessment Programme 2008 -2011

The Trust acknowledges that considerable work has been scheduled in 2008, to undertake a corporate review of functions and services. To ensure existing impact assessments are up to date and action plan programs.

It has prioritised high, medium, and low equality impact relevance and a priority assessment programme is outlined below. It is intended that a website page will be developed to publish ongoing action plans and details of the public involvement in the process.

Functions	High	Medium	Low
Communication & Public Affairs			
Medicine Management	*		
Marketing	*		
Patient Information	*		
Internal Communication	*		
Public and Patient Engagement	*		
Communicate advice strategy development	*		
Strategy & Commissioning			
2010 Programme	*		
Now Hospital Building	*		
Service redesigning / reconfigurations	*		
Commissioning	*		
Strategic Partnership			*
Health Strategy	*		
Governance			
Policy Development	*		
Complaints Procedure	*		
Research & Development		*	
Healthcare Standards	*		
Clinical Effectiveness	*		
Medical Staffing	*		
Workforce Development			
Human Resources	*		
Recruitment Services	*		
Occupational Health	*		
Chaplaincy Services	*		
Learning & Development	*		
Finance & Performance			

Functions	High	Medium	Low
Procurement / Purchasing	*		
Financial Strategy			*
Financial Control			*
Local Development Plan			*
Capital Investment			*
Nursing Division			
Therapy Services	*		
Facilities Services	*		
Continence			*
TVS			*
Pallative Care		*	
Patient Support Centre	*		
Women & Child Health Division			
Paediatric Services	*		
Maternity Services	*		
Gynaecology Services		*	
Medicine & Emergency Care Division			
Emergency Care	*		
Diabetes & Endocrinology		*	
Renal		*	
Neurophysiology		*	
Clinical Immunology		*	
Dermatology			*
Clinical Pharmacology & Toxicology		*	
Gastroenterology	*		
Neurology	*		
Rheumatology			*
Elderly Care	*		
Respiratory	*		
Haematology & Oncology	*		
Cardiology	*		
Surgical Division			
General Surgery	*		
Surgical Assessment Unit	*		
Trauma & Orthopaedics	*		
Vascular Services	*		
Colerectal	*		
Endoscopy	*		
Virology	*		

Functions	High	Medium	Low
Ambulatory Care BTC	*		
Surgical Day Unit	*		
Urodynamics	*		
Orthotics	*		
Plastics	*		
Breast Surgery	*		
Theatre	*		
Fracture Clinic	*		
Oral, Maxillo Facial & Dental			*
ENT	*		
Audiology		*	
Ophthalmology	*		
Pathology			
Haematology	*		
Microbiology	*		
Toxicology	*		
Infection Control	*		
Histopathology	*		
Clinical Chemistry	*		
Immunology	*		
Phlebotomy	*		
Imaging			
Plain Radiography	*		
CT	*		
MRI	*		
Breast Screening	*		
Nuclear Medicine		*	
Medical Illustration			*
Specialist Radiology	*		
Ultrasound	*		
Interventional Radiography	*		
Medical Physics		*	
Radiopharmacy		*	
Anaesthetics & Critical Care		*	
Outreach Services		*	
Pain Management (Chronic or Acute)		*	
Critical Care Units		*	

APPENDIX 4

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Single Equality Scheme Action Plan April 2008 - March 2011

The framework for this action is in line the Commission Racial Equality (CRE's) (now EHRC) Equality Human Rights Commission performance framework to ensure equality within the NHS, and will assist the Trust to be compliant by being systematic in the way it promotes the six equality categories, in particular, race, disability and gender across the organisation. It sets a development agenda with realistic objectives which incorporates race, disability and gender equality into performance management arrangements and allows assessment of progress against the NHS Strategic Health Authority performance framework, whilst meeting our legislative duties.

The Trust Equality & Diversity Steering Group will monitor the progress of the action plan on a quarterly basis and an annual report will be published.

SINGLE EQUALITY SCHEME – ACTION PLAN
STRATEGIC LEADERSHIP **EQUALITY & DIVERSITY STEERING GROUP** Executive Lead: Rachel Stevens Non Exec Lead: Group Chair: Rachel Stevens
Outcomes: • Trust Board approved Single Equality Scheme • Trust compliance to equality legislation general and specific duties • Trust compliance to the E&D elements contained within the Healthcare Commission core standards • E& D integrated into organisational core values and operating principles • Established designated E&D staff to manage and coordinated the implementation of the SES • Robust reporting and monitoring framework which will inform the Trust Board of progress and issues • Ensure Equality legislation is integrated into procurement contracts

Actions	Lead	Target Date	Progress	Status
• The Board to formally approve the Single Equality Scheme 2008 - 2011 (SES) and make a public commitment to eliminating discrimination and promoting equality.	Assistant Director of Nursing-Patient Experience	July-08	July Trust Board approved new SES	
• Executive Directors and senior management colleagues act as Equality and Diversity Champions to deliver against the action plan for their organisational areas.	Executive Directors, Senior Management Teams	Jan 09	Master classes commissioned to support exec and senior managers to understand their role and contribution to implementing SES. Reporting framework in place ,groups established and terms of reference agreed	
• Executive lead to ensure Equality & Diversity is a standing item on Trust Board, Executive Board, Operational Management Board, Governance Board and Divisional meetings, with reports on equality, including results of Equality Impact Assessments (EIAs) on progress from all areas.	Assistant Director of Nursing- Patient Experience	Jan09	Agenda item trust board with quarterly reporting cycle in place.	
• The Trust Board to agree that the Single Equality Scheme will be integrated into the Trust Performance and Governance processes.	Trust Board Performance Management Teams	Nov 08	To commence E&D reporting in the November divisional reviews and ward reviews	
• Re-establish the Equality & Diversity Steering Group to include all equality strands to ensure compliance with SES.	Assistant Director of Nursing- Patient Experience	Apr-08	Established and terms of reference agreed with quarterly meetings and reporting to trust board	
• Establish the new sub working groups of Workforce, Independent Living, Service & Policy assessment and Patient Experience groups. All groups will include members of the public, unions and PPI forum members. Make sure these groups have appropriate terms of reference, senior representation and access to resources and decision makers.	Head of Patient Experience/ Deputy Director Workforce/ Director of Governance	Jun-08	Established and terms of reference agreed with quarterly meetings and reporting to trust board	
• Continue to provide robust equality training, induction and awareness for all staff.	Head of L&D	Jan-09	Induction reviewed to make E&D explicit, diversity training to be marketed to increase attendance Diversity adviser appointed. Open learning material under review to expand IT solutions for access to training	

• The SES will be reviewed independently in anticipation of national guideline, unless legislation dictates otherwise.	External contractor/Internal Auditors	July-10		
• Quarterly and annual reports will review the progress of the SES.	E&D Steering Group & subgroups	Quarterly	Quarterly report to be presented to Nov 08 trust board	
• The Trust ensures that all contracts, including procurements, with other bodies include the requirement to comply with equalities legislation and monitoring arrangements are in place.	DGMs/Service Heads Head of Procurement Group	On-going	No progress to report	
• Trust ensures that resource plans (LDPs) take into account the investment needed to implement the requirements of the equalities legislation. In line with the DDA (2005), this includes investment for management time, basic training, appropriate ICT and language services.	DGMs/Divisional Finance Managers	Ongoing	No progress to report	
• Robust monitoring arrangements are in place to identify resource required to meet SES.	Finance Managers	Annually	No progress to report	
• Explore research bids to augment equality and diversity data.	Assistant Director of Nursing Patient Experience	Sept '08	Bid completed funds obtained .SNAP survey software purchased	
• Clinical reference group for commissioning takes account of inequality issues.	Trust Commissioning Lead	On-going	No progress to report	

SINGLE EQUALITY SCHEME – ACTION PLAN

WORKFORCE MONITORING

Executive Lead: Colin Holden

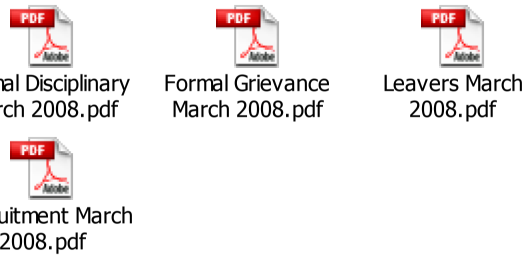
Group Chair: Lesley Barnett

Outcomes:

- Published annually workforce data in accordance with equality legislation
- Completed demographic study to compare workforce data to local communities population
- Completed equal pay audit
- Improved access and uptake of staff training in equality and diversity
- Raised awareness of the SES and staff responsibilities to contribute to its implementation
- Improved employment monitoring data that reflects all equality strands

Actions	Lead	Target Date	Progress	Status
• Trust Board Members and Senior Management teams will be trained on their duties under all equality legislation.	Head of L&D	Nov 08	Trust Board members have received training. Training for senior management teams has been commissioned by Equality Works, and commences in November.	

• Equality and Diversity training to be available for all staff to attend.	Head of L&D	Nov 08	Equality and diversity training within the organisation is currently being reviewed and feedback on progress will be provided to the Workforce Subgroup meeting in December. Uptake of classroom sessions has been poor. The Trust currently provides Diversity training within a range of Trust training activities, as follows: • Induction • Managing for Managers programme. • Conflict Resolution Training • Recruitment and Selection Specific diversity training was provided monthly until August 2008. The programme is currently temporarily suspended pending a review of content. The Learning and Development Department are also reviewing existing diversity e-learning programmes and other options such as 'Forum Theatre' as a means of training large groups at a time. All training is impact assessed to ensure appropriateness	

• SES is built into the annual appraisal procedure based on KSF. All staff to receive annual appraisal.	Deputy Director of Workforce/ Head of L&D	Nov 08	Trust policy requires all staff to receive an annual appraisal which (for staff covered under AfC terms and conditions of service) should be in accordance with KSF requirements of which core dimension 6 is Equality and Diversity. Accordingly the majority of Trust employees should have received an annual appraisal that takes into consideration the requirements of the KSF and therefore diversity and equality competencies and their related development needs. Although the number of staff reported as having had an appraisal is high, the quality of the appraisal process may be questionable and does however require further review. At this time it would also be reasonable to conclude that not all appraisals have been undertaken in accordance with KSF requirements. The appraisal procedure is currently under review as part of the LIA Enabling our People strand, and will take into account the need to build in the requirements of the SES.	
• Complaints of discrimination from staff to be dealt with promptly and effectively.	Head of Complaints/E&D workforce group	On-going	Staff complaints are dealt with in accordance with the Trust's Dignity at Work or Grievance policies as deemed appropriate.	
• Results of statutory monitoring/assessment on equality to be reported to the board via HR & Workforce subgroup.	Deputy Director of Workforce	Oct 08	Statutory monitoring data attached.  Formal Disciplinary March 2008.pdf Formal Grievance March 2008.pdf Leavers March 2008.pdf Recruitment March 2008.pdf	

			 Staff in Post March 2008.pdf  Training Activity March 2008.pdf The trends/issues highlighted by this data will be developed into action plans as deemed appropriate by the Workforce Subgroup. In particular the following issues will be considered: ▪ Action to improve the quality of data held within the workforce information system, particularly of ethnic composition of workforce and disability. ▪ Analysis of the recruitment of Asian/Asian British Applicants to understand why they appear to be less successful at securing employment with the Trust than applicants from other ethnic backgrounds. ▪ Analysis of access to external training to determine why there does not appear to be proportionally equal access to staff regardless of ethnic background. ▪ Further analysis of leavers – by ethnic origin, gender and disability. ▪ Development of a revised Employee Leaver Policy to encourage the collection of more robust data. ▪ Revised recording of appraisal activity to enable this information to be included in the 2008 – 2009 report.	

• Published up to date information about the Trust resident population in appropriate formats.	Head of Communications/ Website Manager	On-going	Information on the local population and comparisons with the Trust's workforce is an action point for the workforce subgroup. A review is on-going by the Workforce Information Manager who will be reporting to the December meeting of the Workforce Sub group.	
• Arrangements are in place to meet the employment duties contained in the equality legislation.	E&D Workforce group	Jan-09	The workforce subgroup will be examining the Trust's employment duties with respect to the following to ensure compliance with equality legislation: • Staff in post • Recruitment activity • Training and Development • Appraisal Activity • HR activity (discipline/grievance etc.) • Leavers	
• Review of Equal Opportunities Monitoring Report and necessary action taken to ensure for example, workforce profile targets are set against that of community to reflect representation, action for recruitment, training and progression, reducing bullying, racial harassment and violence.	Deputy Director of Workforce/Head of L&D	Dec-08	The Workforce sub-group held its first meeting in September 2008 and concentrated on agreeing the terms of reference. Further actions are identified in points 5 and 6 above.	
• Accurate equalities monitoring data is available to measure staff in post, applicants for employment, training and promotion, sickness, retirement, formal grievance and disciplinary procedures and leave policy within the Trust.	Workforce Lead/E&D Workforce subgroup	Oct08	All non-medical recruitment is undertaken using the following national systems: • NHS Jobs (recruitment website) • Electronic Staff Record (ESR) (workforce information and payroll system) Use of these two systems allows the Trust to collect and monitor equalities information.	
• Review current training programmes to ensure E&D integration meets the Single Equality Scheme.	Head of L&D	Nov-08	See point 2 above	

• Continue to provide robust equality training, induction and awareness for all staff.	Head of L&D	Nov-08	See point 2 above	
• Annual equalities monitoring report is published on the Trust Website and intranet.	Head of Communications	Nov 08	Workforce data in relation, to starters, leavers, training, disciplinary and grievances has been published on website.	
• Review monitoring data for staff benefiting or experiencing detriment as a result of performance assessment procedures.	Head of L&D	March 09	See points 7 and 9 above	

SINGLE EQUALITY SCHEME – ACTION PLAN

PATIENT EXPERIENCE GROUP

Executive Lead: Rachel Stevens

Group Chair: Rachel Stevens

Outcomes:

- Improved patient experience
- Measurable improvements in the five key areas contained with in the Patient Experience action plan(Privacy & dignity, hygiene ,nutrition, communication &information and appointments)
- Review and monitor user feedback integrating the findings into service improvement action plans

Actions	Lead	Target Date	Progress	Status
• Develop and implement protocol to address specialist need of patients include trigger mechanism and formats for sending information to patients with mental health issues, Dyslexia etc, to ensure equity in accessing service.	Deputy Director of IM&T /VAP lead/ Head of Comms & Engagement	Jan '09	No progress reported	
• Current Trust Equality & Diversity Website to be further developed and accessible to staff and public by the intranet and internet.	Patient Experience Facilitator/Corporate/ Website Manager	Nov '09	completed	
• Equality and Diversity will be embedded into reporting structures, ward reviews and divisional performance as part of equality awareness and promoting good relations across the Trust.	Head of E&D/ DGMs & service heads	July '09	Discussions regarding access and downloading authorisation ongoing	
• SES Policy and action plan is published on Trust Website and disseminated via intranet to all staff.	Corporate Website officer	Jan '09	published	
• Recruit volunteers to promote way finding assistance to any service users.	Patient Experience Project facilitator	Sept-08	Volunteers recruited	

• Information on services is promoted by various methods and in relevant languages appropriate to local community. Ensure the Review of patient literature continue as an essential part of service provision.	Communication Team	Mar'09 Ongoing	Patient information policy under review. Communication team has been restructured and communication officers allocated to divisions, to work with specialities to improve communications and literature. Several new leaflets produced and new formats are being explored. Associated cost being investigated.	
• Review the Trust 'Meeting the Physical, Spiritual and Religious needs of patients – a guide for staff' resource pack.	Head of Chaplaincy Service/Patient Experience Team	Dec-08	Subgroup met and training resource pack in development	
• Undertake an audit of access to interpreting service for all patients for whom English is not their first language to ensure equitable access	Head of Nurse Bank & Agency Interpreting Services	Jan-09	No progress to report	
• Ensure that the Trust provides multi-faith centre on all sites within the organisation which meets the religious and spiritual needs of staff and patients	Hospital Director/ Head of Chaplaincy services	Oct '08	All sites have facilities	
• Regular feedback from patients and patients' groups on Trust services is obtained to influence changes, especially as part of service redesign or new service development.	2010 Project Team Service Improvement Lead Head of Communications	Quarterly commencing in Qtr 3	No progress to report	
• Explore communication routes for E&D internally and externally in order to ensure capture of the right groups with the right media forms.	Communication Team/ E&D Subgroups	Mar '09	No progress to report	

• Established translation protocols to address language barriers in patient information and improve media formats to target diverse groups. Explore alternative solutions to written information including use of community and BME media.	Communications Team	Mar '09	Ongoing conversations with local community include discussions about format of material. Further work underway. Regular use of BME and community press. Including print and RSL radio. Government office issued translation guidance, to all local authorities which has been circulated to SHA and Trust. The communication department has details of DoH approved translation agencies. Translation is also featured in the Trust Information for Patient Policy.	
• Public consultation on the new Single Equality scheme	Head of Communications	Sept '08	Draft approved following initial consultation Engagement plan to be submitted	
• The Patient Experience Subgroup will be responsible for augmenting all user feedback including Complaints and PALS. Providing relevant and timely feedback on services to all service users. The group will work closely with the Independent Living group on any disability issues identified.	Head of Communications & Head of E&D	Mar-09	Patient experience action plan progressing and re-presented to Trust Board Nov 08	
• Devise and arrange a range of initiatives to involve and consult with patients and stakeholders in order to receive their views on the promotion of equality in service delivery.	Communication Team	Feb-09	This is being developed through the consultation guidance/policy. Mechanisms for consulting with local people already exist through the Communication department, PCT and Local Authorities.	
• Develop a strategy to ensure that local people know how to get involved and how they can actively influence delivery and monitoring of health services.	Communications Team	Dec-09	The SHA has provided feedback on the first draft. National guidance is expected at the end of November, work ongoing.	
• Review voluntary sector action groups and local community groups to ensure inclusion of all six E&D strands.	Head of Patient Experience	Jan 09	RNIB , Deaf association Group joined ILG group more group networks being established	
• Feedback is sought on Trust's equality performance is received from external stakeholders e.g. Local Race Equality councils, Overview and Scrutiny committees and Primary Care.	Head of Communications & Head of E&D	On-going	Initial feedback incorporated as part of consultation in SES. Following the Trust Board, plans will be drawn up for the appropriate circulation of the action plan for comments with stakeholders.	

• The Trust promotes equality within its local stakeholder partnerships ensuring greater benchmarking against local PCTs and their Equality Schemes.	Assistant Director of Nursing Patient Experience	Commencing Oct '08	Work in progress with Sandwell PCT E&D lead SHA membership on E&D network 2010 impact assessment group established	
• Set up network of time limited stakeholder groups to address specific equality strand issues.	Assistant Director Nursing Patient Experience	Dec-08	Sexual orientation group established to assist engagement on gender issues Equality strands training group established	

SINGLE EQUALITY SCHEME – ACTION PLAN

SERVICE & POLICY ASSESSMENT GROUP

Executive Lead: Kam Dhami

Group Chair: Kam Dhami

- Outcomes:
- Procedures are in place to ensure that all policies ,services and functions are impact assessed
- Impact assessment training is available for managers
- All impact assessment results are available and reviewed in accordance with equality legislation
- A public consultation process is developed to ensure user involvement in the impact assessment process
- Complete a demographic study of service users and identify if there are any health inequality issues
- Closing equality gaps in service outcomes
- Service users find the complaint system transparent and user friendly

Actions	Lead	Target Date	Progress	Status
• The register of all existing policies is prioritised in order of schedule for Equality Impact Assessment	Trust Secretary	Dec-08	The policy list has been reviewed and policies have been identified that need impact assessing. Work is underway to confirm with Executive Directors the status and relevance of the policies highlighted.	
• All functions and services to be prioritised for Equality Impact Assessment	Director of Governance	Dec-08	An initial list of services and functions has been collated and a preliminary attempt to assess the priority of the areas has been performed. All DGMs are to be reissued with the list to ensure all services and functions are captured comprehensively and using an evaluation matrix, will be asked to assign a priority rating to each.	
• Establish effective EIA consultation and involvement processes by engaging with trade unions and user involvement in accordance with disability legislation	Head of Communications	Jan-09	Head of Communications and Trust union Convener have been invited to join the membership of the subgroup. Work will be undertaken to develop an effective consultation and engagement process as part of the subgroup's terms of reference.	

• New policies will be equality impact assessed for potential adverse effects before being ratified by the appropriate forum and ongoing register published on SWBH website	Trust Secretary	Ongoing	All policies due for presentation for approval by the OMB and Governance Board are required to be accompanied by a completed initial Equality Impact Assessment. Greater rigour to be applied to ensure that full Equality Impact Assessment performed where a potential adverse effect is identified. A list of policies having undergone initial equality impact assessment is included on the Trust's website	
• Undertake EIA of functions and policies on a division by division basis and develop action plan to ensure compliance with Equality Act 2006.	Chief Operating Officer/Director of Finance and Performance Management	Nov-09	Divisional performance framework is to incorporate a review of two services/functions per review, that have been identified as priorities for Equality Impact Assessment. Policies are assessed for Equality Impact Assessment as part of the presentation for approval at the appropriate ratifying body.	
• Develop and roll out 'equality and diversity' courses for staff. Ensuring that all relevant managers/supervisors receive appropriate training on the Equality Impact Assessment Tool.	Head of Equality and Diversity	Mar-09	Trust Board underwent training in E & D on 3 October. Training for other staff included as part of staff induction and within other mandatory training courses. Equality Impact Assessment training has been arranged for key groups of managers. Work is planned to identify an appropriate longer term solution for a wider group of staff, including the use of an on-line training to supplement more formal methods where possible.	
• Update EIA toolkit for managers	Head of Equality and Diversity	Dec-08	Head of Equality and Diversity is now appointed, who will take responsibility for updating the current toolkit available to staff.	

SINGLE EQUALITY SCHEME – ACTION PLAN

INDEPENDENT LIVING GROUP

Executive Lead: Rachel Stevens

Group Chair: Sheila Peacock

Outcomes:

- Parity in public confidence and satisfaction levels across equality groups
- Measurable improvement in community relations
- Improved access to services and actions to address health inequalities of service users
- Expand the range of communication aids available for patients
- Trust comply with DDA requirements across the three hospital sites
- Improved public signage
- Raised awareness amongst the staff on the needs of diverse groups
- Development of SES resource pack
- Host a community diversity conference

Actions	Lead	Target Date	Progress	Status
• Trust to continue to robustly promote equality with local organisations and within local strategic partnerships and keep a dairy of engagement	Communications Team 2010 Project Team FT team Head of E&D	March 09	A consultation diary was trialled for the first 6 months of 2008, to correspond with the FT consultation. This is being further developed in conjunction with Towards 2010 programme.	
• Audit of all Trust premises to ensure compliance with DDA standards and ensure corporate action plans are in place to address any deficits.	Estates DDA compliance lead	Feb 09	No progress to report	
• Trust to continue to explore visual signage improvements for all visitors and service users.	Head of Patient Experience and Estates lead	Jan 09	No progress to report	

• Review BSL interpreting provision within the Trust.	Head of Nurse Bank & Agency Interpreting Services	Dec'09	No progress reported	
• Trust to ensure promotion of equality and good relations in its public health and regeneration programmes.	Assistant Director of Therapy Services Public Health Lead Service Improvement Team	July '09	No progress reported	
• Network with statutory and non-statutory organisation to explore the maximum use of data intelligence.	Head of Communications/E& D Subgroups	July '09	A regional engagement group is being set up, and further work regarding sharing of contact details and useful information is ongoing.	
• Improve communication aids and media formats for diverse groups and explore alternative solutions to translation of text.	Head of Communication	Mar '09	Working in progress with video companies and revision of the information for Patient Policy underway.	
• Involve and consult with local community, including people with physical, mental health and learning disability, on all aspect of policy development, Trust literature and communication, action planning, reviews of progress. Formulate a PPI register for internal and external groups	Communication Team	On-going	Engagement database exists and is regularly updated. Communication Divisional Leads appointed who will support managers with consultation guidance. Consultation policy under development.	
• Establish community engagement subgroups to contribute to designated projects identified within ILG subgroup	Head of E&D	July '09		
• Equality and Diversity conference to be held as part of awareness training for all working in the organisation and improve community links.	Head of E&D	April 09		
• Analyse patient survey data to identify any potential or actual barriers.	Head of Communications	Dec '08	Work is to be commenced on patient survey analyse due to previous small sample sizes in order to understand key issues.	

Status key:	5	Complete	4	On track	3	Some delay – expect to complete as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Terms of Reference For All Groups

- Equality & Diversity Steering Group
- Workforce Monitoring Group
- Service & Policy Assessment Group
- Independent Living Group
- Patient Experience Group
- Meeting Matrix

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

EQUALITY AND DIVERSITY STEERING GROUP

Terms of Reference

1. Membership

The Committee will comprise:

- Chief Nurse
- Medical Director
- Director of Governance
- Director of Workforce
- Trust Secretary
- A Divisional General Manager
- Head of Communications
- Deputy Director of Workforce
- Assistant Director of Nursing (Patient Experience)
- Trust Union Convenor
- Head of Equality and Diversity
- Business and Environmental Project Manager

A quorum will be five members, including the Chair or a nominated deputy and at least three of the sub-group chairs.

The Chair of the Committee will be the Chief Nurse.

2. Attendance at meetings

Specialists will be invited to attend where an agenda item would benefit from their attendance.

The Assistant to the Assistant Director of Nursing (Patient Experience) will attend as secretary to the Steering Group and maintain minutes of the meetings.

3. Frequency of meetings

Meetings shall be held quarterly.

4. Purpose

The primary purpose of the group is to drive the equality and diversity agenda forward within the services it provides and by the staff it employees to deliver those services.

This will be done by:

- Setting the strategic direction for equality and diversity in line with the Trust's values and strategy.
- To raising the profile of equality and diversity within the Trust, through monitoring progress of the Single Equality Scheme (SES) implementation.

5. Objectives

- To provide evidence of the Trust's performance in relation to the extent to which it demonstrates Sandwell and West Birmingham Hospitals NHS Trust is an equitable employer and values diversity.

- To ensure that the work undertaken as part of the Race, Gender and Disability Equality Schemes and the Sub groups is integrated into one framework and action plan for the Single Equality Scheme is executed.

- To oversee and monitor implementation of the Single Equality.

- To monitor and report on progress/lack of progress on the Single Equality Scheme Action Plan on a quarterly basis and within an annual report.

- To ensure that there are regular reporting mechanisms publishing to the public on the progress of this agenda.

- To ensure that the Trust is operating within the UK legislation in relation to Equality and Diversity.

- To consider how NHS policies and good practice documents might impact on the work that the Trust is undertaking in relation to Equality and Diversity.

- To ensure that all services, functions, proposed and existing policies, promote equality and the Trust is compliant with the statutory duty to carry out equality and diversity impact assessment.

- To ensure the Trust's compliance with HCC core standards concerning equality and diversity, through monitoring and review

6. Accountabilities and Reporting arrangements

The Equality and Diversity Steering Group is accountable to the Trust Board, which will expect the Steering Group to demonstrate that it has met its objectives and has delivered its work plan. This will be monitored through the presentation of a quarterly progress update to the Board.

Four subgroups are accountable to the Equality and Diversity Steering Group, the Chairs of which are included in the membership of the Steering Group:

- Workforce, chaired by the Deputy Director of Workforce
- Independent Living, chaired by the Assistant Director of Nursing (Patient Experience)
- Patient Experience, chaired by the Chief Nurse
- Service and Policy Assessment Group, chaired by the Director of Governance

The Steering Group will expect the subgroups to demonstrate that they have met their objectives and have delivered their work plans. This will be monitored through regular progress reports at the quarterly meetings of the Steering Group.

7. Review

The Steering Group's terms of reference will be reviewed on an annual basis.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

WORKFORCE MONITORING SUBGROUP

Terms of Reference

1. Membership

The Committee will comprise:

- Deputy Director of Workforce
- Deputy Medical Director
- Head of Learning and Development
- Head of Equality and Diversity
- Assistant Director of Therapies
- Assistant Director of Nursing (Workforce)
- Trust Union Convenor
- Workforce Information Manager
- HR Manager (Equality and Diversity)
- Workforce Business Administration Manager
- Recruitment Manager
- Post graduate deanery representative
- Staff representative

- Representatives from workforce user groups: BME, disability, LGB and HPC

A quorum will be four members, including the Chair or a nominated deputy.

The Chair of the Committee will be the Deputy Director of Workforce.

2. Attendance at meetings

Specialists will be invited to attend where an agenda item would benefit from their attendance.

The Assistant to the Deputy Director of Workforce will attend as secretary to the Steering Group and maintain minutes of the meetings.

3. Frequency of meetings

Meetings shall be held quarterly.

4. Purpose

The purpose of the Workforce Monitoring subgroup is to:

- Monitor the data collection and analysis and associated action plans relating to all elements of workforce employment/training.

- Ensure findings will be published and easily accessible to the public.

- Monitor the training and development of Trust employees and new employees in both equality and diversity awareness and undertaking workforce related impact assessments.

5. Objectives

- To oversee the implementation of the Single Equality Scheme action plan in relation to its workforce components and produce progress reports and action minutes.

- To monitor Trust recruitment procedures and associated training to ensure full compliance.

- To monitor the access to and training and development of all Trust employees including new employees to the Trust in both equality and diversity awareness.

- Monitor key HR employment functions, e.g. recruitment, disciplinary, grievances, PDR and training activity for any adverse impact and ensure that relevant data is prepared and made publicly available.

- To monitor the completion of Equality Impact Assessments (EIAs) and development and delivery of associated action plans in relation to workforce policies.

- To identify resources to support workforce improvements and make recommendations to the Equality & Diversity Steering Group as appropriate.

- To ensure policies and procedures related to workforce comply with equality legislation, are impact assessed and updated as appropriate.

- To review Trust's existing training provision and where appropriate make recommendations on the development of appropriate methodologies to ensure equality compliance.

- Review local population demography to allow meaningful comparisons with the Trust's existing workforce and inform the development of action plans as deemed appropriate.

- To monitor recruitment and retention of staff to ensure that there are no untoward trends related to the equality agenda, including analysis of employee leavers.

- To provide the Towards 2010 Programme with advice on workforce equality issues as deemed appropriate.

- Ensure the completion of an equal pay audit and ensure that any associated recommendations/actions are undertaken and reported to the Equality & Diversity Steering Group.

6. Accountabilities and Reporting arrangements

The Workforce Monitoring Subgroup is accountable to the Equality and Diversity Steering Group and will be expected to demonstrate that it has met its objectives and delivered its work plans. This will be monitored through regular progress reports at the quarterly meetings of the Steering Group.

7. Review

The Workforce Monitoring Subgroup's terms of reference will be reviewed on an annual basis.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

SERVICE AND POLICY ASSESSMENT SUBGROUP

Terms of Reference

1. Membership

The Committee will comprise:

- Director of Governance
- Deputy Chief Operating Officer
- Deputy Director of Strategy
- Assistant Director of Nursing (Patient Experience)
- Trust Secretary
- Head of Equality and Diversity
- Head of Communications
- Head of Learning and Development
- HR Manager (Equality and Diversity)
- New Hospital Project Manager
- Trust Policy Co-ordinator

A quorum will be four members, including the Chair, the Head of Equality and Diversity and appropriate representation from service and policy areas.

The Chair of the Committee will be the Director of Governance or the Trust Secretary in the Chair's absence.

2. Attendance at meetings

Representatives from patient users and from appropriate organisations having strong links with equality and diversity issues will be invited to attend.

The Assistant to the Director of Governance will attend as secretary to the subgroup and maintain minutes of the meetings.

3. Frequency of meetings

Meetings shall be held quarterly.

4. Purpose

The Service and Policy Assessment subgroup will be responsible for providing assurance to the Trust Board via the Equality and Diversity Steering Group an equality impact assessment is performed on all policies and services.

5. Objectives

To oversee the implementation of the Single Equality Scheme action plan in relation to Equality Impact Assessments by:

- Monitoring that all new and existing policies have undergone an equality impact assessment

- Monitoring that all services have undergone an initial equality impact assessment

- Monitoring that an action plan is developed which includes public consultation, following a full equality impact assessment being undertaken, as indicated by the initial equality impact assessment exercise

- Updating the current equality impact assessment toolkit and ensuring its dissemination to staff and widespread implementation

- Ensuring that appropriate training is given to managers required to perform equality impact assessments

- Overseeing an awareness exercise, aimed at ensuring that all staff across the Trust are familiar with the need to perform an equality impact assessment as part of policy and service development activity

- Ensuring that all service and policy equality impact assessments are registered on the Trust's external website

- Ensuring that the Trust complies with the legal duty to publish equality impact assessments

- Establishing the priority of all existing policies and services to undergo an equality impact assessment and ensuring that those identified are assessed

6. Accountabilities and Reporting arrangements

The Service and Policy Assessment Subgroup is accountable to the Equality and Diversity Steering Group and will be expected to demonstrate that it has met its objectives and delivered its work plans. This will be monitored through regular progress reports at the quarterly meetings of the Steering Group.

7. Review

The Service and Policy Assessment Subgroup's terms of reference will be reviewed on an annual basis.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

INDEPENDENT LIVING SUBGROUP

Terms of Reference

1. Membership

The Committee will comprise:

- Assistant Director of Nursing (Patient Experience)
- Head of Communications
- Head of Learning and Development
- Head of Equality and Diversity
- Head of Patient Experience
- Emergency Medicine Matron
- Medicine A Matron
- Disadvantaged Groups Representative (cancer)
- User Representatives including: deafness, blindness and wheelchair user
- Vulnerable adults lead
- Deputy Head of Estates
- Psychiatric liaison managers (City and Sandwell sites)

A quorum will be six members, including the Chair or the Head of Patient Experience in the Chair's absence, the Head of Equality and Diversity and two user representatives.

The Chair of the Committee will be the Assistant Director of Nursing (Patient Experience)

2. Attendance at meetings

Specialists will be invited to attend where an agenda item would benefit from their attendance.

The Assistant to the Assistant Director of Nursing (Patient Experience) will attend as secretary to the subgroup and maintain minutes of the meetings.

3. Frequency of meetings

Meetings shall be held quarterly.

4. Purpose

- To receive, influence and inform the environmental elements of hospitalization, access to services and quality of care delivery for disabled and diverse groups, in line with the Trust's Single Equality Scheme.

- To raise the profile of equality and diversity across the Trust in accordance to the Trust's Single Equality Scheme

- To work with PEAT inspection teams and Patient Experience Group to ensure a coordinated approach to service improvement to meet the needs of the disabled and diverse groups.

- To produce Quarterly update reports to Equality & Diversity Steering group

5. Objectives

- To oversee the implementation of the Single Equality Scheme action plan in relation to its access and care delivery of service components and produce progress reports and action minutes.

- To monitor and evaluate the PEAT activities and EIAs action plans specifically related to Disabled and Diverse groups

- To monitor and evaluate the outcome of user feedback trends analysis in relation to disabled and diverse groups.

- To publish and promote service improvements and ensure exchange of best practice Trust wide.

- To support policies, procedures, and services in relation to Independent Living to comply with equality legislation.

- Review local population demography and be aware of the disabled and diverse population.

- Provide community engagement advice on 2010 developments.

- Identify and liaise with all existing groups active within the organisation

- Review training material for Equality & Diversity within the organisation

6. Accountabilities and Reporting arrangements

The Independent Living Subgroup is accountable to the Equality and Diversity Steering Group and will be expected to demonstrate that it has met its objectives and delivered its work plans. This will be monitored through regular progress reports at the quarterly meetings of the Steering Group.

7. Review

The subgroup's terms of reference will be reviewed on an annual basis.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

PATIENT EXPERIENCE SUBGROUP

Terms of Reference

1. Membership

The Committee will comprise:

- Chief Nurse
- Assistant Director of Nursing (Patient Experience)
- Assistant Director of Nursing (Quality)
- Assistant Director of Therapies
- Head of Midwifery
- Head of Communications
- Head of Patient Experience
- Head of Complaints and Litigation
- Head of Equality and Diversity
- A matron
- Essence of Care Lead
- A user representative

A quorum will be four members, including the Chair or a nominated deputy, an Assistant Director of Nursing and a user representative.

The Chair of the Committee will be the Chief Nurse.

2. Attendance at meetings

Specialists will be invited to attend where an agenda item would benefit from their attendance.

The Assistant to the Assistant Director of Nursing (Patient Experience) will attend as secretary to the subgroup and maintain minutes of the meetings.

3. Frequency of meetings

Meetings shall be held quarterly.

4. Purpose

The primary purpose of the group concerns equality of care being embedded in the philosophy of improving patient experience. Many patient focus groups exist and the Patient Experience Subgroup will be responsible for monitoring the progress through user feedback reports.

5. Objectives

- To receive and review the results of user feedback from surveys, focus groups, complaints and PALS concerns.

- To review results of Essence of Care and PEAT audit action plans and assimilate into a Patient Experience action plan providing quarterly progress updates.

- By integrating work streams, to identify key themes to address sub standard care issues.

6. Accountabilities and Reporting arrangements

The Patient Experience Subgroup is accountable to the Equality and Diversity Steering Group and will be expected to demonstrate that it has met its objectives and delivered its work plans. This will be monitored through regular progress reports at the quarterly meetings of the Steering Group.

7. Review

The Patient Experience Subgroup's terms of reference will be reviewed on an annual basis.

MEETING 2008 - 2009	TIME, DAY & VENUE	June	July	August	September	October	November	December	January	February	March	April	May
Trust Board	14:30, Thursday	**6th**	**3rd**	**7th**	**4th**	**2nd**	**6th**	**4th**	**29th**	**26th**	**26th**	**30th**	**28th**
Chair: Sue Davis													
Sec: Simon Grainger-Payne	C=Anne Gibson Board Rm	S	C	S	C	S	C	S	C	S	C	S	C
	S=Churchvale/Hollyoak Rm												
Reort submission deadlines		29-May	26-Jun	31-Jul	28-Aug	25-Sep	30-Oct	27-Nov	22-Jan	19-Feb			
	17/10 Anne Gibson												
Equality & Diversity	12 - 2 pm					**17th**			**15th**				
Chair: Rachel Stevens													
Sec: Sue Gaskin	15/01/09 Exec. Rm, City												
	3-5pm												
Report submission deadlines						10/10/08			02/01/09				
	30/9 Exec Rm, City												
Patient Experience Group	12-2pm	**19th**			**30th**				**5th**				
Chair: Rachel Stevens													
Sec: Sue Gaskin	05/01/09 Exec Rm												
	12-2pm												
Report submission deadlines						10/10/08			02/01/2009				
Independet Living	5/12 - 2pm - 3pm,												
Chair: Sheila Peacock	Postgrad, Tutorial 5			**5th**				**5th**					
Sec: Pauline Beaumont													
Report submission deadlines						10/10/08			02/01/2009				
Workforce Monitoring Group	4/9 - 1-2.30 - Sem Rm												
Chair: Lesley Barnett	4/12 - 2-4 - Sem Rm 4				**4th**			**4th**					
Sec: Sue Day	Summerfield Hse City												
Report submission deadlines						10/10/08			02/01/2009				
Service & Policy Assessment Group													
Chair: Kam Dhami	10/10 Exe Rm, City					**10th**							
Sec: Sharonjeet Kaur	11:30-13:00												
Report submission deadlines						10/10/08			02/01/2009				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Quarterly Infection Prevention and Control Report July - September 2008
SPONSORING DIRECTOR:	Dr Beryl Oppenheim, Director of Infection Prevention and Control
AUTHOR:	Dr Beryl Oppenheim, Director of Infection Prevention and Control
DATE OF MEETING:	6 November 2008

KEY POINTS:

- Organisational structures continue to work well, however it will be important to engage directly with teams and departments to ensure that new policies become embedded
- Numbers of cases of MRSA bacteraemia and Clostridium difficile infections remain low in comparison with previous years, the focus now remains on sustaining these over time
- Audit and directed training continue to be prioritised as a means of delivering continuous improvements

PURPOSE OF THE REPORT:

○ **Approval** ◉ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive and note the Quarterly Report for July to September 2008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

2.1 - Continue to reduce hospital infection rates achieving national and local targets for MRSA and *clostridium difficile* including introducing MRSA screening in line with national guidance.

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quarterly Infection Prevention and Control Report
July – September 2008

Executive Summary

Organisational structures continue to work well, however it will be important to engage directly with teams and departments to ensure that new policies become embedded

Numbers of cases of MRSA bacteraemia and Clostridium difficile infections remain low in comparison with previous years, the focus now remains on sustaining these over time

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

Management and Organisation

The new structures continue to work well however the challenges around implementation of new policies have highlighted the importance of engaging even more widely with front-line staff and every opportunity is being taken to attend departmental meetings to discuss the detailed implications of policy changes.

The appointment of additional senior infection control posts within primary care trusts has improved our ability to strengthen and build on our links with community partners and in addition to the formal Healthcare Economy group a more operational Infection Control Nursing group is being formed which will hopefully foster the development of a consistent approach to infection related issues in the wider community.

A decontamination manager has been appointed to the Infection Control team starting in early November and this post will provide the professional expertise and dedicated time to support the Trust in keeping up to date and meeting standards related to issues around decontamination of medical equipment.

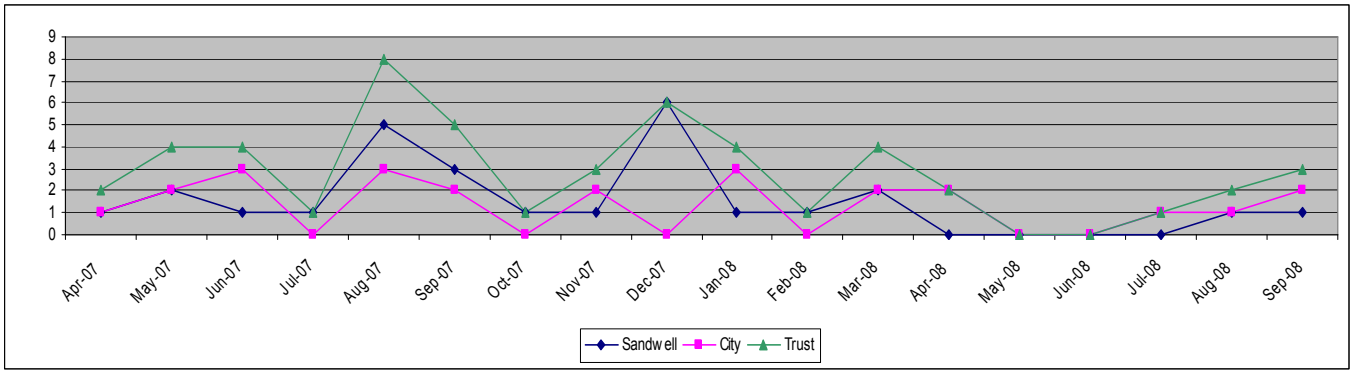
The infection control programme is being regularly reviewed by the Infection Control Team and good progress has been made to date.

MRSA

Mandatory Reporting of MRSA bacteraemia

For the quarter July to September 2008 there were 6 new MRSA bacteraemias of which 4 were from samples taken on admission (Figure 1). This is against a target of 9 and compares to 14 bacteraemias in the equivalent period in 2007.

Figure 1. No of MRSA Bacteraemia cases.



MRSA Screening and Decolonisation Therapy

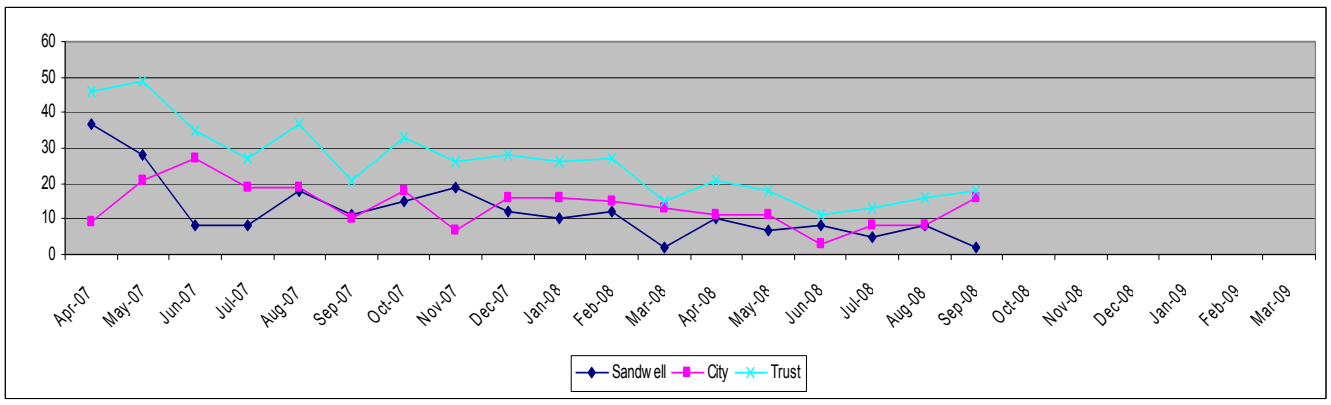
Screening of non-day case elective surgical patients is in place and monitoring of numbers of patients screened shows consistency with the numbers intended to be screened according to plan. Interestingly, positivity rates are low, around 1%, suggesting that MRSA carriage is infrequent in this sub-set of the population compared to those being admitted as emergencies to acute wards. Rapid screening of emergency admissions is currently being rolled out to the assessment units.

The final stage in completing DH requirements for MRSA screening relates to elective day case surgery and discussions are in place as to resource implications and a comprehensive plan is being put forward.

Clostridium difficile infections (CDI)

There were 47 cases of CDI in patients admitted to the Trust in the quarter July to September 2008 which compares to 85 in the comparable quarter of 2007 (Figure 2). Thirty five of these occurred more than 48 hours after admission and are attributable to the Trust trajectory. Table 1 shows recently published provisional data giving comparisons of CDI rates for similar Trusts across the Region in July and August.

Figure 2. Total Number of Cases (including those diagnosed within 48 hours of admission)



Although overall numbers remain low and well below our target, careful scrutiny of cases during September showed an overall increase in numbers at the City site, with most cases concentrated on a very small number of wards. These wards were decanted to allow for deep clean and hydrogen

peroxide decontamination. It is becoming clear that this approach is being used more widely nationally with impressive results, and this highlights the imperative to maintain decant facilities at both acute sites.

Table 1. Comparisons of provisional recently reported CDI rates for similar Trusts across the Region in June, July and August.

	June	July	August
University Hospital Birmingham	1.54	1.23	1.33
University Hospital Coventry and Warwick	0.64	0.51	0.29
Heart of England	1.10	1.08	0.86
Royal Wolverhampton	0.65	0.86	0.59
Sandwell and West Birmingham Hospitals	0.37	0.43	0.49
Shrewsbury & Telford	1.05	0.77	0.43
University Hospital North Staffs	0.80	0.94	0.73
Worcester Acute	1.16	0.71	0.70
Dudley Group of Hospitals	1.44	0.64	0.74
Walsall Hospitals	1.27	1.08	0.70

Audit and training

"Saving Lives" audits are well established and continue to provide a wealth of information on excellent practice. With this in mind a similar database for hand hygiene audits has been developed which will be accessed directly from the intranet and will enable individual areas to directly input data including compliance by professional group which can be readily reviewed by Divisions and other senior staff.

The changeover of junior medical staff in early August was used as an important learning opportunity and all new doctors received training around the key infection rules, hand washing and procedures for taking blood cultures. Further opportunities have also been made available for more detailed training on appropriate antibiotic use and other infection issues for foundation year trainees. Other groups receiving targeted infection control teaching this quarter included 3rd and 5th year medical students and new starter nurses. Regular workshops for infection control and *cleanyourhands* champions were also held.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Infection Control and Cleanliness Trust Board Assurance Framework
SPONSORING DIRECTOR:	Rachel Stevens, Chief Nurse
AUTHOR:	Rachel Stevens, Chief Nurse
DATE OF MEETING:	6 November 2008

KEY POINTS:

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

The framework takes into account standards expected from the HCC, National and local targets, national cleanliness specifications, and the Health Act 2006 – Code of Practice for the Prevention and Control of Health Care Associated Infections (more commonly known as the Hygiene Code) and incorporates recommended actions from documents such as Saving Lives, Bare Below the Elbow and Darzi report.

All assurance will be sought and overseen by the Executive Infection Control Committee.

PURPOSE OF THE REPORT:

○ **Approval** ◉ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the quarterly update on progress with developing the assurance framework.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

2.1	Continue to reduce hospital infection rates achieving national and local targets for MRSA and *clostridium difficile* including introducing MRSA screening in line with national guidance.
2.2	Develop and begin delivery of a plan to enhance the safety culture and systems of the Trust.

IMPACT ASSESSMENT:

FINANCIAL	☑	None
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		Failure to implement the assurance framework risks non-compliance with HCC standards and the Hygiene Code

Sandwell and West Birmingham Hospitals NHS
NHS Trust

24th October 2008

Infection Control and Cleanliness Trust Board Assurance Framework – Version 9

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

The document takes into account standards expected from the HCC, National and local targets, national cleanliness specifications, and the Health Act 2006 – Code of Practice for the Prevention and Control of Health Care Associated Infections (more commonly known as the Hygiene Code) and incorporates recommended actions from documents such as Saving Lives, Bare Below the Elbow and Darzi report.

All assurance will be sought and overseen by the Executive Infection Control Committee. A separate action plan exists that details the specific actions required to gain assurance.

Status	
Green	Complete
Light Green	On track
Amber	Some delay or slippage
Red	Significant delay needs explaining
White	Not yet commenced/new action

Management, Organisation and the Environment					
Duty 1 – General duty to protect patients, staff and others from HCAI's.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	The Board is fully briefed on all matters relating to infection control and cleanliness.	Chief Nurse	Chief Exec	• The Trust Board is equipped to ask relevant questions and seeks assurance that infection control and the environment are being managed.	Green
2	The Trust will receive an annual inspection of compliance with the Code of Practice by a specialist team.	Chief Nurse	Chief Exec	• The Trust will be prepared for annual visit by reviewing compliance against code at least once a year.	Green
3	Well designed environments encourage good practice and are easier to clean and maintain. The Trust Board should ensure new hospital planning takes this into account.	Dir Estates	Chief Exec.	• 2010 programme will comply with relevant HFN guidance. • Infection Control advice will be sought with regard to new hospital design. • New systems/practices for cleaning will be encouraged for new hospital.	Green
4	A system exists that ensures non-compliance with practice/policy is monitored and managed.	Chief Nurse Med. Director	Chief Nurse Med. Director	• Targeted support can be given. • Poor practice is corrected. • Poor practice is identified as part of RCA's.	Green
5	Saving Lives High Impact Interventions are used effectively within the Trust to ensure best practice.	DIPC ICN	Chief Nurse	• Use of national best practice. • Reduction in infection rates. • Reports will guide further action.	Green
6	Infection Control & Cleanliness is embedded within the organisations culture and discussed at all levels.	Chief Nurse	Chief Exec	• There is clear evidence of discussion at various forums, team brief etc. • Divisions are reporting on Infection Control at performance reviews. • Included in ward reviews.	Green
7	There is a programme agreed for Infection Control activity.	DIPC	Chief Nurse	• Infection Control activity is planned and reported to the relevant committee. • Resources are used effectively.	Green

Duty 2 – Duty to have in place appropriate management systems for infection prevention and control.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	The Trust is compliant with HCC core standards, Health Act 2006 and national cleanliness standards.	Chief Nurse	Chief Nurse	• That the Trust Board is assured that appropriate processes and accountability is in place to ensure that infection control is being managed effectively within the organisation.	Green
2	The Trust Board has a collective agreement for its responsibility for minimising infection risk.	Chief Exec.	Chief Exec.	• Trust Board accept responsibility for infection prevention and control role	Green
3	There is a DIPC accountable to the Trust Board.	Chief Exec.	Chief Exec.	• There is an accessible person identified with clear role remit.	Green
4	The Trust should ensure there are sufficient Matrons and other specialist staff in post to deliver the IC agenda.	Chief Nurse	Chief Nurse	• There are sufficient Matrons in post with relevant authority to deliver the actions required.	Green
5	All Matrons have personal responsibility and accountability for delivering a safe and clean environment.	Chief Nurse	Chief Nurse	• Matrons are clear about role and responsibilities.	Green
6	Nurses in charge are directly responsible for ensuring cleanliness standards are met on a shift by shift basis.	Chief Nurse	Chief Nurse	• Shifts are managed consistently.	Green
7	The Trust Board should receive quarterly reports from Matrons and clinical directors on cleanliness and IC.	Chief Nurse/ Matrons	Chief Nurse	• Matrons are able to raise concerns directly with the Trust Board.	Green
8	The Trust Board should ensure that there is a clear route for staff to be heard re IC and cleanliness.	Chief Nurse	Chief Nurse	• Staff are able to raise concerns directly with the Trust Board.	Light Green
9	There will be an audit programme for CDiff in place.	DIPC	DIPC	• Issues relating to CDiff are identified, managed and reported.	Green (Amber)
10	There are programmes of audit in place around cleaning standards.	AD Facilities	Chief Nurse	• Issues relating to cleaning are identified, managed and reported.	Green

Duty 3 – Duty to assess risks of acquiring HCAI's and to take action to reduce or control such risks.					
No	**Assurance required** (standard or policy)	**Who by**	**Lead**	**Outcome expected**	**Status**
1	A process exists for targeted support to high risk areas.	ICN	Chief Nurse	• There will be increased specific support to struggling areas identified through incidents, audit and performance reviews. • Reduction in infection rates in these areas. • Greater compliance with policies and best practice. • Any areas of non-compliance are targeted and support given.	Green
2	Processes exist to ensure risk is identified, assessed and managed appropriately. Risks are detailed on the Risk Register and Risk is mitigated wherever possible.	DIPC ICN Gov. Director	Chief Nurse Gov. Director	• Risk is identified, assessed and being managed. • Assurance is gained that the above is happening. • Risk is detailed on the Risk Register and discussed at the Risk Committee.	Green (Light Green)
3	There are processes in place to identify at risk or infected patients and appropriate action is taken.	ICN	Chief Nurse	• Patients with diarrhoea and CDiff are identified and the appropriate action is taken • An isolation policy exists that is linked to bed management.	Green
4	All cases of MRSA bacteraemias are reported, fully investigated and action taken to prevent re occurrence.	ICN Risk Manager Divisions	Chief Nurse	• MRSA cases are reported and reviewed correctly. • Lessons are learnt and action is taken.	Green
5	All cases where CDiff is cited on death certificates are reported to the SHA as Red incidents and reviewed regularly.	Risk Manager	Gov. Director	• Numbers of CDiff associated deaths will be known. • CDiff mortality report is generated for quarterly review. • All cases are reviewed at Risk Committees.	Green
6	Learning is gained from CDiff associated deaths and systems exist to Reduce risk of reoccurrence. There will be an ongoing audit of CDiff deaths.	Risk Manager ICN	Gov. Director	• Lessons are learnt and action plans put in place to Reduce risk of re occurrence. • Findings from audits are reported and acted upon.	Green
7	Divisions and the Exec Team are aware of incident trends and systems exist to enable immediate action.	DIPC	Chief Exec	• Divisions and Exec Team are able to respond to information quickly. • Trends are reported to OMB, Divisions, SNF and Trust Board.	Green
8.	A policy framework exists for the care and management of patients with infective diarrhoea.	DIPC ICN	Chief Nurse	• Best clinical practice. • Monitoring of care and management of infective diarrhoea.	Green

Duty 4 – Duty to provide and maintain a clean and appropriate environment for healthcare.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	Standards of Cleanliness are achieved consistently in line with Trust policy and national cleanliness specifications	Deputy Dir. Facilities	Chief Nurse	• That the Trust Policy is fit for purpose. • The hospital is cleaned to required standards. • Areas of non compliance are known and action to remedy the gap is identified. • That the Trust Policy is fit for purpose. • A strategy for cleaning exists.	Green
2	The hospitals are cleaned to national cleaning standards.	Deputy Dir. Facilities Matrons	Chief Nurse	• All clinical areas are cleaned to the required standard	Green Light Green
3	All bed spaces are correctly cleaned between patients.	ICN Deputy Dir. Facilities	Chief Nurse	• Patients and staff will have a visible check that beds etc have been cleaned. • Bed spaces will be cleaned properly. • Laminated terminal Bed Clean Sheets have been issued to all wards/departments to be placed on beds once cleaned.	Green
4	All items of furniture, rooms, equipment have a clearly responsible person for cleaning.	ICN Chief Nurse Deputy Dir. Facilities	Chief Nurse	• Sandwell & Rowley equipment clean undertaken. City to be implemented in conjunction with ward services.	Green
5	All ward areas are clean and tidy.	Deputy Dir. Facilities	Chief Nurse	• Enables targeted action. • Improved cleanliness of cupboards, commodes, equipment. • Replacement programme established.	Light Green
6	All areas are properly maintained and in a good state of repair.	Deputy Dir. Facilities Estates	Graham Seager Chief Nurse	• Clinical areas are well maintained. • A refurbishment programme is in place.	Amber
7	The supply of linen and laundry reflects HSG (95) 18.	Deputy Dir. Facilities	Chief Nurse	• Linen and laundry is always available in sufficient quantity for the needs of the service	Green

No	Assurance required (standard or policy)	Who by	Lead	Outcome expected	Status
8	Lead managers have been identified for cleaning and decontamination of equipment.	Dir of Estates	Chief Exec.	• Managers are designated to be responsible for the cleaning and decontamination of equipment	Light Green (Amber)
9	New waste management standards are compiled with.	Deputy Dir. Facilities	Chief Nurse	• Waste is managed in line with national standards. • New policy to be approved at OMB.	Green (Light Green)
10	The DNS, Matrons and IC nurses are involved in cleaning services.	Chief Nurse	Chief Nurse	• Expectations are managed. • Standards are appropriate and effective.	Green
11	A system is in place that allows nurses, to request additional cleaning both urgently and routinely.	Deputy Dir. Facilities	Chief Nurse	• Additional cleaning can be requested via the supervisor's office (bleep out of hours).	Green
12	Commissioning for deep cleaning is appropriately agreed and funded.	Deputy Dir. Facilities DIPC	Chief Nurse	• Environmental & deep cleaning initiative for 2008/09 has been approved at SIRG.	Green

Duty 5 – Duty to provide information on HCAI's to patients and the public.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	An appropriate mechanism is in place for controlling visitor numbers and behaviour.	ADN Matrons	Chief Nurse	• There is a clear policy for visitor handling. • Visitor numbers are kept to a minimum to reduce risk of infection spread. • Visitors take responsibility for own hand cleansing. • Nursing staff feel confident to operate policy.	Light Green
2	Visitors are involved in infection control best practice.	ICN Matrons	Chief Nurse	• Visitors become more compliant with hand washing. • Visitors Policy Launch week commenced 14th July. Infection Control held information stand for all visiting hours on the City and Sandwell sites.	Light Green
3	Patients and users are aware of their responsibilities regarding infection control. Users are not afraid to come into hospital due to infection risk.	Comms Director	Chief Exec.	• Patients and visitors will adhere to policy. • Reduces risk of cross infection. • Prepares patients fro coming into hospital • Patients are well informed. • Positive truthful messages are given • Accurate factual information is given and set in correct context. • Patients are not afraid to come into hospital.	Light Green
4	There is a communication strategy in place aimed at keeping public confidence high.	Head of Comms	Head of Comms	• Public confidence remains high. • Information given is accurate.	Green (Amber)
Duty 6 – Duty to provide information when a patient moves from the care of one healthcare body to another.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	The Trust provides adequate information both on discharge to the patient and community staff and on transfer of any patient to another health care setting.	Deputy CC and Medical Director	COO	• Patients are discharge/transferred safely with due regard to public health	Green
2	A policy exists for the appropriate transfer, discharge, admission and movement of patients.	Chief Operating Officer	Chief Operating Officer	• Evidence of joint working between ICT and bed managers in patient movement.	Green (Light Green)
3	Community staff are aware of patients being discharged with infections.	Medical Director Deputy Chief Operating Officer	Chief Operating Officer	• Community staff will take necessary precautions for the patient, family and community.	Green

Duty 7 – Duty to ensure co-operation.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	The wider Health Economy shares common targets for infection reduction.	DIPC	Chief Nurse	• The Trust will be able to work with the wider health economy to reduce infection rates.	Light Green
2	All staff are aware of their role with regard to infection control. This will include Bank/ Agency staff, students etc.	Execs	Chief Exec.	• Ward managers will know what is expected of them within their role. • Doctors will have clear direction about the key things they can do to make a difference. • All staff will be clear that infection control is a key objective for them as individuals. • All staff will be clear that infection control is a key objective for them as individuals. • Concerns will be escalated to the right place at an early point allowing immediate action.	Green
3	Performance management systems are in place to ensure objectives/targets can be agreed and monitored.	Chief Exec.		• Objectives/targets are agreed at all levels. These are performance managed.	Green
Duty 8 – Duty to provide adequate isolation facilities.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	Patients with infections are always isolated appropriately. There is an appropriate isolation policy in place.	Chief Operating Officer	Chief Operating Officer	• Patients with infections will be appropriately isolated. • Reduces risk of cross infection. • Enables concentration of resources.	Light Green
2	Additional nursing staff may be required to increase isolation of patients.	Chief Nurse	Chief Nurse	• There are sufficient staff to deliver appropriate care.	Green

Duty 9 – Duty to ensure adequate laboratory support.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	The Trust has adequate laboratory support for infection control and prevention.	DIPC	COO	• Laboratory support is available to support effective infection control and prevention	Green
2	The Trust must introduce screening for MRSA for all elective admissions by Mar 09 and for emergency admissions ASAP and no later than 2011.	DIPC	Chief Nurse	• As above.	Green
3	The Trust has sufficient specialist staff to tackle IF.	DIPC	COO	• Specialist staff are available when required.	Green
Clinical Care Protocols					
Duty 10 – Duty to adhere to policies and protocols applicable to infection prevention and control.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	A policy framework exists for the care and management of patients with infective diarrhoea.	DIPC ICN	Chief Nurse	• The policy will provide a framework for: Education of staff. • Best clinical practice. • Monitoring of care and management of infective diarrhoea.	Green
2	The Trust antibiotic policy is in line with national guidance.	DIPC	Medical Director	• The antibiotic policy is current and in line with best practice. • All clinicians are aware of the policy and act within it. • Non compliance without good clinical reason is not accepted and action is taken to ensure future compliance.	Green
3	All staff complies with the Trust uniform policy and standards.	ADN	Chief Nurse	• That all staff comply with expected standards of dress to minimise risk of infection and spread of infection by facilitating proper hand washing, change of soiled clothes etc. • Expect compliance with dress code in every area.	Light Green
4	Practice is always effective and evidence based – Saving Lives recommendations and tools have been adapted and are regularly audited.	Matrons	Chief Nurse/ Medical Director	• All aseptic technique is underpinned by competency based training, assessment and ongoing monitoring. • Line associated contaminants and/or bacteraemias are reduced. • Reduction in line associated infection and sample contamination. • Reduction in patient self contamination and recontamination. • Increased compliance with good practice from medical staff. • Reports are produced regularly based on monthly Saving Lives audits.	Light Green

No	Assurance required (standard or policy)	Who by	Lead	Outcome expected	Status
5	Best practice is adopted for the taking of blood cultures.	Medical Director Chief Exec	Medical Director	• Increased compliance with best practice for blood sampling • Reduction in the number of contaminants.	Amber (Light Green)
6	The Trust has all of the appropriate policies and protocols in place applicable to infection control and prevention.	DIPC ICN	Chief Nurse	• Staff are fully aware of clinical practice and behaviours expected.	Green
7	Best practice with regard to handwashing is embedded within the organisation.	DIPC	Chief Nurse/ Medical Director	• Staff wash hands appropriately at all times. • Audits identify individuals/areas of weakness. • Patients adopt correct handwashing.	Light Green
8	A system exists for the management of non compliance with policy.	Chief Nurse	Chief Nurse/ Medical Director	• Non compliance is dealt with effectively within a management framework. • Reports on known non compliance are generation and acted upon.	Green
9	A system of escalation exists for poor performance.	Chief Nurse	Chief Nurse	• Targeted action occurs for poor performing wards/departments. • Resources are targeted appropriately. • Individuals are held to account.	Green
10	Clinical staff always adhere to hand washing best practice.	Matrons DGMs	Chief Nurse	• Greater compliance with hand washing. • Targeted action as a result. • Reduction in infection rates.	Light Green

Healthcare Workers					
Duty 11 – Duty to ensure, so far as is reasonably practical, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work and that all staff are suitably educated in the prevention and control of HCAI's.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	• Outcome expected	**Status**
1	All staff have received relevant training in infection control.	L+D	HR Director	• Increased compliance with good practice from clinical staff. • Increased compliance with good practice from non-clinical staff.	Light Green
2	All staff are aware of their role with regard to infection control.	Execs	Chief Exec.	• Ward managers will know what is expected of them within their role. • Doctors will have clear direction about the key things they can do to make a difference. • All staff will be clear that infection control is a key objective for them as individuals. • All staff will be clear that infection control is a key objective for them as individuals. • Concerns will be escalated to the right place at an early point allowing immediate action.	Green (Light Green)
3	Occupational policies exist for the prevention and control of infection in health workers.	OH Physician	Director of HR	• Staff do not put staff or public at risk through spread of infection.	Light Green
4	The Trust minimises the use of temporary staffing.	Chief Nurse	Chief Nurse	• Better use of temporary staff. • Temporary staff properly supervised. • Temporary staff are appropriately trained.	Light Green
5	HR policies appropriately encourage mandatory training, induction and disciplinary action in relation to IC.	Dir HR	Chief Exec.	• Staff management re infection control procedures etc. are appropriate.	Green (Light Green)

Please note the audits and monitoring methods described throughout this document will enable the trust to comply with Duty 2e of the Health Act

Other reference docs:

DOH Winning Ways 2003
Getting ahead of the curve 2002
Matrons charter 2004
Towards cleaner Hospitals

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Cleanliness/PEAT Report
SPONSORING DIRECTOR:	Rachel Stevens, Chief Nurse
AUTHOR:	Steve Clarke, Deputy Director of Facilities
DATE OF MEETING:	6 November 2008

KEY POINTS:

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

PURPOSE OF THE REPORT:

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

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

2.1	Continue to reduce hospital infection rates achieving national and local targets for MRSA and *clostridium difficile* including introducing MRSA screening in line with national guidance.

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

SWBTB (11/08) 116 (a)

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD REPORT

6TH NOVEMBER 2008

NATIONAL STANDARDS OF CLEANLINESS (NSoC)

The Trust continues to improve its NSoC audit scores in both the critical areas for 'very high' and 'high' level cleaning.

The audit returns at Sandwell are indicating an improved level of cleaning, the main differential is the standard of equipment cleaning. The cleaning of equipment at Sandwell is undertaken by the Ward Service Officers (WSO's) ensuring a systematic clean is undertaken daily. However with the implementation of WSO's at City and equipment cleaning being part of their duties the standards will improve and should reflect in the overall audit scores, this will contribute towards the Trust meeting the target of 98% for 'very high' risk areas.

In terms of development, a computerised system has been purchased for the NSoC, the software is specifically designed for the NHS to set and manage cleaning standards and specifications in Hospital premises. It has been funded and developed by the Department of Health.

The system produces individual Service Level Agreements for each functional area and produces a range of cleaning performance reports and the monitoring system conforms to the National Standards.

The system also allows Managers to benchmark performance, balance costs, forecast new demand and manage budgets, expenditure and productivity.

Audit Scores

The following audit scores are for the first 6 months of 2008/09 and give a comparison against 2007/08.

	Overall 07/08 Very high	Overall 07/08 High	April - Sept 08 Very high	April - Sept 08 High
City	92	90	94	94
Sandwell	95	91	97	95
Rowley	N/A	95	N/A	97
BTC	98	97	95	97
Overall %	**95**	**93**	**95**	**96**
Target %	**98**	**95**	**98**	**95**

ADDITIONAL INFORMATION

- Discharge Cleaning Teams
  - The discharge cleaning teams are now operational 7 days a week at both City and Sandwell.

City	Bed Cleans	Average per day
May 08	479	17
June 08	709	25
July 08	853	32
August 08	943	34
September 08	970	35

- Figures exclusive of MAU
- MAU have a dedicated member of staff
- No definitive comparisons against total discharges

Sandwell	Bed Cleans	Average per day
May 08	602	22
June 08	719	26
July 08	824	30
August 08	1055	39
September 08	1082	40

- Figures exclusive of EAU
- No definitive comparisons against total discharges

- Deep Cleaning
  - All deep cleaning procedures are now agreed with Infection Control and all cleaning requests are in line with the agreed cleaning matrix, all deep cleans are recorded.

- Decontamination cleaning
  - All cleaning of side rooms are now standardised and being recorded, the information can be accessed on the Facilities shared folder.

- Ward Service Officers (WSO's)
  - The programme is on track, first phase of the implementation has been achieved, D11, D12, D41 and MAU went live on the target date 15th October 2008. There will be a dedicated Facilities Manager assigned to all areas to assist on every service for the initial period of each phase.

    The WSO's will also be responsible for the cleaning of the general ward equipment.

PEAT

- The PEAT management inspections are continued to be undertaken weekly, all action plans can be accessed on the shared folder by key stakeholders for progress updates.

- The redecoration programme is continuing, there are currently 10 agency staff (decorators) employed each month.

- The majority of flooring work has been completed on the link areas at Sandwell and the Neurophysiology Department at City, the next major flooring scheme will be the A&E Department at City.

ENVIRONMENTAL SPEND TO DATE (OCTOBER) 2008/09

	Budget	Committed	Residual
Agency (Estates)	£404k	£123k	£281k
Ward Equipment - Optimal Ward - LIA	£250k	£70k £17k £7k £94k	£156k
PEAT	£200k	£160k	£40k

STEVE CLARKE
DEPUTY DIRECTOR - FACILITIES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Infection Control and Cleanliness – Matrons' Report
SPONSORING DIRECTOR:	Rachel Stevens, Chief Nurse
AUTHOR:	Trust Matrons
DATE OF MEETING:	6 November 2008

KEY POINTS:

"Safe, Clean care" Department of Health (DoH) 2008 and previous DoH circulars stressed the need for Matrons to be given the opportunity to raise concerns regarding Infection Control and Cleanliness directly with the Trust Board.

A system has been established that invites Matrons to give comments and concerns to the Chief Nurse to be collated into this quarterly report for the Trust Board.

PURPOSE OF THE REPORT:

○ **Approval** ◉ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

2.1	Continue to reduce hospital infection rates achieving national and local targets for MRSA and *clostridium difficile* including introducing MRSA screening in line with national guidance.

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☑	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Matrons' Report on Infection Control and Cleanliness

Introduction

"Safe, Clean care" DoH 2008 and previous DoH circulars stressed the need for Matrons to be given the opportunity to raise concerns regarding Infection Control and Cleanliness directly with the Trust Board. A system has been established that invites Matrons to give comments and concerns to the Chief Nurse to be collated into a quarterly report for the Trust Board.

What The Matrons Say

On the whole Matrons continue to be satisfied with the level of cleaning in ward areas. Attention has now turned towards non ward clinical areas with support from the PEAT team.

De-cluttering programmes continue and a system for removing mattresses and other large items of equipment has now been put in place with proper mattress stores. This also includes a twice daily "corridor monitor" system.

The Discharge Cleaning team continues to be very well received and the Matrons now feel confident that bed spaces are generally cleaned well between patients. A "this bed has been cleaned ready for use" sticker tape has also been introduced to improve public confidence.

The clarification to nursing staff of different types of cleaning available has been welcomed and ensures all areas are now getting the correct clean in a timely fashion.

The Matrons also welcome the Trust's commitment to close areas to allow cleaning to take place where there is any indication of the possibility of an outbreak.

Saving Lives and Hand Hygiene audits continue on a monthly basis (weekly for areas falling below 95%). There continues to be improvement generally across the Trust, especially with Saving Lives audits. Hand Hygiene is currently showing a Trust average of 80%. This has improved from earlier in the year where commonly the Trust was at around 65% but there is clearly some way to go. On the whole, non-compliance with Hand Hygiene tends to be amongst visitors and medical staff. To improve visitor compliance, new floor signage is being considered. More detailed reports are being developed to enable targeting of medical staff.

Disposable bowls are currently being considered to replace the existing reusable plastic bowls. Pilots have shown disposable bowls to be well received by patients and saves nursing time washing bowls between patients. There is obviously a cost associated with this development and this is currently being evaluated.

Finally, approval has been given for significant bed replacements, along with the establishment of a more robust maintenance programme. This will allow the removal of many old mechanical beds and replacement with modern electrical beds that enable easier movement of patients and less physical stress on nurses. Alongside this there continues to be an ongoing programme of bedside furniture replacement.

Rachel Stevens
Chief Nurse

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Safeguarding Adults
SPONSORING DIRECTOR:	Rachel Stevens, Chief Nurse
AUTHOR:	Rachel Stevens, Chief Nurse
DATE OF MEETING:	6 November 2008

KEY POINTS:

The purpose of this report is to alert the Trust Board to the structures that are now developing across health and social care communities for which the Trust is being asked to take part, and also to advise the Trust Board of it's duties under the Adult Safeguarding agenda.

PURPOSE OF THE REPORT:

○ **Approval** ◉ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board are asked to note the contents of this report and support the proposed management and monitoring structure.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically

IMPACT ASSESSMENT:

FINANCIAL	☑	Will require some resourcing for a lead officer and training – approved at SIRG October.
ALE	☐	
CLINICAL	☐	
WORKFORCE	☑	All staff who have contact with adult patients will require additional POVA/CRB checking on appointment. All staff who have contact with adult patients will require training on adult safeguarding and a fairly significant number will require level 2 training. An executive lead is required – Chief Nurse.
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Safeguarding Adults

Introduction

In recent years serious incidents have demonstrated the need to produce policies which ensure vulnerable adults at risk of abuse receive support and protection, that agencies work together to aid prevention and produce a consistent approach to investigation and action. This closely mirrors earlier policy work around Safeguarding Children.

A vulnerable adult is someone described as being at risk of mental or physical abuse or neglect, as a result of disability, impaired mental capacity, learning difficulty, old age or ill health. Abuse could be intentional or non intentional and could be caused by family, friend, stranger or carer (including health care professionals).

The purpose of this report is to alert the Trust Board to the structures that are now developing across health and social care communities for which the Trust is being asked to take a part, and, also to advise the Trust Board of it's duties under the Adult Safeguarding agenda.

Organisational Capacity Audit Questions

The following questions will be asked in future audits of the Trust by the Commission for Social Care Inspections. An audit of Sandwell Health and Social Care Organisations is planned for 5th December 2008 – it is expected that the Trust will be asked to provide information as part of this audit. The following are the areas that we will be asked to provide evidence against:

Does your organisation have:	Yes	No	Comment
A lead person at Board level with responsibility for Safeguarding Adults?	√		Chief Nurse
Does the Board receive an annual report on your work?		√	Planned for May 2009.
Does your organisation have a Lead Officer/Manager for Safeguarding?	√		Currently Assistant Director of Nursing – Quality. Paper approved at SIRG requesting additional funding for a Lead Officer.
Does your organisation have a reference group for Safeguarding?	√		First meeting November 2008
Is there an appropriate representation on SSAB with a clear line of responsibility back to your organisation?	√		Chief Nurse
Is there a financial commitment to multi-agency Safeguarding work?		√	The PCT's make this commitment on behalf of health
Is there a clear reporting structure which staff can use to raise concerns of abuse/neglect?	√		Vulnerable Adults Policy

Can your organisation supply 24 hour access to Safeguarding Adults information?		√	An assessment of need is required before the type of access is determined.
Can your organisation supply 24 hour access to all previous case record?		√	As above
Can your organisation gain access to other agencies information?		√	As above
Can your organisation gain access 24 hours to a person with Safeguarding expertise?		√	As above
Does your organisation have a lead person for ensuring CRB, POVA and other relevant vetting/barring checks are made?	√		Needs further work and possible additional resourcing.
Does your organisation have a person who leads on ensuring professional staff are registered with their professional body?	√		Not a single person but a system within Divisions and HR.
Does your organisation have clear Service Specification standards for safeguarding work?		√	
Does your organisation have a training strategy for all staff and volunteers?	√		Part of mandatory training policy but currently very limited training provision. Resources now agreed via SIRG.
Does your organisation have a monitoring system for Safeguarding work?		√	Please see below.

Proposal for Supporting Safeguarding Adults within the Trust

Structures

- The Chief Nurse has been identified as the Lead Executive Officer for Safeguarding Adults and will sit on the Health and Social Care Safeguarding Boards. It will be her responsibility to ensure the Trust meets its statutory requirements and standards around safeguarding.

- The Assistant Director of Nursing – Quality, has been identified as the Lead Officer for Safeguarding Adults and will ensure requirements and standards are operationalised, monitored and reported upon.

- A Trust Adult Safeguarding Committee has been established and meets for the first time in November. It will be chaired by the Chief Nurse. The Committee will report to the Governance Board and to the Equality and Diversity Steering group. Reports to the Trust Board will come via the Equality and Diversity Steering group on a twice yearly basis.

- A Lead Manager and training resource has been identified which will enable:

    - Monitoring and reporting mechanisms to be established.
    - The development of a detailed action plan for improvement.
    - The development of training packages for all relevant staff to enable them to identify adults at actual or potential risk and take action to prevent harm or further harm.
    - The development of training packages for mental health and falls prevention.
    - The development of appropriate record keeping.
    - The collection of relevant data and information intelligence.

Rachel Stevens
Chief Nurse

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Health Care for All - Sir Jonathon Michael (2008)
SPONSORING DIRECTOR:	Rachel Stevens, Chief Nurse
AUTHOR:	Debbie Talbot, Assistant Director of Nursing - Quality
DATE OF MEETING:	6 November 08

KEY POINTS:

The report is an independent enquiry into access to healthcare for people with Learning Disabilities (LD) in response to Mencap's 'Death by Indifference' about the experiences of 6 families whose relatives died (perhaps avoidably).

10 recommendations are made for the DOH and individual Trusts and providers to action:

1. The DOH should Amend Core Standards for Better Health to include explicit reference to making 'reasonable adjustment' to provision and delivery of services to vulnerable groups.
2. DOH should direct PCTs to commission services that have made 'reasonable adjustments' including health checks and evidence of partnership working.
3. To raise awareness regarding the risk of premature avoidable death and undertake a confidential enquiry into premature deaths of people with LD
4. Pre and post registration training should include Mandatory Training in LD and be competency based.
5. Inspectors and regulators should monitor the standard of health services delivered to people with LD and monitor compliance to DDA.
6. All healthcare organisations should ensure they collect data and information to ensure patients with LD and their pathways of care are tracked and reviewed.
7. All Trusts should demonstrate in routine public reports they have systems to deliver 'reasonably adjusted' health services for those patients with a LD. These systems should include advocacy and PALs services.
8. Section 242 of the NHS Act 2006 requires NHS bodies to show involvement and consultation of patients and the public in service and policy planning.
9. Families and carers should be involved in provision of treatment. This will include provision of information.
10. PCTs should include needs of patients and cares in LAA.

✓ Noting

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to note the summary of actions required as a result of this enquiry, proposed approach and progress to date. Progress will be reported in the future via the Safeguarding Adults Structure.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically, although does support the following:

- Access to services
- Improve quality of services
- Improve effectiveness of the organisation

IMPACT ASSESSMENT:

FINANCIAL	☑	Need for training, information and expert provision. Business case submitted to SIRG for Safeguarding Lead and training resources – which will incorporate elements of LD as vulnerable adult- which has been approved. No other LD post in the Trust. No pay or non-pay budget attached to LD.
ALE	☐	
CLINICAL	☑	Health care workers need knowledge and skills around Safeguarding and LD agenda, clinical presentations, communication aids. No training programme currently. Some elements of culture and diversity on MT programme. Evidence of person centred care – achieved via review Patient Assessment Record.
WORKFORCE	☑	Access to liaison nurses to provide expert advice and support to patients and carers with LD in acute hospital – particularly around consent, capacity and discharge planning. Liaison service available to City site but no on site accommodation. Complex cases may require extra staffing- expert or non expert- financial implications to ward.
LEGAL	☑	Requirement for inclusion in Local Area Agreements- actioned Availability of advocacy services – via Pals and IMCA services Data collection and monitoring (coding suggest 300 pts in last 12 months) and Governance reporting process requires further refinement.
EQUALITY & DIVERSITY	☑	Compliance with DDA. LD are a minority, vulnerable group - E&D group and facilities are monitoring action plan.
COMMUNICATIONS	☑	Partnership arrangements with local PCTs and LA- via Boards and liaison arrangements. Patients, staff, carers need access to Easy Read and other communication aids. Routine reports need to illustrate evidence of 'reasonable adjustment' to accommodate access to services.

PPI	☑	Representation from the LD community (patients and carers) is required as part of service and policy review (2010, reconfiguration)- this should include membership on key decision making groups , patient surveys (appropriate format) and focus groups.
RISKS		Failure to meet the standards outlined in the Jonathon Michael Report – 'healthcare for all' ▪ Complaints ▪ Delayed discharges ▪ Cancelled procedures ▪ Clinical incidents ▪ Avoidable death

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Learning Disabilities Action Plan

Post Healthcare for All Independent Inquiry. Summary of Recommendations

Debbie Talbot – ADNS Quality

October 2008

Status:

5	Complete
4	On track
3	Expect to be completed as planned
2	Significant delay/unlikely to be completed as planned/will have explanation attached
1	Not yet commenced
0	Objective revised

Team Key:

DT	Debbie Talbot (Nursing)	**MM**	Mathew Maguire (coding)
SP	Sheila Peacock (Nursing)	**KD**	Kam Dhami (Governance)
AR	Adam Ruddock (L&D)		
JK	Jessamy Kinghorn (Comms)		

	Recommendation	Action for SWBH	By Whom	Time frame (End of Month)	Progress	Status
1.0	The DOH should amend core standards for Better Heath, to include an explicit reference to the requirement to make ' reasonable adjustments' to the provision and delivery of services for vulnerable groups in accordance with the disability equality legislation. The framework that is planned to replace these core standards in 2010 should also include	1) Compliance with DDA 2) Implementation of SES 3) Compliance with mental capacity act 4) Allocation of Trust Safeguarding Lead	SP	Nov 08	DDA compliance officer employed by the Trust to lead action planning to ensure environment meets needs of legislation (includes walkaround audits and replacement programmes for ramps etc) Independent Living Group champion DDA elements. E & D steering group. SES approved by Board in July 08- recruitment of designated E&D team to implement action plan.	**4**

	a specific reference to this requirement.	5) Position Statement and action plan against ADSS national standards for Safeguarding			Patient Experience sub group and action plan Equality and impact assessment for services and policies Mixed sex wards policy under consultation (includes process for breaches). Signage- audit cycle implemented (Oct 08). P&D signage implemented on wards Interpreting service Facilities dept are exploring use of pictorial signage to meet needs of vulnerable and diverse groups MC Act and training implemented – formal end of year required mar 09 Appointment of Safeguarding Lead and business case submitted for operational lead.	
2.0	The DOH should direct PCTs to secure general health services that make a 'reasonable adjustment' for people with LD through a Directed Enhanced Service. In particular the DOH should direct PCTs to commission enhanced pc services which include regular health checks provided by GP practices and improve data ,communication and cross boundary partnership working . This should include liaison staff who works with primary services to improve the overall quality of healthcare for people with LD across the spectrum of care.	1) Representative at senior level on partnership boards	DT	Dec 08	LD partnership Board representation at Sandwell , membership not actioned at B'ham. Liaison services on City site based in hospital and working in close partnership with Safeguarding Lead to raise profile of service in the hospital and support provision of information and training.	**3**
3.0	To raise awareness in the health service of the risk of premature avoidable death , and to promote sustainable good practice in local assessment, management and evaluation of services , the DOH should establish a LD Public Health Observatory. This should be supplemented by a time limited Confidential Enquiry into premature deaths in people with LD to provide evidence for clinical and professional staff of the extent of the problem and guidance on prevention.	1) Staff training plan regarding assessment on admission, vital sign monitoring and escalation, common conditions and symptoms e.g. heart murmur in patients with Down's Syndrome 2) recording , reporting and analysis of deaths in hospital of patients with LD – coding, coroners and risk data	DT/clinical lead/ AR Tbc ?KD	Mar 09	Review and implementation of initial assessment document for all adult in patients. Implementation of SAP. Use of early warning observation charts. Training of HCA's in vital sign monitoring. No specific training re patients with LD Need to determine analysis and reporting data	**2**
4.0	Those with the responsibility for the provision and regulation of undergraduate and postgraduate clinical training must ensure that curricula include mandatory training in LD . It should be competence based and involve people with LD and their carers in providing training.	1) awareness of inclusion and curricula content of main professional groups – nurses, doctors and AHP 2) evidence of post graduate training and information collection on database of attendance 3) competency framework (KSF)	AR, EH, DD	tbc	Culture and diversity training	**1**
5.0	Inspectors and regulators of the health service should	1) evidence of compliance with the DDA	SP SC		A process exists , lead by the Governance team, which disseminates and	**3**

	develop and extend their monitoring of the standard of health services provided for people with LD , in both the hospital sector and in the community where pc providers are located. The aim is to support appropriate, reasonable adjustments to general health services for adults and children with LD and their families and to ensure compliance with and enforcement of all aspects of the DDA . Healthcare regulators and inspectors (and the Care Quality Commission once established) should strengthen their work in partnership with each other and with the Commission for Equality and Human Rights , the National Patient Safety Agency and Office for Disability issues.	2) development and implementation of SES 3) recruitment of E&D lead /team to implement SES action plan.	KD		monitors actions following NPSA alerts. SES accepted by Trust Board July 08, action plan monitored by E&D group E&D lead and team appointed.	
6.0	All health care organisations , including the DOH should ensure they collect the date and information necessary to allow people with LD to be identified by the health service and their pathways of care cracked.	1) establish coding report to identify admissions /op activity for patients with LD 2) review coroners cases to determine number of cases where patient has learning disability.(include age profile) 3) Review referral patterns to liaison services and reasons for referral and outcome (Minimum data set)	DT/MM	Dec 08	Draft coding report actioned – requires further refinement to clarify accuracy of reporting and coding. Education of medics via induction programmes ongoing. Pathway of care monitored via clinical condition e.g. fracture femur	**1**

7.0	All Trust should demonstrate in routine public reports that they have effective systems in place to deliver effective , 'reasonably adjusted' health services for those people who happen to a learning disability . This adjustment should include arrangement s to provide advocacy for those who need it , and arrangement to secure effective representation on PALS from all client groups including people with learning disabilities.	1) Availability/accessibiliy of advocacy services 2) Evidence of reporting structure to include Board.	**JK** **SP**	Oct 08	The Head of Comms meets publication duties in accordance with legislation. Several groups have representation from PPI and vulnerable groups. There is an active PPI forum. Independent Advocacy is available via PALs information leaflets and via IMCA services in both B'ham and Sandwell – available via intranet and ward leaflets for staff ,patients and carers. Pals collect and report quarterly statistics and include actions in Patient Experience action plan The Head of Comms will be reporting quarterly on Patient Views to the same group as part of the re-structuring of the E&D agenda.	**4**
8.0	Section 242 of the NHS Act 2006 requires NHS bodies to involve and consult patients and the public in the planning and development of services, and in decisions affecting the operation of services. All Trust Boards should ensure that the views and interests of people with learning disabilities and their carers are included.	1) evidence of consultation with public including minority and vulnerable groups for 2010 rebuild, reconfiguration, foundation status 2) Nominate Exec Lead for consultation	**JK**	**Sept 08**	The designated 2010 planning process includes a public engagement strategy which includes involvement of voluntary sector. The executive lead for consultation is the Head of Comms- who has developed a database of diverse groups . 6,000 members of the public have volunteered to be involved in consultation around foundation status.	**4**
9.0	Family and other carers should be involved as a matter of course as partners in the provision of treatment and care unless good reason is given and the Trust boards should ensure reasonable adjustments are made to enable them to do this effectively . This will include provision of information but may also involve practical support and service co-ordination.	1) Evidence of PPI/LINKs members on key decision making groups. 2) Patient information availability on services, Trust profile, outcomes and clinical conditions 3) Publishing of annual report and availability to the public.	**SP** **DT** **/LDLN** **JK**	**Sept 08**	Resource folder –communication aids in progress for each ward/dept Development of web page to include advice and referral contact numbers- for Safeguarding/LD 3 pt information centres , designated Pals/PPI websites Patient support centre (PALS ,PPI and volunteers) Use of plasma screens , health exchange Carer's strategy in final draft awaiting approval Carer's support network existing for some specialities – arthritis, cardiology and to be expanded to neurological conditions	**3**
10.0	PCTs should identify and assess the needs of people with learning disabilities and their carers as part of their Joint Strategic Needs Assessment . They should consult with their Local Strategic Partnership Boards and relevant voluntary use-led learning disability organisations and used the information to inform the development of Local Area Agreements.	1) LAA for Sandwell and West Birmingham.	**tbc**	**Dec 08**	Both Birmingham and Sandwell LLA contains specific reference and priorities in its key outcomes – working with people with LD to enable sustained employment, improve the quality of life, ensuring services respond to the diverse needs of minority groups, increase life expectancy and improve accommodation for people with LD 18-64 and reduce delayed discharges from hospital.	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Patient Experience Action Plan
SPONSORING DIRECTOR:	Rachel Stevens, Chief Nurse
AUTHOR:	Pauline Richards, Head of Patient Experience
DATE OF MEETING:	6 November 2008

KEY POINTS:

The report is intended to share with the Trust Board the amended version of the Patient Experience Action Plan for approval. The original action plan came to the Trust Board in June 2008.

The action plan was developed as a result of Patient Surveys, PALS data, Complaints trends and meetings with the PPI forums. It is intended to focus on a number of key areas:
Privacy and Dignity
Nutrition/Meal Service
Hygiene Needs
Communication and Information
Appointments Processes

When previously presented, the Trust Board requested more detail around responsibility and timescales within the action plan. At the time the action plan was in draft pending the first meeting of the Patient Experience Group. This group has now met twice and the action plan further developed and progressed.

PURPOSE OF THE REPORT:

To provide the Trust Board with assurance that a structure and action plan now exists to consider patient views and improve the patient experience in a systematic manner.

✓ Noting

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to note the approach taken in delivering an improved Patient Experience. The action plan will be monitored by the Patient Experience Group and progress reported via the Equality and Diversity Steering Group to the Board.

The Trust Board should consider whether it requires a separate Patient Experience report which summarises key actions and progress.

The action plan aligns with the Trust Strategic Objectives in relation to:
Objective No 5 – Improve Quality and Standards of Care
Objective No 4 – Respond to our Patients

HCC core standards.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

The action plan aligns with the Trust Strategic Objectives
No 4 Respond to our patients
No 5 Improve quality and standards of care
No 7 Promote education, training and research
HCC core standards
Essence of Care standards

IMPACT ASSESSMENT:

FINANCIAL	☐	None known currently although may be some as the action plan is implemented.
ALE	☐	
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	Single Equality Scheme (SES)
COMMUNICATIONS	☐	
PPI	☐	Patient user representatives have been actively involved in the development of this action plan and have agreed to monitor its implementation and service improvements.
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PATENT EXPERIENCE ACTION PLAN

NOVEMBER 2008 (Version 6)

PATIENT EXPERIENCE ACTION PLAN

PATIENT EXPERIENCE GROUP

Executive Lead: Rachel Stevens

Group Chair: Rachel Stevens

Core Objectives - developed as a result of the National Inpatient Survey 2007, PALS data 2007/8, Complaints trends analysis 2007/8, local internal EOC and PEAT audits 2007/8 and meetings with the PPI forums.

Outcome:

- The principles of equality and diversity will be embedded services and day to day activities as corporate and divisional reports
- To monitor the on-going development and implementation of the Patient Experience Action Plan.
- Trust Board members will be informed of improved patients' experiences within the areas outlined below, via quarterly reports from the Patient Experience Group
- Patients' satisfaction surveys [national & local] will demonstrate improved patient experience
- User feedback will be evident in all practice and service developments.

Trust Board Commitment

PRIVACY & DIGNITY (P&D)	The Trust is committed to providing services across all activities within the organisation that are: ▪ within aesthetically pleasing and safe environment. ▪ that respects and values the individual. Ensuring privacy and dignity is integral to all care and treatment delivered.
NUTRITION	All patients can expect to have their basic needs met whilst in our care which includes their nutritional needs.
HYGIENE	The Trust is committed to ensuring patients basic care needs are met.
COMMUNICATION & INFORMATION **(Encompasses staff attitude)**	**The trust will ensure that**; ▪ All patients and users can expect to be communicated in a polite and respectful manner. ▪ All written communication will be in accordance with the 'Plain English' campaign and of a high quality when produced in other languages, ensuring that contents are validated by an accredited translation service. Wards and departments operate a "meet and greet" and "farewell" standard for all patients and visitors.
APPOINTMENTS	**The Trust will ensure that**: ▪ A review of current appointments systems and ensure that a centralised approach to appointments is adopted trust wide.

	Patients/users will have a positive experience accessing the services of the organisation for their health care problems.

PATIENT EXPERIENCE ACTION PLAN

PRIVACY & DIGNITY

Executive Lead: Rachel Stevens

Group Chair: Rachel Stevens

Status key:	5	Complete	4	On track	3	Some delay – expect to complete as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Outcomes:

- Improved patient experience
- Patient environment is aesthetically pleasing and safe environment.
- Patients are respected, valued and treated as individuals.
- Privacy and dignity is integral to all care and treatment delivered.
- User feedback is an integral part of service improvement action plans

Actions	Lead Responsibility	Target Date	Progress	Status
• Areas highlighted in the PEAT report as problematic in maintaining privacy & dignity will have service improvement action plan(s) to address issues identified.	**Service Managers Lead**	Dec '08	• Progress will be monitored following implementation of Privacy and Dignity section within PEAT. • MAU have action plan in place – environmental changes expected in January '09.	
• Short lived User-focused action group to be pulled together to audit against service improvement plans to confirm compliance.	**Head of Patient Experience**	Jan' 09		
• Approval of new Mixed Sex Accommodation and Privacy & Dignity policies.	**Head of Patient Experience**	Nov '08	• Met with bed management teams at both city and Sandwell who will record breaches of mixed sex accommodation. • Policies have been amended following	

			consultation and awaiting submission to next Governance Board.	
• Improve privacy and dignity signage within the clinical environments across the organisation.	**Head of Patient Experience**	Sept. '08	• Privacy & dignity signs have been distributed to all wards and departments on Sandwell & City sites – good response from areas now in receipt of signs. • Signs to be delivered on Rowley site. • Bathrooms and toilets are clearly labelled appropriately as 'Male' and 'Female'. Privacy and & dignity signs are now being used on closed curtains	
• Raising staff awareness in the utilisation of the existing privacy & dignity training pack contained within the Older People project.	**NSF Older People Lead**	Oct '08	• Met with Older person lead to discussed increased marketing of on-line training contained within the Older People website that staff can access. • Discussions with Learning and Development revealed a major review of all resource to make accessible on line.	
• Utilise Essence of Care audit findings to inform practice.	**EOC lead**	Sept '08	• 2008 audit results have been shared with all matrons, each matron to develop action plan for there area and submit to EOC steering group in Sept '08. Update and good practice to be shared at SNF on 12th Jan '09.	
• Develop and implement continuous monitoring programme to ensure that local EOC action plans translate into service change and improvements.	**EOC Lead/Matrons**	Feb'09		
• Review skill mix across the organisation to ensure all areas are appropriately staffed with numbers and skills, in order that care and treatment is delivered to a high standard and individualised.	**ADN Workforce & Strategy**	Dec '08	Work in progress – Strategic Direction 2010 – looking at: • Level 4 Healthcare Assistants practitioners. • Ward Services (food only) ❖ Appointment of Project Mgr (facilities) to lead on Ward services Programme	

• Improve the care of the Bariatric deceased patients in a respectful and dignified manner.	**Bereavement & Supportive care pathway Co-ordinator (SCP)**	Jan '09	• Staff training implemented across the Trust. • Route from clinical areas to mortuary reviewed and necessary amendments made to facilitate a more dignified transportation of the deceased to mortuary. • Risk assessment completed on transfer of Bariatric patients which resulted in the re-introduction of the Bariatric concealment trolley on the City site and a purchased of Bariatric concealment trolley on the Sandwell site.	
• Improve the care of the Neo-nate and Paediatric deceased patients in a respectful and dignified manner.	**Bereavement & Supportive care pathway Co-ordinator (SCP)**	Jan '09	• Introduced baby concealment Trolleys to transfer babies to the mortuary instead the Moses basket. • Rapid release of a child was reviewed and changed accordingly – e.g. all children are released via the mortuary within organisation. • Digital camera purchased to facilitate parents receiving a photograph of the child along with a lock of hair, foot and hand prints, in a memory book.	
• Ensure appropriate bereavement facilities are available and accessible for patients, across the organisation.	**Bereavement & Supportive care pathway Co-ordinator (SCP)**	Oct '08	• Private rooms are available on both sites (protected) for returning property and receiving dead certificate.	
• Design and implement an appropriate condolence card for ward staff to give to bereaved relatives/carers.	**Bereavement & Supportive care pathway Co-ordinator (SCP**	Sept '08	• Funding for sympathy cards have been secured from charitable funds.	
• Design a Mental Capacity training framework to ensure that all staff has access to training to ensure the mental health needs of their patients are met in accordance to the	**NSF Mental Health Lead**	Jan '09	• Training dates out for band 7 and above. • Ward based training programme commenced in Medicine • E- Learning packs available.	

Mental Capacity Act.				
• Monitor staff attendance on Mental Capacity Training programme and provide quarterly update to Patient Experience Group.	**NSF Mental Health Lead/ Learning and Development**	Jan '09	• Register kept by Professional Development Nurse • Awaiting advice re e- learning outcomes	
• Launch the Visitors Policy across the Organisation	**ADN Patient Experience**	July '08	• One week awareness campaign and implementation Visitors Policy completed.	
• All wards/departments must enforce the visitors policy to ensure that there is a clear Patient/visitor understanding.	**Matrons and Ward Managers**	July '08	• Following implementation of Policy Ward Managers and Matrons are actively promoting and policing compliance in practice.	
• Ward reviews will incorporate visitor policy compliance as part of its review process.	**ADN Workforce**	Nov '08		
• Utilise the PPI forum members to undertake Visitor Policy compliance Audits.	**ADN Patient Experience**	Dec '08	• Members at the August PPI forum agreed to participate in the Visitor Policy audit. • Members are to receive training in September.	
• Provide quarterly update to Patient Experience Group of analysis of Breach in relation to Mixed Sex Accommodation	**Bed Manager Lead**	Quarterly- commencing in Qtr 3 '08/09		

PATIENT EXPERIENCE ACTION PLAN

NUTRITION

Executive Lead: Rachel Stevens

Nutritional Steering Group Chair: Lead Clinician nutritional support – Dr Lewis [City] and Dr Mohammed [Sandwell]

Status key:	5	Complete	4	On track	3	Some delay – expect to complete as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Outcomes:

- Patient satisfaction survey will show Improved patient experience
- Patients' nutritional assessment is completed on admission and reviewed regularly in accordance with care plan.
- Essence of Care audits will demonstrate measurable improvements in patients' nutritional status.
- Meal time assistants will be integral to the ward team.
- User feedback is an integral part of service improvement action plans

Actions	Lead	Target Date	Progress	Status
• Meal time Assistants will be recruited and trained and a quarterly report submitted to track progress.	**Ward Project facilitator – Volunteer Feeding.**	Sept'08	• Open day for Volunteers took place – 68 potential volunteers attended the day. Recruitment of volunteers commenced – 17 volunteers recruited to date; recruitment to continue throughout month of August. • Induction programme developed for commencement of Volunteers in September '08. Meal Time Assistance workshop devised to be delivered in September '08. • Negotiations with Ward Managers ongoing to support volunteers in their area. • Work with catering is on-going to ensure effective implementation	
• Introduce the blue beakers water		Nov '08	• Blue Beakers are being sourced currently	

scheme to promote hydration and patient comfort.	**Ward Project Facilitator/Catering**		by Catering with a view to introduce the scheme shortly.	
• Develop and implement both the 'Red Tray and Blue Beaker' and 'Protected Meal Time' policies.	**Head of Patient Experience/Ward Project Facilitator.**	Nov '08	• Policies amended following consultation • Equality Impact Assessment and Implementation plan to go back out for wider consultation	
• Utilise PPI forum members to undertake Red tray Scheme audit to confirm compliance – results to be feedback to Patient Experience Group.	**Head of Patient Experience**	Dec '08	• PPI forum members have agreed to participate and attended volunteers' induction. • Further audit training to be delivered in September.	
• Implement Malnutrition Universal Screening Tool (M.U.S.T.) nutritional assessment tool and launch the weight & height campaign.	**Dietetics Service Lead**	Aug '08	• Malnutrition Universal Screening Tool (MUST) implemented on 29th September 2008. • Training dates for City wards have been published as the first phase of the training programme. • MUST trainer attending the safeguarding conference on 4th November to promote the work.	
• Following implementation of M.U.S.T Training programme, undertake audit to confirm compliance and/or improvement	**Dietetics Service Lead**	Jan '09		
• Implement the new meal service and ward service officers on the City site.	**Facilities Project manager**	Oct 08	• New meal service being introduced with a phased approach from Oct'08 – Jan'09. Recruitment of staff is on going. • Training taking place on wards at City to ensure new meal service effectiveness.	
• Monitor use of heated trolley and Hostess service to ensure the quality of food received by patients has improved.	**Monitoring Manager – facilities**	July'08	• New heated trolleys have been purchased for all wards at City. The meal service has been implemented on the following to date - D43, D17 and D15 on city site. • Older trolleys at Sandwell will be replaced in the next 12 months.	

• Utilise Essence of Care audit findings for nutrition to inform practice.	**EOC lead**	July'08	• 2008 audit results shared with Nutritional steering group. Action plan to be submitted to EOC lead deadline Sept '08.	
• Develop and implement continuous monitoring programme for Nutrition to measure improvements.	**EOC lead**	Oct '08	• Following launch of Admission documentation and nutritional care plan (MUST tool) - Audits are planned to be undertaken.	
• Review trust menus and ensure that it reflects the dietary needs of BMEC groups.	**Catering Manager**	Jan '09	• Trust Menus have been reviewed and sent out for comments. It provides options to meet the BMEC requirements.	
• Undertake Patient Satisfaction survey on new Menu choice to ensure it meets all patients nutritional needs	**Monitoring Manager – facilities**	March '09		
• Improve access to ward information on nutrition and healthy eating options.	**Dietetics Service Manager**	Sept '08	• Healthy eating booklets have been distributed to wards. • Patients are encouraged to contact the Health Information service in the PSC.	

PATIENT EXPERIENCE ACTION PLAN

HYGIENE

Executive Lead: Rachel Stevens

Group Chair: Rachel Stevens

Status key:	5	Complete	4	On track	3	Some delay – expect to complete as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Outcomes:

- Patient satisfaction survey and local audits will show improved patient experiences.
- Essence of Care audits will demonstrate measurable improvements in ensuring patients' basic care needs are met.
- Patients will be actively involved when possible in their treatment plan.
- Ward will have systems in place to ensure equipments are appropriate clean to maintain good hygiene standards
- Staff are trained in continence management and there is a reduction in continence products expenditure
- User feedback is an integral part of service improvement action plans

Actions	Lead	Target Date	Progress	Status
• Undertake documentation and EOC observational audits to assess to what extent patients have their basic hygiene care needs met.	**EOC lead**	April '08	• EOC audit completed in April '08 – results feedback to all relevant groups and action plans are being submitted to EOC leads by September 2008.	
• Ensure that the EOC audit results for continence and hygiene are integrated into local action plans for improvement.	**Matrons**	July'08	• Action plans have submitted to EOC to address these issues at ward level. EOC steering group monitoring completion of plans.	
• Undertaken patient surveys locally to assess level of which patients feel their hygiene needs have been met.	**ADN – Patient Experience/ Matrons**	Feb '09	• SNAP survey IT package purchased in order to affect Palm Pad local ward audits. • Small focus groups to be established to develop standardised questionnaires.	

• Undertake corporate continence audit and feedback a result to staff in order to raise awareness, develop a service improvement plan to track improve improvements.	**Continence Team**	Sept' 08	• Continence audit carried out early in 2008 – presented to SNF in August and will be feedback to ward areas. • Continent Nurses are commencing weekly review of Patient notes/care plans to determine standards of care relating in particular to catheterisation. • Working with L&D there is a 12 month rolling programmes which covers 5 modules on continence care – update to courses poor therefore there is a focus an increased in staff training on the wards.	
• TENA (providers) in conjunction with Continence team carry out quarterly audits on Products cost and usage. The results will be reported to the Patient Experience Group and serve to inform current practice and improve standards.	**Continence Team/TENA**	Quarterly Commencing in Qtr 3 08/09		
• Undertake corporate Tissue Viability audit feedback audit result to staff in order to raise awareness developing a service improvement plan.	**Head of Tissue Viability**	Sept '08	• Improvement in data collection and increased training provision.	
• As a result of increased training provision and data collection, undertake bi annual audits to confirm improvements in patient care	**Head of Tissue Viability**	Quarterly Commencing in Qtr 3 08/09		
• Patients' care plan to include patient involvement and participation in care to ensure that staffs empower patients in self care when and where appropriate.	**Matrons/EOC lead**	Dec '08		
• Following the implementation of new Admission assessment document, undertake audit to confirm compliance and improvements in patient care	**EOC Lead**	March '09		

• Provide patients with disposable hand wipes or access to hand cleaning facility especially at meal times and after use of commode.	**Matrons/Ward Managers**	Sept '08	• Ward Managers are in the progress of ensuring stocks are available and accessible for patients.	
• Ensure that commodes are cleaned between patients according to standards set by DOH.	**Facilities Manager/Ward Managers**	Oct '08	• Cleaning Equipment schedule developed which includes commodes and in the process of being implemented.	
• Undertake audits quarterly to confirm compliance and improved patient experience.	**EOC Lead**	Quarterly Commencing in Qtr 3 08/09		
• Promote patient option of washing daily e.g. bath / shower / bowl and ensure their choice is communicated within the Care Plan.	**Ward Managers**	Aug '08	• The choice of washing is included in the new admission documentation and care plans.	
• Undertake audits quarterly to confirm compliance and improved patient experience.	**EOC Lead**	Quarterly Commencing in Qtr 3 08/09		
• Explore cost of toiletries dispensers and standardisation of products used for hygiene needs across the trust e.g. toothbrush / toothpaste / wash bag.	**Facilities Project Manager**	Nov '08	• Facilitates is currently exploring this option with different providers.	
• Ensure patients have easy access to Chiropody / Manicurist for fingernails.	**ADN Therapies**	Dec '08		
• Develop plans for the introduction of mobile Hairdresser / Barber on call	**Facilities Project Manager**	Dec '08	• Hairdressing facility is available on City site – discussions to review service Trustwide is taking place. • Rowley Regis contracted terminated deputy DGM Med B to review.	

PATIENT EXPERIENCE ACTION PLAN

COMMUNICATION & INFORMATION
(Encompasses staff attitude)

Executive Lead: Rachel Stevens

Group Chair: Rachel Stevens

Status key:	5	Complete	4	On track	3	Some delay – expect to complete as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Outcomes:

- There will be a demonstrable reduction in the number of PALS concerns and formal complaints from patients/users to the trust in relation to overall communication and information
- Patients/users will be spoken to in a polite and respectful manner.
- All written communication will be in accordance with the 'Plain English' campaign and of a high quality.
- Information produced in other languages will be validated by accredited translation service.
- Wards and departments will operate a "meet and greet" and "farewell" standard for all patients and visitors.
- Patient satisfaction survey and local audits will show improved patients' experiences.

Actions	Lead	Target Date	Progress	Status
• Review Trust Induction Program and ensure that it includes Customer service/relations for all new Employees.	**Head of Learning & Development**	Sept '08	• Reviewed and revised version of Trust Induction Programme implemented which now includes ½ interactive sessions.	
• Develop and introduce corporate communication standards as part of the Trust Communication Strategy.	**Head of Communications & Engagement**	Dec'08	• Standards exist within the current strategy. Revised (although largely unchanged) standards exist in draft form and will accompany the new Trust communications strategy which will be presented to the Trust Board in December 2008 following sufficient time for consultation and development through engagement. The Communications team held a workshop on the Strategy in October.	

• Customise EIDO and launch information database on intranet. Together with internal ratified Patient information leaflets	**Head of Communications & Engagement**	Sept '08	• Link from Internet to Intranet have been completed to improve usage as only some consultants are currently using EIDO. • EDIO was publicised to consultants in the summer 2008. Capacity issues have made it difficult to fully customise each of the leaflets.	
• Implement ward based user satisfaction audits using Palm Pads.	**Head of Communications & Engagement**	Mar '09	• Demonstrations have taken place from four companies, together with further development of software to ensure it meets Trust needs. A paper is due to go to the Executive Team in November.	
• Develop and introduce customer service competencies that all staff are required to achieve and maintain – to be delivered in conjunction with the Optimal Ward program.	**Head of Learning and Development**	Dec '08	• Learning and Development have developed Customer Service competencies which are being led by Sonia Oliver. Ward by ward approach is being adopted in line with the Optimal ward initiative	
• Individual ward profile folders to be developed and implemented and accessible to patients to improve communication and information	**Productive Ward Facilitator**	Jan '09	• Ward profiles are being developed in conjunction with Ward Managers	
• Develop website for all wards	**Productive Ward Facilitator**	Jan '09	• Work with Ward managers is on-going in the development of their websites.	
• Information boards to be introduced for each ward showing key performance indicators within the organisation.	**Productive Ward Facilitator**	Sept '08	• Information boards are now in place outside pilot clinical areas on the city site	
• Improve signage with display boards, plasma information screens and expansion of information boards trust wide.	**Productive Ward Facilitator**	Sept '08	• Plasma screens are currently installed and functional in A&E and the BTC – work in progress to expand across Sandwell site.	
• Promote the Patient Support Centre [PSC] health information service to patients and users to enable wider access to information.	**Head of Patient Experience**	July '08	• PSC open day held in June '08. Update by staff and patients have improved. Staff awareness is ongoing.	

• Improve handover of patient information including use of MDT white boards.	**Productive Ward team Optimal ward project**	Sept '08	• Boards have been introduced onto relevant pilot wards with a view to expand across the organisation.	
• Introduce Information on Prescription (HOB).	**Patient Information Lead**	Oct '08	• Currently available within the BTC, working towards achieving this outcome on the wards.	
• Improvements in Admission & Discharge Advice for asylum seekers and migrant communities.	**E&D Lead**	Jan '09		
• Review media formats on how best to address the barriers in relation to the Mental Capacity Act and vulnerable adults.	**Vulnerable Adults lead/ Head of Communications**	Aug'08		
• Ensure there is adequate information regarding public health targets (e.g. substance misuse, obesity, self harm) are provided in appropriate formats.	**ADN Therapies**	Dec '08		
• Analysis of Patient survey and data to identify potential or actual barriers and inequalities	**Head of Communications**	Mar '09 Ongoing	• Presented to the Patient Experience Group. Further work underway	
• Develop and produce appropriate media format to address specific needs of diverse groups	**Head of Communications**	Mar '09	• Work starting with film companies to look at options. Plans for other formats in development.	
• Develop meet, greet and farewell standards for all areas	**Matrons**	Oct '08		
• Recruit and implement Meeters and Greeters volunteers for ward.	**Ward Project Facilitator**	Sept'08	• Volunteers have been recruited, and attended Induction – waiting CRB clearance	

• Develop and Implement Supportive Care pathway in accordance with the National End of Life Strategy (July 2008).	**Bereavement & Supportive Care pathway Co-ordinator (SCP)**	Dec '08	• Pathway developed with support from Pan-Birmingham Palliative Care Network. • Piloted on Elisa Tinsley Ward at Rowley – pre & post audit completed. • Audit recommendation – fulltime SCP facilitator, recruitment in progress. • Teaching packing for all disciplines and staff has been developed and delivered to all wards. • Website information available to all staff. • Roll-out implementation completed. • Algorithm for symptom control completed and distributed to all clinical areas.	
• In order to ensure that end of life patients' experience meets gold standard all patients are registered with the bereavement team to ensure seamless care.	**Bereavement & Supportive Care pathway Co-ordinator (SCP)**	Feb'09	• Exploring suitable IT system to support the implementation of an electronic register.	
• Improve breaking bad news practice through use of updated policy and comprehensive training programme	**Palliative Care Lead Nurse**	Dec'08	• Review of Breaking Bad News Policy is being undertaken. • Rolling training programme for breaking bad news is on-ongoing.	
• Specialist palliative care nurses to support clinical areas and patients with symptom control.	**Palliative Care Lead Nurse**	Sept '08	• Increased training and awareness for staff on the wards. • Appointment of Lead Nurse who is currently reviewing service. • Appointment of matron for Haematology/oncology who is also reviewing services to improve the patient experience.	

PATIENT EXPERIENCE ACTION PLAN

APPOINTMENTS

Executive Lead: Rachel Stevens

Group Chair: Rachel Stevens

	Status key:	5	Complete	4	On track	3	Some delay – expect to complete as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised	

Outcomes:

- There will be a demonstrable reduction in the number of PALS concerns and formal complaints from patients/users to the trust in relation to appointments
- Patients/users will be able to access the appointment system without delay or complications
- GPs will be provided with accurate and real time information about our services via our improved 'Choose and Book' homepage.
- There will be reduction DNA rates with better information sent out in patient letters.
- Protocols in place will ensure that patients with specialist needs are accessing services appropriately.
- Patient satisfaction survey and local audits will show improved patients' experiences.

Actions	Lead	Target Date	Progress	Status
• Audit interpreter usage at clinic appointments and introduce robust processes to ensure appropriate use of service.	**ADN Workforce & Strategy**	Dec '08		
• Undertake appointment system review to identify services that manage their appointments and ensure that they comply with the agreed standards for appointments system and produce a service improvement plan.	**Deputy Director of IM&T**	Nov '08	• Centralised system reviewed - the processes for making new appointments have been changed – An appointment date is now sent directly to pt following triage of referral letter instead of pt invite letter under choice. • Simple triage system has been improved to triage referral within 24 – 48 hrs. • Choose and Book on-line booking is available to patients. • Review of other appointment services outside the centralised system to take following agreed standard of service. • Rescheduling and cancellation services for clinic	

			have been centralised to make a more effective service.	
• Undertake a baseline audit of the appointment resources and activities to include a Gap analysis for future provision of speciality teams.	**Deputy Director of IM&T**	Dec '08	• Referral team is now centralised and will be working to speciality based teams on an incremental phase approach, to be completed by the end of the year - this will create better understanding booking rules, codes and the service.	
• Review the processes of the 2 weeks rapid access clinic to streamline across the Trust and improve patient access and pathways	**Deputy Director of IM&T**	Oct '08	• Proposal has been drafted to improve a more efficient service across the Trust. Meeting to be arranged with Consultants and Divisional team to move this forward.	
• Design a page on the Trust GP homepage about Choose and book and our directory of services to provide better information about our services	**Deputy Director of IM&T**	Nov '08		
• Review sample of patient appointments letters and develop Trust templates to ensure the quality and clarity of appointments letters sent to patients. Letters are sent out in realistic timescales to reduce DNAs.	**Deputy Director of IM&T**	Nov '08	• Review of appointments letters was completed in Aug 07 and further to be completed in light of patient access. • Appointment date is sent directly to pt following triage of referral letter instead of pt invite letter under choice. This has improved	
• Explore and introduce different modes of patient communication e.g. texting and emails to reduce DNA and improve patient experience.	**Deputy Director of IM&T**	Jan '09	• New practice of sending out appointment date initially appears to have influence the DNA rate positive. • Currently exploring 'VOICESAGE' automated telephone reminder service – looking to pilot in Ophthalmology and Paediatrics.	
• In accordance with Single Equality Scheme provide quarterly reports outlining demography in relation to access to services uptake of local communities.	**Richard Kirby**	Oct '08	• Service redesign teams and 2010 project team have undertaken demography analysis.	
• Develop and implement protocol to address specialist need of patients include trigger mechanism and formats for sending information to patients with mental health issues, Dyslexia etc, to ensure equity in accessing service.	**Deputy Director of IM&T /VAP lead/ Head of Comms & Engagement**	Mar '09	▪ Explore Focus groups to understand the issues and the way forward.	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Annual health check 2007/08 – Trust performance report
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	Mike Harding, Head of Planning & Performance Management
DATE OF MEETING:	6 November 2008

KEY POINTS:

To formally report the Healthcare Commission's assessment as to the Trusts Quality of services and Use of Resources in respect of the period 1 April 2007 to 31 March 2008.

The Report confirms that:

The Trust's ratings for 2007 / 2008 are:

- **GOOD for Quality of Services**, and
- **GOOD for Use of Resources.**

Disclosure is made of areas of non-compliance and the Trust's scores are set in the context of national results for all organisations.

PURPOSE OF THE REPORT:

✓ For Noting

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to:

NOTE the outcome of the annual Health Check process in respect of 07/08

And;

RECEIVE plans designed to deliver further improvements in future

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Performance against the Healthcare Commission's annual health check contributes towards the delivery of several of the Trust's strategic objectives for 2008/09:

- Accessible and Responsive Care
- High Quality Care
- Good Use of Resources
- An Effective NHS Foundation Trust

IMPACT ASSESSMENT:

FINANCIAL	☑	The Use of Resources element of the Annual Health Check comprises 5 areas of assessment of the Trust's management of its finances.
ALE	☑	The Use of Resources element of the Annual Health Check is inextricably linked to the Audit Commission's Auditors Local Evaluation (ALE) assessment.
CLINICAL	☑	The Quality of Services element of the Annual Health Check comprises a number of indicators of performance directly linked to the improvement of clinical quality.
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

ANNUAL HEALTH CHECK: 2007 / 2008 PERFORMANCE RATINGS

INTRODUCTION:

On the 16th October 2008 the Healthcare Commission published the results of the Annual Health Check for the year up to 31st March 2008. Every organisation is given a rating which is comprised of two parts – Quality of Services and Use of Resources, both rated on a scale of WEAK, FAIR, GOOD and EXCELLENT.

The Trust's ratings for 2007 / 2008 are:

- **GOOD for Quality of Services**, and
- **GOOD for Use of Resources.**

The table below summarises the performance of the Trust during the three years of the annual health check.

	2005 / 06	2006 / 07	2007 / 08
Quality of Services	**FAIR**	**GOOD**	**GOOD**
Use of Resources	**WEAK**	**FAIR**	**GOOD**

This year's ratings reflect the Trust's ability to maintain its quality of care, whilst continuing to improve the way in which it manages its resources.

This report provides a summary of the results for 2007 / 2008.

QUALITY OF SERVICES:

Quality of Services comprises 3 components:

1) Meeting Core Standards
2) Existing National Targets, and
3) New National Targets

The Trust scored Good for Quality of Services, and would have scored Excellent if it had scored 'Fully Met' for Core Standards. National performance for Quality of Services is indicated in the table below:

Excellent	30.3%
Good	**46.7%**
Fair	18.9%
Weak	4.1%

1) Meeting Core Standards

The rating for this component is on a scale of Not Met, Partly Met, Almost Met and Fully Met. The Trust was rated **Almost Met**, defined as '*meeting almost all of the Core Standards set by the government'.* The Trust rating during 2005 / 2006 and 2006 / 2007 for this component was similarly, Almost Met.

National Performance for meeting Core Standards (%)	
Fully Met	69.8
Almost Met	**23.7**
Partly Met	4.7
Not Met	1.8

The Core Standards are made up of seven key areas of health and healthcare and include such areas as infection control, patient care and environment, safety and clinical and cost effectiveness.

The Trust's Core and developmental standards declaration for 2007 / 2008 identified three standards as not being met (out of 43 in total);

- C04b – Safe Use of Medical Devices
- C07e - Discrimination
- C08b – Personal Development

All elements of non-compliance relating to these standards have been addressed in 2008/09.

2) Meeting Existing Targets

Rating for this component is also on a scale of Not Met, Partly Met, Almost Met and Fully Met. The Trust was rated **Fully Met**, defined as '*performing consistently well for this assessment.'* The Trust rating during 2006 / 2007 was also Fully Met and for 2005 / 2006, Almost Met.

This score is based on whether levels of service set through the Department of Health's 2003 – 2006 planning round are being maintained.

National Performance for meeting Existing Targets (%)	
Fully Met	**71.0**
Almost Met	20.1
Partly Met	5.9
Not Met	3.0

Of the 10 Existing Targets, the Trust:

- Achieved 8
- Underachieved 2
- Failed 0

Targets achieved were:

- Maintain a maximum wait of 26 weeks for inpatients
- Maintain a maximum wait of 13 weeks for an outpatient appointment
- All cancers: Two months urgent referral to treatment
- All cancers: One month diagnosis to treatment
- Provider information in place to support patient choice
- Maintain a 2 week maximum wait for rapid access chest pain clinics
- Total time in A/E: 4 hours or less
- Maintain a 3 month maximum wait for revascularisation

The two targets Underachieved were:

- Cancelled Operations (0.912%) – this represents a modest improvement on 2006 / 2007 (0.971%). Performance for 2008 / 2009 year to date is 1.0%, with no breaches of the 28-day guarantee.
- Cancers: two week wait (97.05%) – performance for 2008 / 2009 year to date is 99.4%.

3) Meeting New Targets

Rating for this component is on a scale of Weak, Fair, Good and Excellent. The Trust was rated **Excellent**, defined as '*performing well beyond the minimum requirements and the reasonable expectations for the new national targets assessment'.* The Trust rating during 2006 / 2007 was Good, and for 2005 / 2006, Fair.

National Performance for meeting New National Targets (%)	
Excellent	**44.9**
Good	42.0
Fair	10.7
Weak	2.4

Of the 10 New National Targets, the Trust:

- Achieved 9
- Underachieved 1
- Failed 0

Targets achieved were:

- Obesity: compliance with NICE Guidance 43
- Drug Misusers: information, screening and referral
- Reduce health inequalities by 2010
- Access to genito-urinary medicine clinics
- Experience of patients
- Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases
- Self-harm: compliance with NICE guidelines
- Ensure that by 2008 nobody waits more than 18 weeks from GP referral to hospital treatment
- Reduce Emergency Bed Days

The Target Underachieved was:

- Achieve year on year reductions in MRSA levels. National performance against this target is illustrated below:

Achieved	50.0%
Underachieved	**40.6%**
Failed	9.4%

A total of 43 cases of MRSA Bacteraemia was reported by the Trust in 2007 / 08, against a trajectory of 33. The actual numbers represent a significant reduction from 2005 / 06 when 108 cases were reported and from 2006 / 07 when 61 cases were reported.

During the first 6 months of 2008 / 09 a total of 8 cases have been reported, against a trajectory for the period of 18 (33 full year).

USE OF RESOURCES:

This score looks at how well an organisation is managing its finances. Scores (1 – 4) for each of 5 areas are based on work carried out as part of the Audit Commission's Auditors Local Evaluation (ALE) Assessment. The five areas covered, with the Trusts score (indicated) are:

- Financial Reporting (3)
- Financial Management (3)
- Financial Standing (3)
- Internal Control (2)
- Value for Money (3)

Score definitions are:

4. Well above minimum requirements – performing strongly
3. Consistently above minimum requirements – performing well
2. Only at minimum requirements – adequate performance
1. Below minimum requirements – inadequate performance

The Healthcare Commission's overall assessment of the Trust is:

'*This organisation has been given a score of good for use of resources as it is performing well. The organisation has met its financial targets for the last two years. Its financial management, financial reporting and consideration of value for money were assessed as good. The arrangements in place appear to be operating effectively'.*

Overall ratings for Use of Resources are on a scale of Weak, Fair, Good and Excellent. National performance is indicated in the table below:

Excellent	39.6%

Good	**24.3%**
Fair	29.0%
Weak	7.1%

CONCLUSION:

The Trust has maintained the Quality of Services offered to patients whilst at the same time continued to improve the management of its Financial Resources, and in doing so achieved its Financial Targets.

The objectives of the Trust include the delivery and demonstration of further sustained improvement such that positive movement is seen as part of the Annual Health Check ratings for 2008 / 2009 when published in 12 months time.

The Trust will, through its Board and supporting sub-committees, continue to monitor performance against the various national and local targets. This process is on-going and identifies any remedial action necessary to address adverse performance. Performance assessment against targets remains a fundamental component of the Trust's Divisional Review process.

The Trust Board is asked to:

NOTE the outcome of the annual Health Check process in respect of 07/08

And;

RECEIVE plans designed to deliver further improvements in future

John Adler
Chief Executive

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance and Performance Management Committee – V0.2

Venue Executive Meeting Room, City Hospital **Date** 25 September 2008; 1430h – 1630h

Members

Mr R Trotman [Chair]
Mrs S Davis
Dr S Sahota
Mrs G Hunjan
Ms I Bartram
Mr J Adler
Mr T Atack
Mr R White

In Attendance

Mr M Harding
Mr P Thomas-Hands [item 2 only]
Mr P Stanaway [item 2 only]
Ms J Smith [item 2 only]

Apologies

Cllr B Thomas
Prof D Alderson
Mr T Wharram
Mr J Adler

Secretariat

Mr S Grainger-Payne [Minutes]

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Cllr Thomas, Derek Alderson and Tony Wharram.	
2 Presentation by Medicine B Division	**SWBFC (9/08) 046**
Roger Trotman welcomed Phillip Thomas-Hands, Paul Stanaway and Jenny Smith, who presented an overview of the performance of Medicine B division. Mr Thomas-Hands explained that the remit of the division mainly concerns Sandwell and Rowley Regis hospitals, although the division also supports clinical haematology and oncology on a Trust-wide basis. On review of the summary activity plan for the division, Mr Trotman noted the significant adverse variance against outpatient follow-up performance. Mr Thomas-Hands advised that this fall is in line with the PCT requirements to ensure that there is an increase in new appointments and less follow-up appointments required. A number of consultants have acknowledged that follow-up appointments are not needed, which together with the introduction of the community respiratory team, has had a good effect on outpatient follow-up performance. The Committee was pleased to hear that reduction in follow-up appointments is likely to have a positive knock-on effect on waiting times.	

The division's CIP target is set at slightly in excess of £1m and is currently on track to being met. Reconfiguration of beds across Sandwell and Rowley hospitals has been undertaken, reducing the number of beds in line with the 2010 trajectory. Sue Davis remarked that the initiative to arrange step-up beds appears to have been under utilised. She was advised that this is due to a reduction in the reliance on beds across the division. Community therapists are also having a positive influence.

In terms of income, emergency activity has slightly under performed against plan. Excess bed day income is currently exceeding contracted levels, consistent with the same period last year, possibly due to the recent Norovirus outbreaks. There has been an improvement overall at setting the contracted performance for the current year, although in the second half of the year performance against contract may drop due to an expected increase in community capacity. Mr Trotman enquired why there was a negative variance against expenditure on agency and bank staff costs, given the decline in elective activity. He was advised that the need to restrict nursing staff on wards suffering Norovirus caused an increased reliance on bank and agency staff to cover duties usually performed by these nurses. It was noted that agency staff costs also include fees payable to some medical agencies for the services of some agency consultants. Gianjeet Hunjan asked if there were vacancies in medical staff across the division. She was informed that there were gaps as a result of consultant sickness absence, where two cardiology consultant posts have had to be temporarily filled by locum staff. Sickness in nursing staff is higher than the Trust target (6% vs. 4.25%). Over the winter however it is expected that this level will reduce as a consequence of measures being put into place to address sickness absence and encourage rehabilitation. Mr Thomas-Hands reported that the new electronic recruitment process is working well allowing maternity leave to be covered quickly. Isobel Bartram asked whether the division was waiting for newly qualified nursing staff to start employment. Mr Thomas-Hands reported that 15 newly qualified nurses have been recruited and induction to the Trust has been efficient. He noted that over recruitment of nursing staff was not successful last year, resulting in poor nursing cover over the winter period, however measures have now been put into place to ensure that the division reaches full nursing establishment.

Non pay issues were discussed, where it was reported that the underspend in-month and year to date relates to drugs and medical consumables.

The priorities for the division were described as being: maintaining financial balance in a time of service reductions and change; improvement in care for the sick; and maintaining the pace of change towards the 2014 models of care, by engaging cardiologists, acute physicians and respiratory consultants.

Mr Thomas-Hands remarked that nursing morale has improved significantly, mainly as a consequence of strong leadership by the Chief Nurse and her team. The Listening into Action approach is also working well, including the recent stroke event. A session to give staff feedback from the patient session is due to be arranged shortly.

Additional focus is planned to improve doctors and nurses integrated working; this will be undertaken once the new acute physicians have arrived on EAU. It is anticipated that the acute physicians will have a positive effect on length of stay for short stay patients, such as stroke patients. Better administration support is now in place to support the ward rounds. As a result, activity is now recorded far more efficiently.

Mr Thomas-Hands was asked to suggest additional measures that can be taken to improve patient experience. He recommended that 'front door' teams should be strengthened and there should be an improvement in the way in which complex

medical patients, such as the elderly are managed. It was suggested that physicians can contribute to these improvements by linking various issues, including social care considerations. Sarindar Sahota asked how wheelchair access was managed by the division. Mr Thomas-Hands explained that Sandwell on the whole, provides good access, particularly into the emergency facilities. Access is not good on some wards however, such as Newton 4 and Lyndon 5. Availability of wheelchairs is good as many have been purchased recently, although management of wheelchairs needs to be improved. Mrs Davis concurred with the view that availability of wheelchairs should be maintained where possible. Robert White noted that Medicine B had submitted an exception report for consideration by the Financial Management Board. Mr Thomas-Hands reported that there was no slippage on bank savings by year end, however the reduction in bank and agency expenditure will not be achieved in line with the initial timescales, as the phasing of new nursing staff is different to first anticipated. Mr Trotman thanked Mr Thomas-Hands, Mr Stanaway and Ms Smith for the informative presentation.	
3 Minutes of the previous meeting	**SWBFC (8/08) 041**
It was suggested that amendment to the minutes of the previous meeting should be made to reflect the discussions regarding equal pay claims expenditure and capital catering investment within the financial position and forecast section. Subject to these amendments, the minutes were accepted as a true and accurate reflection of discussions held on 28 August 08.	
ACTION: **Simon Grainger-Payne to amend the minutes of the meeting held on 28 August 08** **AGREEMENT:** **Subject to the amendments proposed, the minutes of the previous meeting were approved**	
4 Matters arising from the previous meeting	**SWBFC (8/08) 041 (a)**
There were no outstanding actions.	
5 Trust Board performance management reports	
5.1 2008/09 month 5 financial position and forecast	**SWBFC (9/08) 043** **SWBFC (9/08) 043 (a)** **SWBFC (9/08) 043 (b)**
The Committee was pleased to hear that all divisions reported an in-month surplus, resulting in an overall surplus of £369k being achieved against a target of £248k, £121k ahead of plan. The year to date surplus was reported to be £1,625k. A year end forecast of £2.5m surplus continues to be anticipated. Activity was reported to be strong for both commissioners. In-month WTEs are 183 below plan and cash balance was reported to be £4.3m below plan as at 31 August 08. Capital expenditure has risen by £1m in month, principally due to the acceleration of the pathology reconfiguration and neonatal unit development. It was requested that an analysis of capital expenditure approvals should be included in the report to	

show the lag between approval and actual expenditure incurred. It was suggested that this information is contained within the appendix detailing commitments. Pay costs were noted to be higher than budgeted levels as a consequence of waiting list initiatives and increased activity. A discussion ensued regarding the ongoing presentation of significant underspending arising from vacancies being offset against unbudgeted bank and agency spending. Mr White explained that this is a function of assumptions made that divisions will attempt to reach full establishment during the year whereas the reality is that this rarely occurs. There is a challenge in identifying the most appropriate level especially as the organisation should be discouraging any planned use of external agencies. This issue will be given formal consideration during the financial planning period commencing in November so that sufficient time exists to amend 09/10 budgets. Mr White agreed to liaise with Tony Wharram in order to identify any proposed changes. Sue Davis suggested that information from HR and medical staffing, including maternity leave information could be used to inform any analysis. Planned and actual cash balances were reviewed. Significant payments in-month relate to 2010 project fees. The cash position remains strong at £24m as at the end of August, which is reflected in the positive interest earnings.	
ACTION: **Robert White to consider changes to the presentation of underspending arising from vacancies being offset against unbudgeted bank and agency spending as part of establishing 09/10 budgets**	
5.2 Performance monitoring report	**SWBFC (9/08) 044** **SWBFC (9/08) 044 (a)**
Mike Harding presented the Trust's summary performance for the period July 2008. Cancelled operations information is now represented by speciality and target reductions for each are assigned. The percentage overall increased slightly during August, given the lower number of operations performed. Given feedback that the current numerical targets by specialty were too ambitious, there are plans to amend them such that they align to the overall (%) target. Thresholds have now been established for theatre performance, which monitor late starts and early finishes. It was recommended that targets for early finishes may need to be more flexible, extending to a 30 minute trigger. There is much work to be done to improve theatres' performance, although the current focus is on surgical reconfiguration and meeting the 18 week waiting times. It is anticipated that the Listening into Action initiatives will assist with this work. During the next financial year there will be much effort dedicated to increasing theatre productivity, although measures are underway at present to revise the preoperative processes and maximise the utilisation of main spine theatres. Delayed transfers of care increased to 3.3% during August, predominantly due to an increase at the Sandwell site. There is a possibility that this target will be impacted over the next few months by the closure of a major nursing home in HoB, which represents the loss of 1-2 beds per month. Regular updates regarding the situation are being received from HoB. The situation may be exacerbated by the delayed opening of a care centre in HoB due to an issue with the nurse call centre, although there are plans to open this within the next 2-4 weeks. Winter plans may however be jeopardised if this is delayed. Four months of primary angioplasty performance data is included within the report, which reports that 82% eligible patients have received primary angioplasty within 90	

minutes 'call to balloon' time.

Stroke data has been verified and shown to be correct: only 22% stroke patients spend in excess of 90% of the time of their stay on a stroke unit. There are a number of reasons for this, mainly concerning the pathways of care involved: of the 6-7 days a short stay stroke patient may stay in the hospital, one of these is spent on EAU or MAU; interim beds are being used in the case of delayed discharge; some patients are treated for palliative care rather than being directed to a stroke unit. It is anticipated that many of the issue may be resolved through the Listening into Action event around stroke planned shortly, where the stroke pathways will be reviewed. During discussions regarding the LDP, the Trust's commissioners acknowledged a need to look at stroke in the context of appropriate clinical care, suggesting that there may be funding available to address stroke performance.

GU Medicine performance further improved during August with 86.5% of patients being seen within 48 hours of contacting the service, increasing the year to date performance to 74.5%. Patients offered an appointment was 100% for the third consecutive month.

Continued vigilance has been urged following the two MRSA bacteraemia cases reported during the period; one case was pre 48-hour and is therefore not classified as attributable to the hospital stay.

Completeness of coding of ethnic origin has fallen to 83%, although a plan is in place to address this, including the introduction of new monitoring reports and engagement of the ward clerks and receptionists in the collection of data.

RTT (Admitted Care and Non-Admitted Care) data was reported to be 95.4% for non-admitted care patients and 94.1% for admitted patients. A number of diagnostic waits in excess of six weeks were reported, all attributed to audiology. Reasons for these delays include staff annual leave and staff working term time only. Roger Trotman asked what effect a patient declining the offer of an appointment due to holiday commitments had on the diagnostic waiting time target. He was advised that any delay caused by the need to reschedule would still count within the Trust's target; if the patient does not attend however and needs to be rescheduled, the target is suspended.

Activity levels were noted to have dipped during August, although the position is still healthy year to date. A 1% drop has been seen in elective activity and a 2% drop in outpatient. The overall good position is largely due to the increased outpatient referrals. As outpatient referrals are anticipated to continue strongly, no decline in activity is expected.

Length of stay has increased for patients staying both in excess of 14 days and in excess of 28 days. A significant increase has been seen at the City site in particular.

Ambulance turnaround times are now reported against targets set for the proportion of individual events in excess of 30 minutes and 60 minutes. The Trust is performing well against the 60 minutes target in comparison to other Trusts in the region and satisfactorily against the 30 minutes target. The SHA is currently developing an agreed protocol for measuring and reporting ambulance turnaround times. It is likely that it will be proposed that 90% cases should be handled in 30 minutes or less and any case in excess of 60 minutes will be treated as a serious incident. It is notable that during the recent acute bed issues, ambulance turnaround performance only deteriorated slightly, suggesting that the improvement seen is predominantly due to more effective management of ambulance crews by WMAS.

The number of PDRs submitted is 3216, representing over 60% of the 2008/09 target

now being met.	
6 Cost improvement programme (2008/09)	
6.1 CIP delivery report	**SWBFC (9/08) 045** **SWBFC (9/08) 045 (a)** **SWBFC (9/08) 045 (b)** **SWBFC (9/08) 045 (c)**
RW reported that the position has improved since the previous month, with the programme on course to deliver by year end.	
7 Minutes for noting	
7.1 Minutes of the Financial Management Board	**SWBFM (8/08) 043**
The minutes of the FMB held on 28 August 08 were noted by the Committee.	
7.2 Minutes if the Strategic Investment Review Group	**SWBFC (9/08) 047**
The Committee noted the minutes of the SIRG on 19 August 08.	
7.3 Summary of decisions from SIRG	**SWBFC (9/08) 048**
The Committee noted the summary of decisions arising from the meeting of SIRG held on 5 September 08.	
8 Any other business	**Verbal**
There was none.	
9 Details of next meeting	**Verbal**
The next meeting is planned for 30 October 2008 at 1430h in the Ground Floor Meeting Room, Sandwell Hospital.	

Signed .....

Print .....

Date .....

MINUTES

Audit Committee – Version 0.2

Venue Executive Meeting Room, City Hospital **Date** 11 September 2008; 1000h – 1130h

Members

Mrs G Hunjan [Chair]
Ms I Bartram

In Attendance

Mr R White
Mr P Dudfield
Ms R Chaudray
Mr P Westwood
Mr M McDonagh
Ms S-A Moore

Apologies

Cllr B Thomas
Mr R Trotman
Dr S Sahota
Prof D Alderson
Mr J Adler

Secretariat [Minutes]
Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Cllr Bill Thomas, Mr Roger Trotman, Dr Sahota, Professor Derek Alderson and Mr John Adler.	
2 Minutes of the previous meetings	**SWBAC (5/08) 013** **SWBAC (6/08) 020**
Subject to slight amendment the minutes of the meetings held on 8 May 08 and 19 June 08 were agreed to be a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meetings	**SWBAC (5/08) 013 (a)**
An update on all actions raised at previous meetings was given. All actions have been completed since the last meeting.	
3.1 Recovery of charges from overseas visitors	**SWBAC (9/08) 028** **SWBAC (9/08) 028 (a)**
Robert White presented a summary of the existing policy that governs payment taking and recovery of debts for treatment of overseas visitors. The majority of treatment is medical emergency and cardiology cases in particular. Communication of the policy requirements is an issue that needs to be addressed, particularly as recovery of debts for visitors returning to their home country is a	

difficulty. Proposals are being considered regarding the introduction of enhanced cover responsible for payment-taking in clinical areas outside office hours. A cost:benefit analysis may reveal poor VfM but this will be looked at to decide next steps. Contact with other Trusts has occurred and the Trust has confirmed that they too have policies based on DH guidance. Isobel Bartram enquired what the definition of visitors was in the context of this policy. She was advised that this was people not eligible to live in the UK. Clarity as to what constitutes acceptable identification for proof of identity needs to be confirmed, to address the issue of identity fraud. The chair asked for an indication of the income attributed to overseas visitors. She was informed that this amounts to less than £100k, with a proportion written off each year as unrecoverable. Mr White offered to determine the trend of uncollected debts from overseas visitors and to consider whether the requirements of the policy could be incorporated into Mandatory Training, particularly within the area of Cardiology.	
ACTION: **Robert White to determine the trend of uncollected debts from overseas visitors** **ACTION:** **Robert White to consider incorporating the requirements of the recovery of overseas visitor debts within an appropriate Mandatory Training package**	
3.2 Management costs	**SWBAC (9/08) 032**
In response to a request at the May meeting, Robert White provided a summary of the changes in management costs from the previous financial year. The Committee was advised that the majority of the cost change is attributed to inflation and increments required as a consequence of the Agenda for Change implementation. Expenditure on agency staff is also a major contributor, with an increase of £259k. It was noted that the in-year movement, vacancies and definitional changes makes the analysis unclear in terms of WTE increases or the identification of specific posts. Any further analysis to determine the position in greater detail is possible, however this needs to be evaluated in terms of benefit, cost and resources required. The committee confirmed however that it understood the analysis of how costs have changed from one year to next.	
4 External Audit matters	
4.1 External audit plan 2008/09	**SWBAC (9/08) 023**
Mike McDonagh presented the external audit plan 2008/09, which covers two scenarios for the current financial year: the first assumes that Foundation Trust status will be authorised and the second covers the eventuality that the Trust remains as an Acute Trust. The audit fees for each scenario vary to reflect this difference in status.	

Should the Trust retain its status as an Acute trust, the audit fees on a like for like basis are less for 2008/09 than those for 2007/08. This is in reflection of the strong year end and the improved ALE assessment process. The fee proposed is £198,800 + VAT. The external audit team for the current year will comprise Mr McDonagh, supported by Sarah-Ann Moore and Chloe Bowes. It was confirmed that KPMG will not be involved in the Historical Due Diligence exercise planned for October 08. The chair thanked Mr McDonagh for the useful report.	
4.2 Annual audit letter	**SWBAC (9/08) 024**
Mike McDonagh presented the annual audit letter, which summarises key issues arising from the work of external audit during 2007/08. The themes within the letter have been discussed previously, particularly the outcome of the ALE assessment and requirements for improving the Trust's performance against these standards in future years. The official ALE scores are expected to be published shortly. It was agreed that the annual audit letter should be presented at the next Trust Board meeting. A debrief of the experience of the external audit with members of the Trust has not yet been held. KPMG was asked to expedite this review. It was noted that the year end closure is due to be earlier for 2008/09 (draft accounts ready by 23rd April 2009 and Audited accounts submitted by Friday 12th June 2009). Simon Grainger-Payne was asked to schedule into the corporate meeting plan, the extraordinary meeting at which the annual accounts need to be approved by the Audit Committee.	
ACTION: Mike McDonagh to expedite the debrief session, following the completion of the year end accounts process **ACTION: Simon Grainger-Payne to schedule the special meeting of the Audit Committee at which the annual accounts are reviewed**	
5 Internal Audit matters	
5.1 Internal audit progress report and recommendations tracking	**SWBAC (9/08) 034** **SWBAC (9/08) 034 (a)**
Paul Dudfield advised that progress is on track with the internal audit programme of work for the current year. Since the meeting of the Audit Committee in May, internal audit has been engaged with audits covering a number of areas including: Charitable Funds; information governance; and KSF development/appraisal process. Additional support has also been given to the new hospital project group and to the development of work to introduce the electronic staff record. The Committee was pleased to note that all outstanding high priority recommendations raised have been cleared and of the total 23 recommendations	

raised, only 5 medium priority recommendations remain open. It was noted that there is a gap between the draft audit report and the final audit reports being issued. The target is to issue the final report within 10 days of the draft, however this may be slightly longer dependent on the timeliness of responses to the recommendations. Robert White asked to be contacted in the event that there is a difficulty or a delay in obtaining a response to an audit report issued.	
5.2 Internal audit reports	**SWBAC (9/08) 035** **SWBAC (9/08) 035 (a)**
Rubina Chaudray informed the Audit Committee of the final internal audit reports issued since the May meeting. Reports focussed on capital projects; information governance; and payment by results have been issued, all of which were audits included in the 2007/08 internal audit schedule. It was agreed for future meetings of the Committee that reports for those audits providing 'limited assurance only' need to be presented in full; audit reports providing significant assurance need to be communicated but do not need to be presented in full at the meetings. The Chair asked for a summary of the process by which a final audit report is issued. Paul Dudfield advised that following the initial fieldwork, a draft report is issued for the input of the Executive lead and operational managers, after which the final report is then issued. Start to end, the process spans six weeks. The chair suggested that measures to streamline the process may need to be considered over future months. Isobel Bartram enquired where incidents of loss of data are reported. She was advised that these are reported at the Governance Board and discussed at the Governance and Risk Management Committee. It was noted that disclosure of data loss is required to different bodies according to the severity of the incident and nature of data lost. Robert White summarised the disclosure criteria which depended upon the number of records lost and/or patients affected.	
5.3 Review of Counter Fraud	**SWBAC (9/08) 030** **SWBAC (9/08) 030 (a)**
Paul Westwood, the new Local Counter Fraud Specialist, presented an update on progress made towards the achievement of the 2008/09 counter fraud work plan. Progress with the delivery of work is well underway with 25% of the agreed work plan completed as at August 2008. A weekly presentation is now delivered by the LCFS at the corporate induction programme to all new staff joining the Trust. To date 153 members of staff have received the presentation and feedback has been positive. The work plan has also involved handling a recruitment advertising scam which had occurred at other Trusts and recently at a nearby NHS organisation. A staff brief was prepared to ensure staff were aware of this activity. Work has also been undertaken in line with the National Fraud Initiative 2008. The chair expressed her support for this work.	

Isobel Bartram noted that the instances of staff fraudulently being employed at two different places of work has declined significantly from previous reports. Mr Westwood was asked to include a summary table in the next report which shows the cases being handled according to type and severity.	
ACTION: Paul Westwood to include a summary of fraud cases being handled in the next version of the counter fraud report	
5.4 BSIAC merger arrangements	**SWBAC (9/08) 036** **SWBAC (9/08) 036 (a)**
Paul Dudfield reported that the merger of the two consortia, BSIAC and CWAS has been agreed in principle and a business case has been prepared outlining the plans. The proposal has also been presented to the SWBH Trust Board and the CW audit Board and accepted, subject to a couple of caveats that are being addressed. The main benefits of the merger are intangible, however the financial benefits will be clarified shortly when the staffing model has been settled. It is clear however that the robustness of the organisation within the marketplace will be improved by the plans. The staff consultation period is due to start imminently and various staff meetings have been completed which have explained the proposals to the staff. All staff are in favour of the plans. TUPE framework considerations have been taken into account as part of the merger plans. The structure of the organisation will be slightly different and will be led by Warwickshire audit. The business case is due to be presented to the Warwickshire PCT Board shortly and approval is anticipated.	
6 Review of losses and special payments	**SWBAC (9/08) 029** **SWBAC (9/08) 029 (a)** **SWBAC (9/08) 029 (b)**
Peter Smith's paper asked the Audit Committee to note the losses and compensation payments made by the Trust in the period 1 April 08 to 31 August 08. Year to date 469 individual cases of losses and special payments have been made, totalling £189k. All payments are below the limits stipulated by the NHSLA.	
6.1 Pharmacy losses and accounting treatment	**SWBAC (9/08) 026** **SWBAC (9/08) 026 (a)**
In response to the request made at the May meeting of the Audit Committee, Robert White presented a summary of the process for tracking the value of 'spoiled' or expired drugs stocks. Expiry of drugs occurs for a number of reasons, including special medicines being prepared for patients that do not then attend or require a change in their treatment plan. A number of unforeseen events have also required an amount of drugs to be written, including fridge failures and flooding. The Committee noted that in July and August the write offs for pharmacy losses had	

greatly reduced. It was proposed that the current mechanism for identifying and reporting losses in respect of expired stock is adequate and should remain unchanged. The current accounting treatment for expired stocks is also proposed to remain unchanged. The Committee agreed to this approach.	
AGREEMENT: The Audit Committee agreed that the current accounting treatment for expired drugs stocks and the method of identifying and reporting losses of drugs remains unchanged	
7 Review of debtors report	**SWBAC (9/08) 027** **SWBAC (9/08) 027 (a)** **SWBAC (9/08) 027 (b)**
Robert White presented the latest position regarding key debtors, outstanding payments due, action taken and planned to collect the debts. Excluding the impairment debtor, overdue balances amount to c. £3.5m, the majority of which is attributed to the current year. Financial accountants are assigned to each of the outstanding debts and have responsibility for recovering payment. The Committee noted the outstanding debt and endorsed the actions required to pursue payment of the amounts.	
AGREEMENT: The Audit Committee endorsed the actions required to pursue recovery of outstanding debts	
8 Assurance Framework	**SWBAC (9/08) 025** **SWBAC (9/08) 025 (a)**
Simon Grainger-Payne presented the quarterly update on the assurance framework. The plans to address the gaps in control and assurance against the Trust's corporate objectives are largely on track. Although there has been some delay in implementing the plans to address the gaps against three of the corporate objectives, they are still expected to be completed as planned. The Audit Committee noted the update.	
9 Self assessment of Committee's effectiveness	**SWBAC (9/08) 022** **SWBAC (9/08) 022 (a)**
Paul Dudfield outlined the Trust's position against the recommended checklist of performance indicators in the NHS Audit Committee Handbook. The Trust is compliant for all 'must do' requirements, however the position against a number of 'should do' and 'could do' indicators is unclear, therefore the Committee was asked to assess its position against these. The following position and actions against each of the indicators were agreed to be as follows: Training for new members to the Committee – it was agreed that further training may be required to upskill the current members of the Audit Committee. Simon	

Grainger-Payne offered to source local Audit Committee networks and possible Audit Committee training offered by external suppliers that may be useful for members. Mike McDonagh offered to investigate bespoke training for Audit Committee members and provide feedback at the December meeting of the Audit Committee Review of reports – it was agreed that work is underway to address this requirement, particularly with the introduction of the new front sheet for papers and the incorporation of feedback at the meetings into future versions of standard reports Internal Audit performance measures – it was agreed that Paul Dudfield should bring a suggested set of measures to the next Audit Committee meeting for agreement VFM studies – it was suggested that this measure relates specifically to the use of resources and agreed that Sarah-Ann Moore will present the Concordat recommendations at the next meeting of the Committee Assessment of performance of external audit – it was agreed that that this is an area of good practice and should involve challenge and feedback on performance of external audit. Mike McDonagh agreed to circulate a proforma that can assist with identifying appropriate performance measures Costs incurred by the Audit Committee – it was suggested that this indicator relates to the costs incurred by the Committee in relation to procurement of advice from third party organisations to assist with specific issues. It was agreed that the Committee has not been required to procure any additional advice to date. Paul Dudfield agreed to revise the entry against each of these indicators to reflect the discussions and agreed actions at the meeting.	
ACTION: **Simon Grainger-Payne to source local Audit Committee networks and Audit Committee training offered by external suppliers** **ACTION:** **Mike McDonagh to identify and present Audit Committee training options at the December meeting of the Audit Committee** **ACTION:** **Paul Dudfield to bring a suggested set of measures to evaluate the effectiveness of internal audit to the next meeting** **ACTION:** **Sarah Ann-Moore to present the Concordat recommendations regarding VFM at the next meeting** **ACTION:** **Mike McDonagh to circulate a proforma to assist with evaluation of external audit performance** **ACTION:** **Paul Dudfield to revise the Audit Committee effectiveness report to incorporate the updates provided at the meeting**	
10 Annual Audit Committee report	**SWBAC (9/08) 031** **SWBAC (9/08) 031 (a)**
The chair presented the annual report of the Audit Committee which is due to be presented at the next Trust Board meeting to advise the Board of the duties and work programme of the Committee for the period 1 October 2007 – 31 August 2008.	

Simon Grainger-Payne was asked to add the annual Audit Committee report to the agenda of the next Trust Board meeting.	
ACTION: Simon Grainger-Payne to add the annual Audit Committee report to the agenda of the October Trust Board meeting	
11 IFRS project plan	**SWBAC (9/08) 033** **SWBAC (9/08) 033 (a)**
Robert White presented the proposed project plan to prepare the Trust for the introduction of the International Financial Reporting Standards in 2009/10. Further consideration regarding the treatment of untaken annual leave at the year end and unfinished spells as of 31 March 2009 is needed along with all other changes associated with IFRS. The plans need to be checked by external audit. Robert White was asked to update the Committee on the effect of the IFRS on charitable funds at the next meeting.	
ACTION: Robert White to provide a further update of progress against the IFRS action plan at the next meeting, including the effect of the new standards on charitable funds	
12 Minutes from Trust Board committees	
12.1 Finance and Performance Management Committee	**SWBFC (5/08) 017** **SWBFC (6/08) 025** **SWBFC (7/08) 033**
The Committee noted the minutes from the Finance and Performance Management Committee meetings held on 29 May 08, 26 June 08 and 31 July 08.	
12.2 Charitable Funds Committee	**SWBFC (5/08) 008**
The Committee noted the minutes from the Charitable Funds Committee meeting held on 14 May 08.	
12.3 Governance and Risk Management Committee	**SWBGR (5/08) 010** **SWBGR (7/08) 019**
The Committee noted the minutes from the Governance and Risk Management Committee meetings held on 29 May 08 and 24 July 08.	
13 Any other business	**Verbal**
The chair advised that the private meeting between Committee Members and the auditors will be scheduled for the end of the next meeting.	
14 Details of next meeting	**Verbal**
The next meeting is planned for 11 December 08 in the Ground Floor Meeting Room, Sandwell Hospital at 0930h.	

Signed:	
Name:	
Date:	

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Governance and Risk Management Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 18 September 2008; 1400h – 1600h

Members		**Apologies**	
Ms I Bartram	[Chair]	Mr R Trotman	
Mr R White		Prof D Alderson	
Ms K Dhami		Mr J Adler	
Mrs R Stevens		Ms D McLellan	[HoBtPCT]
Mr D O'Donoghue	[Part]	Dr K Sidhu	[Sandwell PCT]

In Attendance		**Secretariat**	
Mr D Masaun	[Items 1 - 4 only]	Mr S Grainger-Payne	[Minutes]
Mrs R Gibson	[Items 1 - 10 only]		
Mr S Parker			

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Roger Trotman, Derek Alderson, John Adler, Donal O'Donoghue, Denise McLellan and Khesh Sidhu.	
2 Minutes of the previous meeting	**SWBGR (7/08) 019**
The Committee approved the minutes of the meeting held on 24 July 2008 as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**Verbal**
All outstanding actions were reported as being due for completion by the next meeting. Dalvinder Masaun presented an update on progress with revising the process to handle Safety Alert Broadcast System (SABS) alerts. The revision is designed to ensure that higher priority is given to the completion of outstanding actions arising. Drug alerts are now included in the alerts received. An action plan has been developed to address the process and quality of reports being presented to the various committees and named Health and Safety co-ordinators for each division have been identified. A reduction in the duplication of meetings has been achieved, with a suggested outcome that a detailed report is presented to the Governance Board on a periodic basis. It is proposed that a summary of this information be presented to the Governance and Risk Management Committee,	

most likely as a section within the integrated risk and complaints report. Kam Dhami suggested that a report needs to be presented at the next meeting, which assures the Governance and Risk Management Committee that measures are in place to address the red status against the alerts presented at the last meeting.	
ACTION: **Dalvinder Masaun to present a report at the meeting to assure the Governance and Risk Management Committee that measures are in place to address the red status against the alerts reported at the meeting on 24 July 08**	
4 Health and Safety annual report	**SWBGR (9/08) 034** **SWBGR (9/08) 034 (a)**
Dalvinder Masaun presented the annual health and safety report 2007/08. He reported that a Health, Safety and Welfare Council has now been established, providing greater engagement on heath and safety matters at a divisional level. A follow-up meeting around the non-clinical aspects concerning CNST has been arranged, including Health and Safety elements of Mandatory Training. In terms of attendance at conflict resolution Mandatory Training, external opinion suggests that the performance of the Trust is good. Training is also offered in moving and handling and DSE training is to be offered by Occupational Health. Given the positive attendance figures reported, John Adler observed that the apparent Trustwide decline in attendance at Mandatory Training must be in areas other than conflict resolution and moving and handling. A waste manager has been appointed and a process to educate staff and provide facilities to enable them to segregate waste into different types has commenced and will be completed in 2009. A web-based reporting system is being developed and will be piloted and implemented on a Trust-wide basis in 2009. The issue concerning migration of information into the system has been problematic but is being addressed. In terms of risk assessment a starter pack has been launched to assist wards and departments complete and review the ten identified health and safety risks. This has been received favourably by staff. A survey of wards and departments has been performed around risk management. The Heath and Safety Executive has visited the Trust and four key messages have been identified around stress and sickness management: an appreciation of the issue by senior managers; deficiencies in stress risk assessment; weakness in formal policies and procedures; and weakness in formal training and awareness. To address this concern, stress awareness and management have been incorporated into the corporate induction programme. The Committee was pleased to note the declining trend of RIDDOR incidents (28% reduction). There is also a reduction in the number of sharps injuries. Incidents of violent abuse have reduced, while verbal abuse incidents have increased. There has been a 31% reduction in the overall number of amber incidents, while red incidents have increased by 24%, a picture skewed to some degree by the small number of incidents (17 in 2006/07 vs. 21 in 2007/08). It was agreed that a summary of the Health and Safety report should be presented at a future Trust Board meeting.	

ACTION: **Colin Holden to present a summary of the annual Health and Safety report at a future Trust Board meeting**	
5 NHS Litigation Authority risk management standards	
5.1 General standards	**SWBGR (9/08) 021** **SWBGR (9/08) 021 (a)**
Ruth Gibson presented an update on the action plan and summary of the Trust's current position against level 2 of the NHSLA risk management standards, in preparation for the assessment planned for December 08. Two indicators are assessed for each criterion within a standard and both must be passed satisfactorily before compliance against the criteria is declared as being achieved. The Committee was advised that should assessment be undertaken against the Trust's current position, there was a likelihood that compliance would not be achieved for any standard. Extrapolating the position to the time of the planned assessment estimates that three out of the five standards would not be achieved. Isobel Bartram asked whether the current position was a surprise. Kam Dhami responded that careful monitoring of the situation has been in place therefore the current position does not present a significant shock, although it is disappointing. There are a number of factors contributing to the position against the standards. The robustness of systems for identifying training needs and recording attendance need to be better developed; the weakness in the risk management framework identified by the ALE assessment and the issues within the maternity area have all contributed to the overall situation. The Committee was asked to consider a number of options, including deferring the assessment until a date between January – September 09 or to a time after the ALE scores for the next year have been published. The Committee agreed that, despite the financial disbenefit of delaying the assessment, that it would be sensible to defer the assessment until September 09 when the ALE scores for 08/09 are understood.	
AGREEMENT: **The Governance and Risk Management Committee supported the deferment of the assessment of the Trust against NHSLA risk management standards until September 2009**	
Donal O'Donoghue left the meeting.	
5.2 Maternity standards	**SWBGR (9/08) 022** **SWBGR (9/08) 022 (a)** **SWBGR (9/08) 022 (b)**
Ruth Gibson presented the position statement against the new pilot maternity standards. There are a number of areas where the Trust's arrangements do not comply with the standards, including guidelines; training and risk management strategy. The standards are currently being piloted, so the Trust will not be assessed against them until 2009.	

6 Integrated risk and complaints	
6.1 Quarterly risk report	**SWBGR (9/08) 023** **SWBGR (9/08) 023 (a)**
Ruth Gibson presented the quarterly integrated risk and complaints report, which had previously been discussed at the Trust Board meeting on 4 September 08. Future versions of the report will include information concerning claims and inquests. Lessons learned will also be included within the report.	
6.2 Analysis of incident cause groups	**SWBGR (9/08) 024** **SWBGR (9/08) 024 (a)**
Following a request at the September Trust Board meeting, Ruth Gibson provided an analysis of the trends around incidents related to clinical care and medical records. A breakdown of the areas was presented for Quarter 4 2007/08 and Quarter 1 2008/09. The Committee was advised that the apparent increased trend of amber incidents may be a result of a correction to the previous under reporting. Incidents involving pressure sores are also now reported, which contribute to the overall increase. The increase in lack of suitably skilled/trained staff incidents reported by the Women and Children's Health division and the increased trend of incomplete/illegible record keeping in the same division are issues being discussed by the Maternity Taskforce and have also resulted in special divisional reviews. Issues concerning the failure to provide healthcare records reported by Surgery B are also to be investigated by the division. Simon Grainger-Payne was asked to circulate the report to members of the Trust Board.	
ACTION: Simon Grainger-Payne to circulate the analysis of incident cause groups to members of the Trust Board	
7 Trust risk register 2008/09 – summary for Quarter 1	**SWBGR (9/08) 027** **SWBGR (9/08) 027 (a)**
The Governance and Risk Management Committee noted the update, which had been presented at the September Trust Board meeting.	
8 Corporate objectives risk register - summary for Quarter 1	**SWBGR (9/08) 026** **SWBGR (9/08) 026 (a)**
The Governance and Risk Management Committee noted the update, which had been presented at the September Trust Board meeting.	
9 Assurance Framework - summary for Quarter 1	**SWBGR (9/08) 025** **SWBGR (9/08) 025 (a)**
The Governance and Risk Management Committee noted the update, which had been presented at the September Trust Board meeting.	

10 Update in the patient safety development plan	**SWBGR (9/08) 028** **SWBGR (9/08) 028 (a)**
Kam Dhami reported that the patient safety development plan had been developed and approved by the Trust Board. Dr Sarindar Sahota has been identified as the Non Executive Director that will act as the patient safety development champion. Structures are currently being developed to ensure that there is clarity as to the responsibility for patient safety development at a divisional level. Executive patient safety walkabouts have been organised and the quality management framework currently in progress is to include elements of patient safety. The proposed revisions to the clinical management structure will also assist with embedding this requirement.	
11 Clinical audit forward plan monitoring	**SWBGR (9/08) 029** **SWBGR (9/08) 029 (a)**
Simon Parker presented an update on the clinical audit forward plan for 2008/09. Following discussion at the July meeting of the Governance and Risk Management Committee, the information concerning audits where there is ongoing data collection, such as national reports, is separated from those where there is an expected completion by the end of the financial year. At present it is suggested that there may be two audits that will not be completed as originally planned.	
12 Clinical guidelines update	**SWBGR (9/08) 030** **SWBGR (9/08) 030 (a)**
Simon Parker presented an update on the status of the clinical guidelines that are available on the Trust's intranet. Many guidelines are past their agreed review date, although the Committee was reassured that this does not necessarily mean that the guidelines are invalid or obsolete. The accountable clinician is responsible for updating the clinical guidelines, which will be reinforced during the introduction of the quality performance framework. Accident and Emergency, Maternity and Paediatrics are currently reviewing the status of their guidelines.	
13 NICE implementation progress report	**SWBGR (9/08) 031** **SWBGR (9/08) 031 (a)**
Simon Parker presented a report outlining the Trust's compliance with guidance published by NICE between January to June 2008. Baseline assessments and appropriate action plans are now routinely reported to the Governance Board. At present there are no identified issues with implementation of NICE guidance.	
14 Dr Foster – RTM alerts report	**SWBGR (9/08) 032** **SWBGR (9/08) 032 (a)**

Simon Parker presented an update on alerts generated from Dr Foster's RTM system based on activity data for the period between the beginning of November 07 and the end of April 08. The thresholds for some alerts have been lowered which should ensure that the number of false alerts is reduced. The SHA has reported on a study undertaken to establish whether there is any link between the Dr Foster mortality data and the quality of care provided. It is suggested that there is no link between the two. A pilot of systematic monitoring of hospital mortality is underway with Birmingham University. An analysis of the Trust's morbidity and mortality data is due to be presented at the next meeting. Assurance is required that each division is routinely examining and considering alerts related to their specialities.	
ACTION: Donal O'Donoghue to present an update on morbidity and mortality at the next meeting	
15 Infection prevention and control – summary for Quarter 1	**SWBGR (9/08) 033** **SWBGR (9/08) 033 (a)**
The Governance and Risk Management Committee noted the update, which had been presented at the September Trust Board meeting.	
16 Minutes from the Governance Board	**SWBGB (7/08) 044**
The Governance and Risk Management Committee noted the minutes of the Governance Board held on 11 July 2008.	
17 Any other business	**Verbal**
There was none.	
18 Details of next meeting	**Verbal**
The next meeting of the Committee is scheduled for 20 November 2008 at 1400h in the Executive Meeting Room at City Hospital.	

Signed .....

Print .....

Date .....