

Midland Metropolitan Hospital

Final Business Case

January 2016

Appendices Volume 5



Where
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Matters



APPENDIX 19a – RISK REGISTER

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

Reference Number	Source of Risk	Corporate Directorate	Clinical Group	Dept. / Clinical Directorate	Speciality / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Who is responsible for implementing plan?	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
WORKFORCE																		
1414MARWK03	Risk Assessment	Workforce		Workforce	Human Resources	Operational/Business	Insufficient policy leavers to ensure effective delivery of Trust workforce plan establishment reduction of 1300 wte's, leading to excess pay costs. WORKFORCE RISKS ARE MANAGED BY THE WORKFORCE DIVISION AND FORM PART OF THE TRUST CORPORATE RISK REGISTER	4	5	20	Review of existing policy leavers to ensure options are maximised and are executed sufficiently early. Development of strategic plans to support workforce pay reduction savings in 16/18. Strong governance oversight by the Trust Board.	Director of Organisational Development	Mar-20	Jun-15	Monthly	3	5	15
1402TNV732	Project Risk assessment	MMH				Organisational (Strategic)	There is a risk that the project process will not be well managed because of lack of resources which could result in project delay, project budget overspend or a poor quality design solution.	3	4	12	Maintain ongoing review of project resource including approach to succession planning and ensuring best skill mix at each stage. Gateway 2 review undertaken March 2014 and action plan in place. Additional temporary management resource for procurement period procured. <u>Assurance</u> Gateway Review undertaken at key stages of project. Project Director report to Configuration Committee.	Commercial Manager	2015/2016	Apr-15	Jul-15	2	4	8
1402TNV61	Project Risk assessment	MMH				Organisational (Strategic)	There is a risk that key staff working on the MMH project suffer from fatigue and illness because there is evidence that some staff are working long hours regularly. Continued pressure at this level heightens the risk of staff fatigue and illness and without a succession plan in place this could result in Project delay and failure to achieve a key beneficial component of PF2.	2	3	6	A procurement resource plan is complete and was sent to Treasury for approval week commencing 11 Aug 14. Provided that Treasury approve the plan, a final resource requirement paper will be submitted to MMH & Reconfiguration Committee. <u>Assurance</u> Resource plan to be agreed at MMH & Reconfiguration Committee and Configuration Board.	Director of Estates and New Hospital Project	Oct-18	Feb-15	May 15 following budget confirmation	2	3	6
IM&T																		
1402TNV733	Project Risk Assessment	MMH				Organisational (Strategic)	RISK: The IM&T specification changes during, or after, procurement incurring cost and time delay during construction. The Trust IM&T strategy is not implemented in time to support Midland Met models of care. The operating model is dependent on an integrated EPR document management solution with no space for document storage. The Midland Met operating model assumes paperlite by Midland Met opening. Definition of IT strategy and requirements/integration with the PFI contractor's scope of works and programme required.	4	4	16	Trust informatics strategy to be reflected in road map outlining vision for delivery. Funding for delivery identified in LTFM. Trust Board oversight of IT Committee <u>Assurance</u> Trust Board oversight of IT Committee	Chief Information Officer/Medical Director	Ongoing	Mar-15	Apr-15	3	4	12
INFORMATICS002	Departmental Review	Medical Directors Office	Informatics Service			Organisational (Strategic)	There is a risk that a not fit for purpose IT infrastructure will result in a failure to achieve strategic objectives and significantly diminishes the ability to realise benefits from related capital investments eg successful move to paperlite MMH, successful implementation of Trust Wide EPR INFORMATICS RISKS ARE MANAGED BY THE MEDICAL DIRECTOR'S DIVISION AND FORM PART OF THE TRUST CORPORATE RISK REGISTER	5	4	20	Approved Business Case for infrastructure stabilisation programme achieved June 2015. Specialist technical resources engaged (direct and via supplier model) to facilitate key activities. Appropriate governance model and controls underway. Phase 1 Deep Dive - commenced to identify detailed IT infrastructure issues - network element completed by end May 2015 Phase 2 infrastructure improvements - addresses need to upgrade to 21st Century IT infrastructure. Procurement strategy under development; key workstreams identified; high-level delivery schedule subject to procurement outcome, in draft, but overall delivery scheduled to complete by end April 2016.	Medical Director	Apr-16	Jun-15	Monthly	5	4	20

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	Di	Me				Org					Appropriate benefits realisation plan to be incorporated within programme plan. Clear identification of dependency linkage between other key programmes of EPR and wider strategic objectives.							
		INFORMATICS003	Departmental Review	Medical Director's Office	Informatics Service	Organisational (Strategic)	There is a risk of failure of a trust wide implementation of a new EPR due to insufficient skilled resources in Informatics, significant time constraints (programme should have started earlier) and budgetary constraints (high risks that in adding the full costs of an EPR into the LTFM that there is insufficient capital for related and pre-requisite schemes eg infrastructure remediation/MMH infrastructure preparation/business plan schemes) INFORMATICS RISKS ARE MANAGED BY THE MEDICAL DIRECTOR'S DIVISION AND FORM PART OF THE TRUST CORPORATE RISK REGISTER	4	4	16	Recruitment of suitably skilled specialist resource for the EPR Programme and associated infrastructure programme. Informatics LTFM will be prioritised to ensure appropriate funding is allocated to EPR and necessary dependencies. Completion of the formal procurement process - SOC/OBC/OBS at speed in attempt to claw back time required for implementation. Managerial and Board support for programme ensuring investment in infrastructure dependencies and required resource is given priority. Management time will be given for programme elements (benefit realisation/change processes etc.) Setup of appropriately manned programme board with strict governance and TORs. Development of contingency plans in relation to clinical IT systems will be established to ensure that if there is any slippage (eg a TDA query/legal challenge) there is an alternative and fully considered option.	Medical Director	Nov-18	Jun-15	Monthly	4	4	16
ESTATES STRATEGY																		
1402TW734	Project Risk Assessment	Estates				Organisational (Strategic)	There is a risk that the delivery of community facilities to plan, and the budget, will be compromised because of changes since 2013 and on-going detailed planning which could result in increased costs and project delay or an inefficient future estate.	3	5	15	Annual review of Estates Strategy to support clinical services requirements. Community facilities project structure set up to plan and implement changes. Estates Strategy updated to reflect Trust Annual Plan (2015/16) Business case to support investment in Rowley Regis approved by Trust Board. Business case to support first phase of investment in Sandwell site to establish Sandwell Treatment Centre approved by Trust Board Development Controls Plans to be developed for Sandwell Treatment Centre site and City Hospital site <u>Assurance</u> Project Director's report to Configuration Committee.	Director of Estates and New Hospital Project	Ongoing	Jul-15		3	5	15
FINANCE																		
1402TW735	Project Risk Assessment	MMH				Organisational (Strategic)	RISK: Local CCG financial position deteriorates during procurement such that CCG is unable to support funding requirements of ABC.	3	5	15	Sustainable approach to activity modelling being developed to embed on-going refinement of activity modelling which informs investment forecasts. These are then discussed with commissioners. LDP regular review of activity performance - quarterly. Produce activity summaries from model for testing sustainable future forecasts. Development of activity modelling by CCG's to determine future activity trajectory. LDP preparation for 2015-2016 and longer-term agreement framework. Shared approach to assessment of future activity levels (Achieved Apr 15). Contract monitoring review process in year. RCRH plan to share updated trajectories as prt of ABC sign-off. <u>Assurance</u> Trust regularly shares high level forecast assumptions/results with commissioners. Innovative risk sharing arrangements are in place as part of annual contract negotiations. Preparation for LDP 14-15 negotiations and opening discussion with commissioners.	Director of Finance/Rod Knight	Ongoing	Apr-15	Jul-15	2	5	10

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1402TW36	Project Risk Assessment	MMH				Organisational (Strategic)	RISK: SWBH financial position deteriorates during procurement such that Trust is unable to form a viable ABC. Healthcare actual inflation may be out of line with funding levels. Project costs could also increase.	3	4	12	Ten year LTFM developed. Trust TSPs developed. Arrangements for TFF monies have remained in place and are renewed each year. Confirm commissioner commitment to these arrangements. The development of a long term LDP agreement with Sandwell CCG shares risk and provides a degree of investment certainty. Ensure in years leading up to MMH that transition funding is spent non-recurrently to enable change. Annual assessment of transition need negotiated at LDP negotiations. Trust reliance on transition has reduced over project timeline. Important that the costs of double running are accurately shown. Delivery of CIP targets including a degree of over recovery to create contingencies. periodic review of long term affordability model to r-test affordability assumptions including inflation. Scenario modelling of alternative inflation assumptions and their impact upon MMH shadow unitary charge. Measure the extent to which healthcare actual inflation may be out of line with funding levels. Annual assessment made in financial plan of levels of anticipated inflation compared with tariff provision. Cost pressure areas highlighted for review as part of planning process (Achieved Mar 14). Further iteration including a review of all of the above in preparation of ABC by March 2015 (Achieved Apr 15) Sustaining process for periodic LTFM refresh - Chris Archer <u>Assurance</u> Trust Board oversight of LTFM via Finance and Investment Committee	Director of Finance/Rod Knight	Ongoing	Apr-15	Dec-15	2	4	8
1402TW37	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that the Trust cannot deliver a viable and affordable confirmatory business case for MMH because financial markets may not respond to the funding competition at the preferred bidder stage as predicted which could result in increased costs or a non-viable scheme.	2	3	6	Analyse market before funding competition. Clear programme in place and approval bodies aware of timescales. Build contingencies into project budget. Routine review of financial market. Reviewed as part of bidder submission and development of ABC (February-July 2015) <u>Assurance</u> Project Director's report to Configuration Committee	Director of Estates and New Hospital Project	Ongoing	Jul-15		2	2	4
1402TW38	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that the expected capital costs for MMH will increase due to changes in conversion rates because the construction industry workload is increasing which could result in increased costs or a non-viable/unaffordable scheme.	1	4	4	Routine review of construction and inflation indices Introduction of 'value engineering' workstream Bidder final bid required to comply with financial hurdles and constraints. Project currently planned for financial close in December 2015. Based on appointment of preferred bidder in August 2015. Provides six months protection against inflation up to June 2016 from financial close. Carillion submission of final bid planned for July 2015 including capital cost. <u>Assurance</u> Routine reporting of inflation indices and success of value engineering workstream.	Director of Estates and New Hospital Project	Ongoing	Jul-15		1	4	4
1402TW39	Project Risk Assessment	MMH				Organisational (Strategic)	There is risk that failure to generate sufficient financial resources to support necessary capital programme will result in consequent risk to project delay, fitness for purpose of retained estate and realisation of savings from reconfiguration of services.	3	4	12	Routine scrutiny of financial plans [near and medium term] and financial performance by Executive. Development of Midland Met Appointments Business Case to include future proof clinical models and necessary efficiency improvement. Specific attention to be given to workforce plan and financial assessment of safe, bottom up view. Capital plans reset as part of ABC development. Regular in year reviews. <u>Assurance</u> Challenge and confirmation through Finance & Investment Committee.	Director of Finance/Rod Knight	Ongoing	Apr-15	Dec-15	2	4	8

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1402TWT40	Project Risk Assessment	MMH				Organisational (Strategic)	RISK: VAT recovery of PFI Unitary payment not approved resulting in 20% increase in capital costs	1	4	4	Keep up to date with HMRC view on this and work with other stake holders to seek to mitigate (Achieved Mar 15). Review within remit of Deloittes and VAT advisors at key milestones. <u>Assurance</u> Board approval of ABC and FBC	Director of Finance/Rod Knight	Ongoing	Apr-15	Jul-15	1	4	4
1402TWT60	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that bidders may not adequately resource the competitive dialogue stage because of lack of finance or time which could result in project delay.	2	3	6	To be assessed as part of evaluation process. Contractual mitigation of the risk. Ongoing monitoring. To continue to be assessed as part of bidder design development process . Carillion on programme to submit final bid in July 2015 having maintained 'competitive dialogue' throughout bid/design development process. <u>Assurance</u> Project Director report to Configuration Committee	Director of Estates and New Hospital Project	Aug-15	Jul-15		1	2	2
LAND REMEDIATION																		
1402TWT41	Project Risk Assessments	MMH				Organisational (Strategic)	There is a risk that during the remediation phase we may identify hidden antiquities or fossils on the Grove Lane site because extensive excavations are required which could result in project delay and increased cost.	2	4	8	Full geotechnical study being undertaken on land with completion due August 2014. Heritage survey reviewed. Trial pits were taken pre OBC to support desk top study. Site demolition works planned for completion February 2015. Approval to site remediation works by Trust (March-September 2015) from February 2015 Trust Board. Carillion to be part of project team continuing scope and monitoring of works. Site remediation works ongoing and on programme for completion late August 2015. No antiquities or fossils found. <u>Assurance</u> Project Directors report to MMH & Reconfiguration Committee	Director of Estates and New Hospital Project	Aug-15	Jul-15		2	4	8
1402TWT42	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that the project may be delayed because Grove Lane decontamination requirements, which have been expected/allowed for in the PSC, could result in increased cost and delay to the Trust and other bidders.	3	4	12	Site demolition works completed. Approval for site remediation works (March-September 2015) given at February Trust Board. Carillion part of project team continuing scope and monitoring of works. Land remediation works on programme for completion late August 2015. <u>Assurance</u> Project Director's report to MMH & Reconfiguration Committee .	Director of Estates and New Hospital Project	Aug-15	Jul-15		2	4	8
HEALTH ECONOMY																		

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1402TW743	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that the local health economy models of care do not change in the way predicted because CCGs short-term plans are inconsistent with the service, capacity and activity plans underpinning the RCRH Programme and Midland Met OBC which could result in the planned capacity for the Midland Met being incorrect.	3	4	12	<ul style="list-style-type: none"> MMH activity, income and capacity assumptions based on RCRH Activity and Capacity Model updated at key stages of project to reflect latest position: latest update v5.7b (includes service development activity) Commissioner support to MMH QIPP schemes focus on activity shifts from acute to community and primary care based on RCRH redesigned care pathways SWBH clinical input to development of CCG commissioning specifications Central Business Development team to assist clinical services in responding to competitive commissioning Scenario modelling Clarity about activity shifts and service developments through IBP and Change Plan Annual contract discussions need to relate to/reference RCRH Activity and Capacity model and trajectory <p><u>Assurance</u> Bi-monthly reporting to MMH & Reconfiguration Committee and bi-monthly report to Configuration Committee</p>	Chief Operating Officer/Deputy COO - Transformation	Autumn 2018 with trigger review date of 2017	Jan-15	May 15 once 15/16 contract agreed and activity confirmed	2	4	8
1402TW745	Project Risk Assessments	MMH				Organisational (Strategic)	There is a risk that changes in local/regional service models or changes resulting from healthcare trends/innovation or structural change invalidate project assumptions and could result in the capacity and functional content planned for the Midland Met no longer meeting the demand or service requirements.	3	3	9	<ul style="list-style-type: none"> MMH & Reconfiguration CLE Committee oversees externally and internally driven reconfigurations Structured project management approach to clinical service reconfigurations Generic design in MMH and planned future flexibility/change in use of space - evaluate designs for future flexibility/change as part of procurement process - Spring 2015 Review underlying activity and productivity assumptions as part of A&C Model update for ABC - April 2015. Scenario Modelling Board assurance work around MMH flexibility and likely innovations Evaluate designs for future flexibility/change as part of procurement process <p><u>Assurance</u> Monthly report to MMH & Reconfiguration Committee and Bi-monthly report to Configuration Committee</p>	Chief Operating Officer/Deputy COO - Transformation	Ongoing	Jan-15	May-15	2	3	6
1402TW746	Project Risk Assessment	MMH				Organisational (Strategic)	RISK: Delay to approval of ABC and FBC impacting on success of Trust Foundation status application (impact on deed of safeguard and process for financial assurance from Monitor)	3	2	6	<p>It needs to be explicitly noted in the DoH approval letter that FT status will not affect the Deed of Safeguard or business approval. Project timelines allow for planned FT application timescale.</p> <p><u>Assurance (of MMH and/or FT)</u> Project Director report to MMH & Reconfiguration Committee at key milestones</p>	Director of Finance/Rod Knight	Ongoing	Jun-14	Key milestones	2	2	4
1402TW747	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that there is a delay in approval because of loss of programme ownership/loss of visibility within the local health economy which could result in project delay.	2	4	8	<p>On-going engagement through RCRH programme structures. Action plan completed following Gateway report recommendations April 2014. Current arrangements reviewed by new Director of Estates and New Hospital Project. Formal support for MMH project reaffirmed by Sandwell CCG as part of gABC approval process. Programme ownership and visibility increased via gABC and demolition and land remediation works undertaken on Grove Lane Site. Action plan developed following Healthcheck 3a review undertaken June 2015.</p> <p><u>Assurance</u> Project Director's report to Configuration Committee.</p>	Director of Estates and New Hospital Project	Ongoing	Jul-15		2	3	6
APPROVALS PROCESSES																		

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1402TW48	Project Risk Assessment	MMH				Organisational (Strategic)	<p>There is a risk that the appointments business case approval process is delayed because of a structural change within the health and social care bodies (HMT/DH/NHSTDA) which could result in project delay and increased cost.</p> <p>The following specific conditions apply to the DH Approval of the Outline Business Case for the Right Care, Right Here Programme Acute Hospital Development (MMH).</p> <p>i: The Trust will need to demonstrate at subsequent business case approval points that the value for money case still favours PF2.</p> <p>ii. The financial plan for affording the scheme is dependent on income growth. The Trust and Right Care Right Here commissioning partners must submit by ABC a jointly agreed plan for managing stranded fixed costs in the event of an income downturn at the Trust after the scheme opens compared to the income figures assumed at OBC.</p> <p>iii. The Trust, along with the NTDA and DH, explores the possibility of using land sales proceeds to improve affordability by draft Appointment Business Case.</p> <p>iv. At ABC, the Trust will be expected to demonstrate that it remains on track to deliver the significant workforce savings that are envisaged under the long-term financial model that underpins the scheme's affordability, and that it has robust, evidence-based plans that will deliver the full value of the necessary savings.</p> <p>v. The Trust further develops a robust set of mitigation plans that it can call on in a downside scenario, before draft Appointment Business Case approval, and the key commissioners must approve any that involve service changes in principle at, or by that point, and commit themselves to supporting the Trust in sustaining its CSSR.</p> <p>vi. Commissioners support of the Trust activity and income assumptions must be reconfirmed at each subsequent business case approval stage, and the income 'actuals' for the prior year and the plan for the next year must be evidenced as congruent to the OBC and its underpinning long-term financial model.</p> <p>vii: The Trust must implement quickly its existing recruitment plan to prepare its scheme properly to progress the procurement effectively, and the Trust should work closely with Infrastructure UK (IUK) and the DH to ensure that the Trust's resourcing plans are sufficient to manage the procurement effectively, including the boot camp process, before issuing the definitive Invitation to Participate in Dialogue.</p> <p>viii: The Trust must identify in early dialogue sessions with bidders and in consultation with the NTDA, DH and HM Treasury whether delivery in July 2018 can be afforded within the Unitary Payment Cap set out in the OBC, or there would be material savings from another timetable.</p> <p>ix: The Trust must maintain strong performance against CQC and NTDA metrics of quality, safety, finance and performance in each financial year and specifically achieving performance consistent with CCG and NTDA recommendations to Monitor during 2015-2016.</p> <p>x: The Trust must achieve its Capital and Cash plans in 2014-15 and is able to satisfy the NTDA that it's continuity of service risk rating for 2015-16 and 2016-17 is consistent with, and remains foreseeably consistent with, the agreed long term financial model. This must include auditable visibility of the <i>Right Care, Right Here</i> reserve which services in 2018-19 the unitary payment.</p> <p>xi: The Trust should maintain a Gateway rating of amber-green or better on the project.</p> <p>xii: The Trust must achieve approval, prior to financial close, of its IT business case (funded within the LTFM) or agree mitigation measures for and delay in approval or implementation of this scheme with the NTDA.</p>	3	3	9	<p>Agree approval plan with DH/HMT and NTDA. Participate in stakeholder Boards throughout competitive dialogue process.</p> <p>MMH project remains on programme for financial close n December 2015.</p> <p>i: See risk 51 ii: See risk 35 iv: See risk 03 (Corporate risk register) v. Refer to Integrated Business Plan June 2014, pages 156 - 164 vi: See risk 43, 45 vii: See risk 32 viii: See risk 49 ix: See risk 46 x: See risk 36 xi: See risk 32 xii: See risk 33</p> <p><u>Assurance</u> Project Director's report to Configuration Committee</p>	Director of Estates and New Hospital Project	Ongoing	Jul-15	3	2	6	

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1402TW749	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that bidders will dispute changes to the standard form Project Agreement because of PF2 which could result in project delay and increased costs to adviser support.	4	3	12	Continue to work closely with DH and HMT on revisions to documents. PFI procurement documentation and plans previously developed in detail. Existing PF2 guidance already implemented into Trust PFI documents allowing areas where gaps exist to be identified. Regular contact with HMT to ensure guidance received on 'gaps' as soon as available. Compressed timescales as a result of PF2 increase the risk of project slippage and poor delivery. Experience of dealing with bidder shows little appetite to question PF2. Likelihood reduced accordingly. <u>Assurance</u> Project Director's report to Configuration Committee	Commercial Manager	Jul-14	Feb-15	May-15	2	3	6
1402TW750	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that the project may be delayed because the Trust changes its requirements which could result in additional cost during procurement or inability to achieve a signed-off design solution.	2	4	8	Robust engagement and sign-off process underway which empowers the clinical lead and technical team to deliver within project constraints. PPDD and operational policy sign-off to be completed before CD process and management of expectation during competitive dialogue process to take place. Manage the change control process during procurement. Carillion to submit final bid July 2015. No material changes resulting in additional cost being instructed by the Trust as at 7 July 2015. <u>Assurance</u> Project Director's report to Configuration Committee.	Director of Estates and New Hospital Project	Aug-15	Jul-15		1	4	4
1402TW751	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that there may not be robust competition for MMH because a) insufficient quality bidders may apply or b) bidders may pull out during the competition which could result in a poor value bid or non-viable scheme or difficulty in proving that the PF2 solution is value for money in the Appointments Business Case. UPDATE 22/01/15 Three bidders were issued ITPD in September 2014. One immediately withdrew and one did not engage fully in dialogue and did not submit an interim bid. Therefore the risk of insufficient bidders has crystalized. The Trust is currently reviewing whether sufficient proxy for competition can be built into the procurement to mitigate the risks of a poor value/non-viable bid from the remaining bidder.	3	4	12	Agree strategy for supplementing procurement controls eg: add demonstration extra competition to supply chain, increased transparency of accounting etc. <u>Assurance</u> Extraordinary Trust Board 16 January 2015 reviewed option appraisal between continuing with single bidder and adding additional criteria to mitigate lack of competition versus starting again with public procurement. DH approved continuing with single bidder on 26 Mar 15.	Commercial Manager	Sep-15	Apr-15	Jul-15	2	4	8

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1402TW52	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that full planning permission is delayed because SMBC will not approve the preferred bidder's proposals which could result in project delay and increased cost of the PF2 scheme.	2	3	6	Agreed planning evaluation criteria to ensure that bids are reviewed objectively. Close liaison with Local Authority and preferred bidder. Carillion planning application registered by SMBC on 3 July 2015. Planning application to be determined 23 September 2015. <u>Assurance</u> Project Director report to Configuration Committee.	Director of Estates and New Hospital Project	Sep-15	Jul-15		1	3	3	
1402TW53	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that a judicial review of a) full planning permission and b) OJEU process will cause project delay because an objection is raised during the judicial review period which is not allowed for in the project programme.	2	3	6	Robust processes and engagement should reduce potential for challenge. Positive dialogue being maintained with both SMBC and BCC. Carillion reporting programme being made with SMBC re Grove Lane Development. Planning application submitted by Carillion on 3 July 2015. Planning application to be determined on 23 September - six weeks thereafter for party to seek judicial review. Remains a live, but low, risk. <u>Assurance</u> Project Director report to Configuration Committee	Director of Estates and New Hospital Project	Ongoing	Jul-15		2	2	4	
1402TW55	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that the proposed allocation of risk between Project Co and the Trust may be inappropriate because one party may be better able to control that risk than the other which could result in increased cost and programme delay.	3	3	9	Use project risk identification and mitigation process to effectively identify and assess risks before allocation. Proposed project agreement to be reviewed as part of competitive dialogue process. <u>Assurance</u> Project Director report to Configuration Committee	Commercial Manager	Ongoing	Apr-15	Jul-15		2	3	6
1402TW56	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that the estimated costs of satisfying full planning permission and Section 106 are incorrect because the actual plans produced by the MMH preferred bidder are different to the PSC on which outline planning permission was approved which could result in an increase in cost.	3	4	12	Ensure bidders have ongoing dialogue with the local authority during stages 3 and 4 of competitive dialogue. Close liaison with local authority planning teams being maintained. Ongoing dialogue with SMBC re S106 and 278 costs whilst planning application being determined. Estimated costs for S106 and 278 works to be provided by Carillion for review. <u>Assurance</u> Project Director report to Configuration Committee.	Director of Estates and New Hospital Project	Mar-16	Jul-15		2	4	8	
EQUIPMENT																			
1402TW57	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that the opening of MMH could be delayed because we fail to manage the purchase, commissioning and transfer of equipment which could result in commissioning delays, insufficient equipment, service delays and increased costs.	3	5	15	Careful consideration of equipping strategy and feasibility, whilst maintaining control of capital programme. Existing equipment group receive input from operational policies. Beneficial access requirements are defined. Managed Equipment Service (MES) Project Group, as sub-committee of MMH & Reconfiguration Committee, has been established and will produce OBC and programme plan resulting in appointment of preferred bidder before end March 2016. The MES is for major imaging equipment. MMH – MES Plan/Programme to be reviewed and continued <u>Assurance</u> Project Director report to Configuration Committee.	Director of Estates and New Hospital Project	Ongoing	Jul-15		3	4	12	

Reference Number	Source of Risk	Corporate Directorate	Clinical Group	Dept. / Clinical Directorate	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Who is responsible for implementing plan?	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
1402TWT58	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that the Trust may have to review its output specification because of technical/legislative changes which could result in an increase in equipment and capital cost and/or inappropriate equipment purchase.	3	4	12	The Trust is unlikely to change requirements unless forced by legislation. Trust to monitor potential legislative changes and seek to mitigate where possible. Regular review of medical equipment strategy required. <u>Assurance</u> MMH Equipment Group and Configuration Committee	Director of Estates and New Hospital Project	Ongoing	Jul-15		2	4	8

Reference Number	Source of Risk	Corporate Directorate	Clinical Group	Dept. / Clinical Directorate	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Who is responsible for implementing plan?	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
ENGAGEMENT/COMMUNICATION																		
1402TW/59	Project Risk Assessment	MMH				Organisational (Strategic)	There is a risk that the project may be delayed because of a lack of patient and public communications and engagement which could result in damage to Trust reputation and potential project delay leading to concern and protest .	2	3	6	Development of communication channels. Positive media engagement. Regular updates to FT members. Remains a live, but low, risk. Positive steps being taken to ensure effective communications with key stakeholders. <u>Assurance</u> Project Director report to Configuration Committee.	Director of Estates and New Hospital Project	Ongoing	Jul-15		1	3	3

RISK ASSESSMENT MATRIX

1. LIKELIHOOD: What is the likelihood of the harm/damage/loss occurring?

LEVEL	DESCRIPTOR	DESCRIPTION
1	Rare	The event may only occur in exceptional circumstances
2	Unlikely	The event is unlikely to occur (remote chance)
3	Possible	The event may occur occasionally (25-50% likelihood)
4	Likely	The event is likely to occur (above 50% likelihood)
5	Almost Certain	The event will happen (and frequently)

2. SEVERITY: What is the highest potential consequence of this risk? (If there is more than one level, choose the highest)

Descriptor	Potential Impact on Individual(s)	Potential Impact on Organisation	Financial Impact	Number of people affected	The Potential for complaint / litigation
Insignificant	No / superficial harm	No impact	No litigation, Less than £100 to reduce risk, Financial risk less than £50K	Only 1 person	Unlikely to cause complaint / litigation
Minor	SHORT TERM INJURY / DAMAGE e.g. injury that is likely to be resolved within one month, Increased level of care 1-7 days	Minimal risk to organisation	Litigation between £100-£25k, £100-£10K to reduce risk, Financial risk £51K - £500K	Greater than 1 but less than 5	Complaint possible, Litigation unlikely
Moderate	SEMI-PERMANENT INJURY/DAMAGE, e.g. injury that may take up to 1 year to resolve, Increased level of care 8-15 days	Some disruption in service with unacceptable impact on patient, Short term sickness	Litigation between £25k-£250k, £10k-£50K to reduce risk, Financial risk £501K - £2M	Greater than 5 but less than 50	High potential for complaint Litigation possible but not certain.
Major	PERMANENT INJURY, Loss of body part(s), Increased level of care over 15 days, Loss of sight	Long term sickness, Service closure, Service/dept external accreditation at risk	Litigation between £250k-£1m, £50k-£250K to reduce risk, Financial risk £2M - £4M	Greater than 50 but less than 200	Litigation expected /certain, Multiple justified complaints
Catastrophic	DEATH, Suspected Homicide, Suicide	National adverse publicity, External enforcement body investigation, Trust external accreditation at risk	4 Litigation greater than £1m, Greater than £250k to reduce risk, Financial risk greater than £4M	Greater than 200	Multiple claims or a single major claim

3. RISK RATING: Use the matrix below to rate the risk (e.g. 2 x 4 = 8 = Yellow, 5 x 5 = 25 = Red)

Element of Risk	SEVERITY				
LIKELIHOOD	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

Green = LOW risk

Yellow = MODERATE risk

Amber = MEDIUM risk

Red = HIGH risk

APPENDIX 20a – EQUALITY IMPACT ASSESSMENT

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

Equality Impact Assessment Toolkit



A guide for staff who need
to complete Equality Impact
Assessments

Equality & Diversity
Team



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Introduction

The equalities duties provide a framework for the Trust to carry out its functions more effectively and to tackle discrimination in a proactive way. It ensures that equality considerations are consistently integrated into day-to-day business through Equality Impact Assessments. This will not only engender legal compliance, but also help to ensure that Trust services best support the healthcare needs of the local population it serves and its workforce.

As a manager or someone who is involved in a service, policy, or function development, you are required to complete an Equality Impact Assessment (more commonly referred to as Equality Analysis) [EIA] using this toolkit.

Service	A system or organisation that provides for a public need.
Policy	A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue.
Function	Any of a group of related actions or functions contributing to a larger action.

Age Discrimination ban

On 1st October 2012, new provisions in the Equality Act 2010 come into force, extending the ban on age discrimination to cover services. Direct and indirect age discrimination, harassment and victimisation will be unlawful when providing services and when carrying out public functions.

The new ban means that in most cases service providers will not be able to operate upper and lower age limits.

There is no express exception for health and social care. This means that organisations responsible for planning, commissioning or delivering health or social care services can only differentiate in the treatment of service users in different age groups if this can be objectively justified. However, many age-based services currently provided in these sectors will be able to satisfy this legal test; for example, winter flu injections for over 65s.

The ban on age discrimination in services and public functions does not apply to those under 18 years of age. In contrast, the ban on age discrimination in clubs and associations applies to all ages.

What is the Equality Impact Assessment (EIA) Toolkit all about?

The EIA toolkit aims to make the process of equality impact assessing easier to understand and implement. It is designed to make it simpler for you to complete your EIA and make the process and outcomes meaningful for you and others involved. It is also intended to provide a sensible and proportionate approach that ensures the Trust gives due regard to the requirements to promote equality alongside other competing requirements such as Health & Safety.

What is an EIA?

Equality Impact Analysis [EIA] is a way of examining your services, functions and policies to see if it could have a negative or the potential for a negative impact on any member of the protected characteristics.

The Equality Act covers nine protected characteristics on the grounds upon which discrimination is unlawful.

Protected Characteristic	Descriptor
Age	The length of time that one has existed; duration of life, from cradle to grave.
Disability	A person has a disability if s/he has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.
Gender Reassignment	<p>A personal process (rather than a medical process) which involves a person expressing their gender in a way that differs from or is inconsistent with the physical sex they were born with. This may include undergoing medical procedures or it may simply include choosing to dress in a different way as part of the personal process of change.</p> <p>Trans man – someone who has transitioned from female to male. Note that some people, following treatment, strongly prefer to be thought of as simply a woman.</p> <p>Trans woman – someone who has transitioned from male to female. Caveats as per trans man.</p>
Marriage and civil partnership	The legally or formally recognized union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship:
Pregnancy and maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.
Race	This could include Asian or Asian British people, Black or Black British people, Chinese people, Gypsy, Roma or Traveller people, Irish people, People of mixed heritage, White people, people of other ethnic backgrounds and Asylum seekers and refugees.
Religion and belief	<p>Includes any religion and any religious or philosophical belief (such as humanism or atheism). It also includes a lack of any such religion or belief.</p> <p>Religious belief' goes beyond beliefs about and adherence to a religion or its central articles of faith and may vary from person to person within the same religion.</p>

Sex	A person's sex refers to the fact that they are male or female. In relation to a group of people, it refers to either men or women or to either boys or girls.
Sexual orientation	<p>Sexual orientation means the attraction a person feels towards one sex or another (or both), which determines who they form intimate relationships with or are attracted to.</p> <p>Some people are only attracted to those of the same sex (lesbian women and gay men).</p> <p>Some people are attracted to people of both sexes (bisexual people).</p> <p>Some people are only attracted to the opposite sex (heterosexual people).</p>

We also have to pay due regard to members of other socially excluded groups e.g. Homeless people, sex workers, drug users, obese patients.

Aims

Why should I carry out an EIA?

An EIA allows you to find out whether your service, policy or function has a negative or potential negative impact on anyone from the protected groups.

Importantly EIAs allow the Trust to establish meaningful outcomes for its diverse communities and workforce offering a pro-active approach to achieving equal outcomes.

- **Direct discrimination:** treating staff or workers or job applicants less favourably than others because they belong to a particular equality group.
- **Indirect discrimination:** Having policies or practices in place that applies to all employees however they could disadvantage people.
- **Associative discrimination** - This is direct discrimination against someone because they associate with another person who possesses a protected characteristic, e.g. an employee is stopped from promotion as he is the main carer for his disabled wife.
- **Perceptive discrimination** - This is direct discrimination against an individual because others think they possess a particular protected characteristic. It applies even if the person does not actually possess the characteristic.

For existing services, policies or functions, an EIA should be undertaken when formally reviewed. An EIA should be carried out every three years or when changes are required.

When should an Equality Impact Assessment be undertaken?

An EIA should be carried out at the same time as developing a new service, policy or function and also at the review stage of said service, policy or function.

Once the service, policy or function has been developed/reviewed an EIA must be completed and present for submission/ratification. It should be monitored to ensure the intended outcome is being achieved. Any concerns about the way it is working can then be addressed.

What are the main aims of an EIA?

The main aim of an EIA is to:

- Take account of services provided by The Trust and those affected by what it does.
- Consider other ways of achieving the outcomes of the service, policy or function.
- Allow you to have more contact with the diverse groups in our community.
- Change the way you think about your work and the decisions you make.
- Help you to think more about the needs of the community we serve.
- Remove any negative impact for members of the protected groups.
- Implement any reasonable adjustments as and when required.

The EIA process allows you to assess whether your services, policies or functions:

- eliminate unlawful discrimination, harassment or victimisation;
- advance equality of opportunity; and
- foster good relations.

Note: In relation to marriage and civil partnership, the assessment applies only to the elimination of discrimination.

What is a Reasonable Adjustment?

Under the Equality Act 2010 an employer has a duty to make reasonable changes for service users and employees. These are known as 'reasonable adjustments'. Adjustments should be made to avoid you being put at a disadvantage compared to others.

Reasonable Adjustments could include:

- changing standard procedures, such as admissions or assessment procedures
- adapting facilities, such as those in laboratories, or library or IT facilities
- providing additional services, such as a sign language interpreter or information materials in alternative formats
- altering the physical environment to make it more accessible.

How to determine what is reasonable

What is deemed reasonable depends on the individual circumstances of the case, including how important the adjustment is, how practical it is, and the financial or other resources of the institution.

It is the financial resources of the institution as a whole and not the budget of an individual department or service area that counts

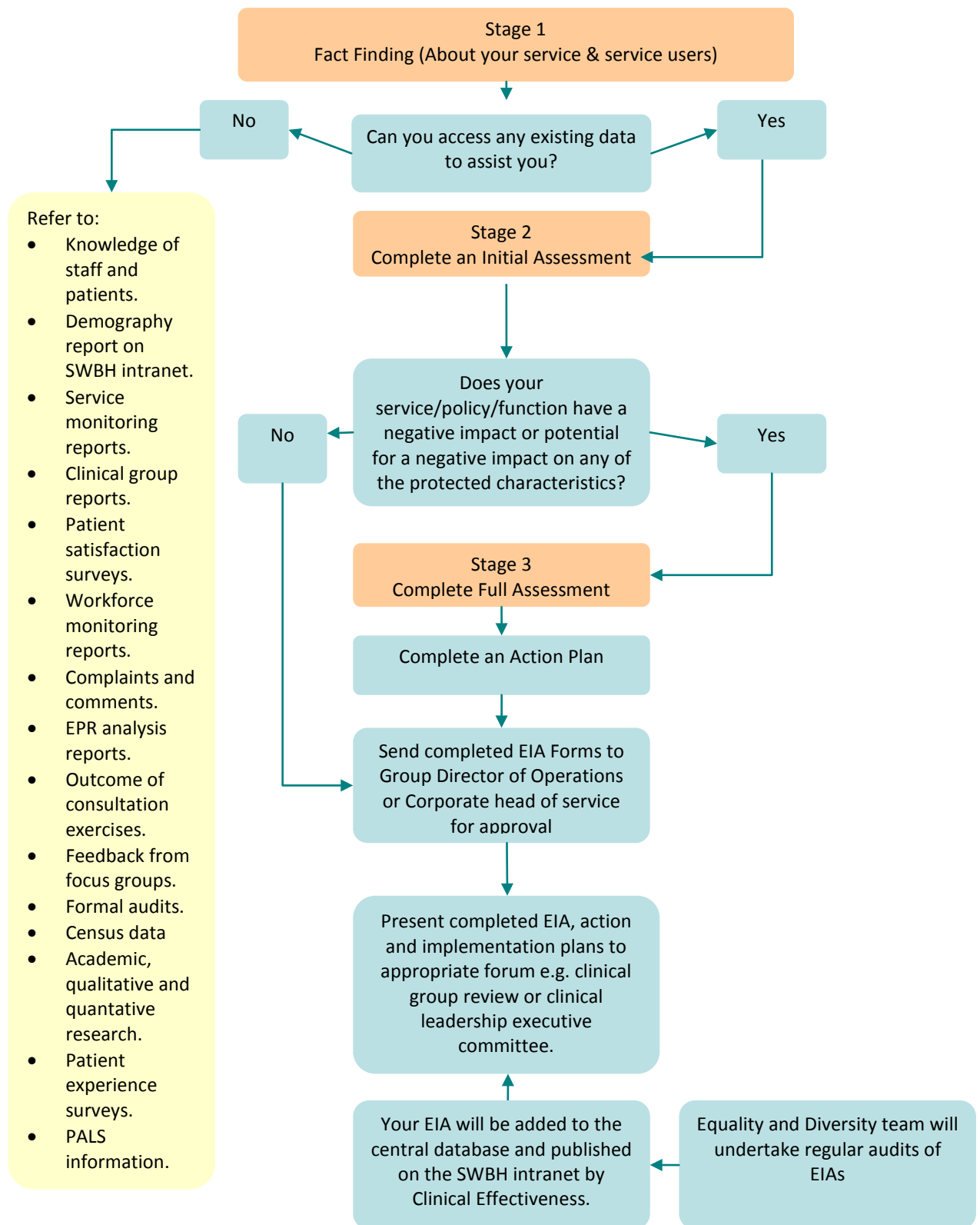
How will the information collected be used?

By gathering and using equality information from our service users the Trust will be able to:

- Improve services.
- Establish and improve the outcome/experience of our patients.
- Stop discrimination happening now and in the future.
- Make sure that services are accessible to everyone in the local community.
- Help improve the way staff and patients are treated.
- Understand the effect of our current and proposed services, policies and function have on members of the protected groups.
- Identify the key priority equality issues for the Trust.
- Set the most appropriate equality objectives and measure our progress against them.
- Demonstrate compliance with equality legislation
- Demonstrate to our service users how we are performing and what we are achieving.

Monitoring Actions

The Trust holds a central database and of the actions required to be undertaken as a result of the Equality Impact Assessment. These actions are monitored on a quarterly basis and included in a quarterly progress report to Trust Board.



How do I begin my EIA?

There are three stages to our EIA process:

Stage 1

This is the fact-finding stage where you gather as much information about the service, policy or function you intend to EIA. Who will be using the service, policy or function and the outcomes you want to achieve. It is important to make sure that your service, policy or function has clear aims and objectives.

Stage 2

This stage allows you to identify whether your policy, service or function has a negative or potential negative impact on the protected characteristics. In some cases an initial EIA (Appendix A) is all you will need to establish whether you are providing equal outcomes for staff and/or patients. On discovering a negative or the potential for a negative impact you will need to undertake a full EIA (Appendix B), unless it has already been identified as a corporate trend, in which case you must identify the reasonable adjustment you have put in place to mitigate the impact.

Stage 3

This stage involves questioning aspects of a proposed/existing service, policy or function and forecasting the likely effect. The answer to the questions will require time and research in order for you to answer them sufficiently. The Trust can provide you with some of the data you require, although the sources of information will vary depending on the nature of the service, policy or function.

Remember, it is vital to concentrate on the main objectives of the EIA and not lose sight of the outcomes, know when to stop! Look for practical outcomes and focus on identifying any negative impact in the current provision. If it is not possible for you to get data easily or immediately, this should be highlighted in your final action plan.

Action Planning

The real value of completing an EIA comes from the actions that will take place and the positive changes that will emerge through conducting the assessment. To ensure that the action plan is more than just a list of proposals and good intentions, the following should be included:

- Each action be attributed to a key person who is responsible for its completion
- An achievable timescale that is also at the same time reasonable
- Relevant and appropriate activities and progress milestones
- Any cost implications and how these will be addressed.
- If the concerns identified cannot be addressed because of other considerations (such as financial constraints) say what they are.

It is necessary that the action plan feeds into service and team plans and links to the Trusts Equality Objectives (EDS), which can be found on the Trust intranet/internet site.

The action plan should include realistic and achievable actions or activities likely to have an impact. This should not be a comprehensive list of all the possible things that might help. It is unlikely that any action plan will have less than four activities, but an action plan that rolls over to six pages is unlikely to be providing sufficient focus for most activities.

Corporate trends must be included on the action plan along with what actions (reasonable adjustments) are being taken locally whilst the corporate trends are being addressed.

Submission of completed EIAs and related documents

Equality and Diversity will provide advice and support throughout the process of completing EIAs. Once you have completed your EIA you must submit these documents to your Group Director of Operations or Corporate Head of Service for approval, you are then able to present them at clinical group /ward reviews or to the clinical leadership executive committee.

The central Equality Diversity team will undertake regular audits of the EIAs.

Frequently asked Questions

How will EIAs help me improve my service?

Equality Impact Assessments involve looking at your equality information and the outcome of any engagement activity in order to understand the effect or potential effect of your decisions on members of the different protected groups. It will help you to identify practical steps you can take to tackle any negative effects or discrimination, and to advance equality of opportunity.

What are the benefits of EIAs?

EIAs are an opportunity to promote inclusive and fair service delivery. They identify where users may be unfairly discriminated against, or where particular sections of a community are not benefiting from a particular service. It is impossible to deliver excellent services for all without due regard to this process.

The EIA process will help to avoid claims of unlawful discrimination as it provides a framework that ensures the Trust meets its legislative duties. The process helps the Trust to anticipate problems and make informed and open decisions. This process will guide The Trust from where we are now to where we want to be.

Can a negative impact ever be justified?

Although unlawful discrimination can never be justified, there may be occasions where it is appropriate that an activity impacts less favourably on some people. For example, The Trust may be targeting services to a particular part of the population that have been historically referred to as 'hard-to-reach' or 'traditionally disadvantaged'. Increasing involvement levels for that community but not for some others who are traditionally easier to engage is acceptable. It will be necessary to consider whether the potential for less favourable impact on one or more communities can be justified.

What is positive action?

There are some situations in which a healthcare provider can provide (or refuse to provide) all or some of its services to people based on a protected characteristic.

Equality law also allows a healthcare to treat disabled people more favorably than non-disabled people. The aim of the law in allowing this is to remove barriers that disabled people would otherwise face to accessing services. For example, a hospital provides parking spaces for disabled patients closer to the entrance so they don't have so far to go (this may also be a reasonable adjustment).

In addition, it may be possible for a healthcare provider to target its services at people with a particular protected characteristic through positive action. You must be able to show that the protected characteristic these people share means they have a different need or a past track record of disadvantage or low participation in the sort of services you run. If you are thinking about taking positive action, you must go through a number of steps to decide whether positive action is needed and what sort of action to take.

Scoring your adverse impact

You will also need to score each of your negative impacts and record the scoring in your Action Plan (page 18).

Matrix for Full Equality Impact Assessments (Stage 3)

- 1. PROBABILITY** - What is the likelihood of the service, policy or function having an impact on staff or patients of the Trust? Use the table below to assign this incident a category code.

MEASURES OF PROBABILITY		
Descriptor	Level	Description
Rare	1	The service, policy or function will only impact under exceptional circumstances
Unlikely	2	The service, policy or function is not expected to have an impact but will do in some circumstances
Possible	3	The service, policy or function may have an impact on occasion
Likely	4	The service, policy or function is likely to impact, but not on a persistent basis
Almost Certain	5	The service, policy or function is likely to impact on many occasions and on a persistent basis

Descriptor	Potential Impact on Individual(s)	The Potential for complaint/ Litigation	Potential Impact on Organisation	Number of Persons likely to be affected
Negligible 1	<ul style="list-style-type: none"> No impact or adverse outcome 	<ul style="list-style-type: none"> Unlikely to cause complaint/ litigation 	<ul style="list-style-type: none"> No risk at all to organisation 	0-1 Person
Low 2	<ul style="list-style-type: none"> Short term impact 	<ul style="list-style-type: none"> Complaint possible Litigation unlikely 	<ul style="list-style-type: none"> Minimal risk to organisation 	2-4
Medium 3	<ul style="list-style-type: none"> Semi-permanent impact 	<ul style="list-style-type: none"> Litigation possible but not certain. High potential for complaint. 	<ul style="list-style-type: none"> Needs careful PR Reportable to SHA External investigation (e.g. HSE) 	5-10 Persons
High 4	<ul style="list-style-type: none"> Permanent impact 	<ul style="list-style-type: none"> Litigation certain expected to be settled for < £1M 	<ul style="list-style-type: none"> Service closure Threat to Divisional/Directorate objectives/priorities Local publicity 	10-20 Persons
Very High 5	<ul style="list-style-type: none"> Permanent and severe impact 	<ul style="list-style-type: none"> Litigation certain expected to be settled for > £1M 	<ul style="list-style-type: none"> National adverse publicity Threat to Trust objectives/priorities 	Over 20 persons

- 3 Equality Impact Score** - Use the matrix below to grade the risk.

E.g. S-2 x P-4 = 8 = Yellow or
S-5 x P-5 = 25 = Red

Probability	Severity of Impact				
	Negligible 1	Low 2	Medium 3	High 4	Very High 5
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

Examples of Discrimination according to descriptor

Descriptor	
Negligible 1	Patient complaining that their dignity has been infringed due to having to wait in reception after eyes being dilated.
Low 2	Temporary relocation of Clinic due to refurbishment. Patients required to travel longer distance to attend clinic.
Medium 3	Uneven surfaces making it dangerous for wheelchair users to manoeuvre across.
High 4	Service excludes particular patients due to their religious requirements.
Very High 5	Emergency Fire Escape: Lack of accessible escape routes for disabled patients.

Roles and Responsibilities

Lead person completing EIA

- To complete EIA toolkit
- To obtain Group Director of Operations or Corporate Head of Service approval.
- To present EIA at ward / clinical group review

Group Director of Operations / Corporate Head of Service

- To provide support and guidance in the completion EIA
- To review all Full Impact Assessment Action Plans.
- To review each action against the EIA Matrix
- Group Director of Operations / Corporate Head of Service to monitor actions on a quarterly basis and escalate all Medium, High and Very High impacts to the relevant CLE (Clinical Leadership Executive) Committee.

Equality & Diversity

- To randomly audit EIAs on a monthly basis.

CLE (Clinical Leadership Executive) Committee

- To agree and discuss likely outcome and agree actions to follow.
- To monitor all medium, high and very high impact action plans quarterly.

Equality Impact Assessment

Stage 2 Initial Assessment form

The Initial Impact Assessment is a quick and easy screening process. It should:

1. Identify those services, policies, or functions which require a full EIA by looking at:
 - Negative, positive or no impact on any of the protected characteristics.
 - Opportunity to promote equality for the protected characteristics.
 - Data / feedback prioritise if and when a full EIA should be completed
2. Justify reasons why a full EIA is not going to be completed

Group:

Estates

Directorate:

New Hospital Project

Speciality/Service Area

New Hospital Project

Is it a Service, Policy or Function:

Lead officer (enter name and designation):

Dawn Webster, MMH Project Manager

Title of service , policy or function :

New Hospital Project

Is this service aimed at:

Adults ☐ Paediatrics ☐ Both ☒

Existing:

☐

New/proposed:

☒

Changed:

☐

Equality & Diversity
Team



Q1) What is the aim of your service, policy or function (you may want to refer to the Operational Policy for your service)?

Design and access arrangements for the Midland Metropolitan Hospital

Q2) State which Trust strategic objective this service, policy or function relates to:

21st Century Facilities

Q3) Who benefits from your service, policy or function?

Patients, staff, visitors and the local community

Q4) Do you have any feedback data that influences, affects or shapes this service, policy or function?

Yes	No
<input checked="" type="checkbox"/> Please complete below.	<input type="checkbox"/> Please go to question 5

What is your source of feedback?

- ☐ Monitoring Data
- ☐ PALS
- ☒ Previous EIAs
- ☐ National Reports
- ☐ Internal Audits
- ☐ Patient Surveys
- ☐ Complaints / Incidents
- ☒ Focus Groups
- ☒ Equality & Diversity Training
- ☒ Equality & Diversity Team
- ☐ Other (please state) Equality Impact Assessment Steering Group

What does this source of feedback reveal?

Feedback revealed possible issues for a variety of protected groups in the design of the new hospital

Q5) Thinking about each group below does or could the service, policy or function have a negative impact on members of the protected characteristics below?
(Please refer to pages 3 & 4 for further definitions of protected characteristic)

Protected Characteristic	Yes	No	Unclear
Age	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Race	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sex	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Gender Reassignment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sexual Orientation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Religion or belief	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pregnancy & Maternity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Marriage & Civil Partnership	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other socially excluded groups	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If the answer is "yes" or "Unclear" please complete a full EIA

Q6) Who was involved in the EIA and how?

<p>Who:</p> <p><input checked="" type="checkbox"/> Staff members</p> <p><input checked="" type="checkbox"/> Consultants</p> <p><input checked="" type="checkbox"/> Doctors</p> <p><input checked="" type="checkbox"/> Nurses</p> <p><input checked="" type="checkbox"/> Local patient/user groups</p> <p><input checked="" type="checkbox"/> Other</p> <p>Please specify Foundation Trust Members</p>
<p>How were they involved?</p> <p><input type="checkbox"/> Surveys</p> <p><input type="checkbox"/> Team Meeting</p> <p><input type="checkbox"/> Group Review</p> <p><input checked="" type="checkbox"/> Other</p> <p>Please specify: Local EIA steering group. Foundation Trust consultation events re general design and access. Design Vision and department specific boot camps to discuss design and patient flow.</p>

Q7) Have you identified a negative/potential negative impact (direct /indirect discrimination)?

No	<input type="checkbox"/>	yes	<input checked="" type="checkbox"/>
----	--------------------------	-----	-------------------------------------

Q7a) If 'No' Explain why you have made this decision?

--

Q7b) If 'yes' explain the negative impact – you may need to complete a full EIA

<p>Possible negative impact on those with disabilities when moving around building, using reception facilities and using sanitary facilities.</p> <p>Possible negative impact for Age and Disability on accessing the new hospital, due to location if travelling by public transport. However, regular bus services will be provided onto site, at the rate of 24 per hour, which will drop off directly outside the main entrance. Further buses will drop off at a proposed bus terminal on the outskirts of the site with a 150 m walking distance to the main door of the hospital. Continued discussions taking place with local Council and public transport companies to ensure an appropriate provision of public transport from all parts of the catchment area.</p> <p>Possible negative impact on the basis of Race as English may not be their first language so a simple, intuitive way-finding strategy will need to be implemented.</p> <p>Possible negative impact for bariatric patients in regard to provision of appropriate facilities which provide adequate privacy and dignity.</p>

If a negative impact has been identified please continue to Stage 3. If no negative impact has been identified please submit your Initial Equality Impact Assessment to your Group Director of Operations or Corporate Head of Service approval.

Please note: Issues relating to either interpreting/translating, ensuring single-sex accommodation or Bariatric issues have been identified as corporate trends, therefore if the negative impact you have identified falls within these categories a full impact assessment is not required. However you must state what reasonable adjustment you have put in place to mitigate the impact temporarily.

Should you go full impact assessment Corporate trends must be included on the action plan (page 19) along with what actions (reasonable adjustments) are being taken locally whilst the corporate trends are being addressed.

Justification Statement:

As member of SWBH staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete this EIA by law. By stating that you have not identified a negative impact, you are agreeing that the organisation has not discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in the Equality Legislation.

Completed by:

Name:	Dawn Webster
Designation:	MMH Project Manager
Date:	22 April 2015
Contact number:	5469
Head of Service:	Daphne Lewsley

This EIA has been approved by the Group Director of Operations / Corporate Head of Service:

Name:	Daphne Lewsley
Designation:	Commercial Manager
Date:	22 April 2015
Contact number:	5882

This EIA has been audited by Equality & Diversity:

Name:	
Signature:	
Date:	
Contact number:	

Step 8) Now that you have ensured a full impact assessment does not need to be completed we need to publish your results for the public to view.

Tick list

- ☐ Send an electronic copy of ratified EIA for approval to the Accountable Executive Lead and the Trust Secretary in line with the Policy on the Development, Approval and Management of Policies.

Equality & Diversity contact details

You can contact Equality and Diversity by:

Tel: 0121 507 5561 or Email: swb-tr.SWBH-GM-EqualityDiversity@nhs.net

Equality Impact Assessment

Stage 3 Full Assessment Form

Having completed the Initial EIA Screening Form (Appendix A) which identified a negative or potential negative impact, you are required to complete this Full Assessment form. This will involve you questioning aspects of a proposed/existing service policy or function and forecasting the likely effect on different groups.

Step 1) What is the impact?

1) Why have you carried out this Full Equality Impact Assessment?

- Possible negative impact on those with disabilities when moving around building, using reception facilities and using sanitary facilities.
- Possible negative impact for Age and Disability on accessing the new hospital, due to location, if travelling by public transport.
- Possible negative impact on the basis of Race as English may not be a person's first language so a simple, intuitive way-finding strategy should be implemented.
- Potential negative impact for bariatric patients in regard to provision of appropriate facilities which provide adequate privacy and dignity in all relevant areas.

Please mention any additional impacts in the box below. This could include contributing factors or conflicting impacts/priorities (e.g. environment, privacy and dignity, transport, access, signage, local demography) that has resulted in indirect discrimination or anyone else who will be impacted on by your service, policy or function.

N/A

Step 2) what are the differences?

2a) Identify the Equality group(s) that will be affected by the impact and state what the differences are:

Protected Characteristic	Negative / Potential Negative Impact	Positive / Potential Positive Impact	How is the Equality group identified affected in a different way to others as a result of the service, policy or function?
Age	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Possible impact due to ability to travel to the new hospital on amended public transport routes, although hospital is only one mile distant from current site. It may entail changing buses a number of times.
Disability	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Possible impact due to ability to travel to new hospital on amended public transport routes, as above. Also, access to appropriate sanitary and changing facilities and appropriate height reception desks for those in wheelchairs. Hearing loops will be required.
Race	<input checked="" type="checkbox"/>	<input type="checkbox"/>	As English may not be the first language of our local demographic, the way-finding strategy will need to be simple, clear and intuitive, using colour, symbols, maps etc.
Sex	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The new hospital will be built with 50% single rooms and 50% four bedded bays. Each of these rooms will have en-suite facilities.
Gender Reassignment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	All patient bedrooms will have en-suite facilities. One size fits all wcs provided throughout the building, alongside traditional male and female wcs. This provides an option for people with gender-reassignment.
Sexual Orientation	<input type="checkbox"/>	<input type="checkbox"/>	
Religion or Belief	<input type="checkbox"/>	<input checked="" type="checkbox"/>	A multi-faith chapel will be provided within the building providing facilities for group worship, plus specific prayer facilities for muslims and other faiths. Culturally appropriate food choices will be available for patients.
Pregnancy & Maternity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	All maternity and childrens services will be provided from the building. Direct access has been provided for mothers in labour to gain swift access to the department. Independent baby feed and baby changing facilities provided at key locations within building.
Marriage & Civil Partnership	<input type="checkbox"/>	<input type="checkbox"/>	
Other socially excluded groups	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The Trust is leading a project to provide medical care for the homeless in Birmingham

Further positive impact for all groups includes:

- A full range of diagnostic facilities will be undertaken in three of the five community hospitals in addition to the new hospital. X-Ray facilities will also be provided at all five community hospitals. In most cases, this should improve access.
- A whole systems approach to critical care will be implemented which should improve care for all groups.
- There will be an integrated childrens inpatient service in a safe, family-focussed environment.
- The delivery suite will include an assessment function with admission to the Birth Centre, or acute birth rooms with both areas providing single rooms.
- The design vision reflects the requirement for creating a light and airy, uncluttered, non-threatening, confidence-inspiring environment which will help all groups.
- Planned adjacency of clinical departments will improve patient flows and improve the clinical care for all groups.
- Car and taxi drop-off areas provided in under-croft car park close to direct route to main entrance, entailing short distance, direct, indoors travel.
- Operational policies will be reviewed and individual EIAs carried out to ensure that no groups are disadvantaged by change in clinical processes.

2b) This EIA indicates that there is insufficient evidence to judge whether there is differential impact. Please state why below.

N/A

Step 3) You are almost there - now all you need to do is to consult!

3a) Who have you consulted with on your service, policy or function and when did the consultation take place?

Local user group 2009, EIA steering group 2009 – 2011. Foundation Trust members 2013 – 2014. Participation of representatives of the general public involved in Design Vision Bootcamps and evaluation October 2014 – April 2015.

3b) As a result of the consultation are there any further changes to the service, policy or function indicated?

An action plan has been written below

Step 4) Plan to address your Negative Impact

1. It is now time to complete your action plan using the table below. Please detail how you are going to address the negative impact, stating the timescales involved. Please refer to the matrix on pages 11 and 12. When including the rag rating please state how the score was achieved e.g. severity (S) 3 x Probability (P) 4 = 12.

Protected Characteristic	Negative Impact	Negative Impact RAG Rating	Action Required	Cost Implications	Expected Outcome	Lead (name and designation)	Timescale (specify dates)

Disability	Difficulty in moving around building, using reception desks and sanitary facilities		<p>Disabled parking spaces adjacent route to main entrance. Lifts will be primary source of movement around building with horizontal movement across Level 5. Visitor lift exits situated 20 m from entrances to departments, reducing requirement for horizontal movement.</p> <p>All reception desks to be designed to provide appropriate lower height access for people in wheelchairs.</p> <p>Loop systems to be installed within building for those with hearing problems.</p> <p>Sanitary facilities include 'one size fits all' wcs which are 5.5 sq m and allow wheelchair and motorised scooter access.</p> <p>Two x formal 'changing places' wcs, incorporating changing facilities for disabled adults designed into building.</p> <p>Confirmation of facilities for people with sight loss to be confirmed in design.</p> <p>The building will be designed to be dementia-friendly, incorporating key dementia-friendly design principles.</p>				
------------	---	--	---	--	--	--	--

Age and disability	Travel to new hospital for frail, elderly and disabled	P3 x S2 = 6	Following consultation with local council, transport providers and builders regular bus services will be provided onto site, at the rate of 24 per hour, which will drop off directly outside the main entrance. Further buses will drop off at a proposed bus terminal on the outskirts of the site with a 150 m walking distance to the main door of the hospital. Continued discussions taking place to ensure an appropriate provision of public transport from all parts of the catchment area.	Nil to Trust	All patients will be able to access new hospital	Core Project Team	2018
Age and disability	Travel to new hospital for frail, elderly and disabled	P3 x S2 = 6	Consider possibility of providing improved shuttle bus service to include patients, between hospital sites, if necessary, following discussions above.	Cost of shuttle bus and driver	All patients will be able to access new hospital	Core Project Team	2018
Race	Difficulties in way-finding if a person's first language is not English	P4 x S2 = 8	Simple, intuitive way-finding strategy proposed incorporating colour, numbers, symbols, pictures and artwork. Interactive maps to be provided. Ease of visual interaction to all floors from main entrance to view routes from start to finish. Volunteers to be used upon initial opening of building to guide people to destinations.	Nil to Trust, as incorporated in design	Ease of navigation through building for all	Core Project Team	2018

Bariatric	Provision of appropriate facilities throughout the building for bariatric patients which provide adequate privacy and dignity.		<p>Emergency and Elective inpatient facilities will be provided for bariatric patients up to 47 stone, with a reduced number of facilities provided in inpatient wards for patients up to 60 stone. Appropriately sized equipment and hoists will be provided in these areas.</p> <p>Outside of these areas, bariatric patients will be managed operationally, rather than by building design.</p> <p>Bariatric wc facilities will be provided at key locations within the building</p> <p>Lifts will be provided which cater for bariatric patients, including relevant equipment and beds, in both size and weight allowance.</p>	Nil to Trust as incorporated into building design	Bariatric patients will be treated in facilities which provide an appropriate level of privacy and dignity within the building	Core Project Team	2018
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NB: As a requirement of the Clinical Group Review process, please ensure that you include the above actions within your Implementation Plan.

Step 5) Congratulations you have made it.

Completed by:

Name:	Dawn Webster
Designation:	MMH Project Manager
Date:	22 April 2015
Contact number:	5469
Head of Service:	Daphne Lewsley, Commercial Manager

This EIA has been approved by the Group Director of Operations / Corporate Head of Service:

Name:	Alan Kenny
Designation:	Director of Estates and New Hospital Project
Date:	22 April 2015
Contact number:	5676

This EIA has been audited by Equality & Diversity:

Name:	
-------	--

Signature:	
Date:	
Contact number:	

Step 6) Now we need to publish your results for the public to view.

Please complete the tick list below.

- ☐ Send an electronic copy of ratified EIA for approval to the Accountable Executive Lead and the Trust Secretary in line with the Policy on the Development, Approval and Management of Policies.

Equality & Diversity contact details

You can contact Equality and Diversity by:

Tel: 0121 507 5561 or Email: swb-tr.SWBH-GM-EqualityDiversity@nhs.net

APPENDIX 21a – RIGHT CARE RIGHT HERE CONSULTATION DOCUMENTS

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case



Towards 2010 – Investing in a healthy future: Research Report

20 November 2006 – 16 February 2007

Project No. 1294

ACKNOWLEDGEMENTS

This report was prepared by
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Executive summary

The *Towards 2010* consultation process was wide in its scope, covering the opinions and concerns of a diverse array of people. The methods used to capture this range of views were broad, incorporating public meetings, online and paper-based questionnaire responses, advertisements and features in the local media, stakeholder responses and focus groups. The findings of the research are strengthened through this multi-method approach.

The data gathered from the consultation was analysed by **QUAD research**, an independent research organisation based at the University of Warwick.

In total, some 601 single responses were received in response to the consultation. In addition, there were:

- 3,266 signatories to two petitions
- At least 1,891 attendees at public meetings
- Approximately 323 participants in a series of focus groups
- 23 group responses
- 18 formal responses

Quantitative data from questionnaires was analysed to produce demographic information about respondents, and to investigate their opinions about the *Towards 2010* programme. Qualitative data from all types of responses was analysed using a dedicated coding matrix, which identified emerging themes and their frequency.

Demographics

Nearly two thirds (64.1%) of questionnaire respondents were female. The majority of questionnaire respondents (65.7%) were aged 45 or over, 22.3% were aged 30 – 44, and 12% were under 30 years old. Most questionnaire respondents were of white origin (73.7%), 5.8% were Asian or Asian British – Pakistani, and 5.1% were Black or Black British – Caribbean.

A quarter of questionnaire respondents categorised themselves as disabled. Two in five (40.3%) respondents reported they had a long-term health condition. In the past

two years, 79.8% of respondents had visited a family doctor, 63.4% had been treated in hospital, 36.9% had stayed overnight in a hospital, and 4.4% had stayed in a nursing or care home.

It is possible that people may have been more likely to complete the questionnaire (and also to attend public meetings) if they felt their experience of health care services would be directly and immediately impacted by the proposed changes. This might include people with long-term health conditions, disabilities, older people, and so on. The consultation process possibly captured larger amounts of information from those who either have an explicit interest in the changes, or those who are resistant to them.

Support for proposals

There was positive support for the overall proposals. Some three-quarters of respondents to the questionnaire (73.2%) said they supported the proposals, 69.3% thought changes to services were needed in their local area, and 45.8% thought changes will provide the health and social care services important to them. At public meetings, many attendees responded positively to the proposed new specialist hospital. This support was often expressed simultaneously with queries or concerns about the detail and impact of proposals, and it is these queries that constitute a large part of the analysis provided in the report.

Support was also offered from the majority of formal responses (from Primary Care Trusts, NHS Trusts, local authorities and other stakeholder organisations). Often this support was given together with queries or cautions about the impact of the proposals on current and future activity.

There were also some strongly expressed concerns about certain aspects of the proposals, and these have been captured in the analysis of emerging themes. In addition, two petitions were received with over three thousand signatures between them. The largest petition disputed the proposed site of the new hospital, and expressed concerns both that costings were flawed and that the programme for care in the community would not work.

Key themes

Respondents supported the theory behind the process and the need for change, if not always the exact ways in which the change was to be implemented. This may be due to certain concerns being emotive, particularly within the areas of relocation of existing services, transport and travel, and management.

Comments about existing services expressed a preference for changes to current healthcare provision, and questioned the precise implications of the change process, particularly in terms of the relocation of existing services.

Concerns were raised about the transit time to potentially relocated A&E services, as well as the need to establish efficient transport networks in the area. There was a desire for more specific information on the accessibility of potentially relocated services.

Respondents indicated a desire for a greater level of knowledge about how the proposed changes would be managed. There were some doubts about the effectiveness of shifts in care provision, particularly relocation of staff and increases in community care. Resource management was considered an issue. The precise allocation of funds within the proposal and whether these would be enough to cover the entire programme was questioned. Many were sceptical about the use of the Private Finance Initiative.

There was some concern that proposals were a foregone conclusion, and that public involvement was likely to have little effect. Respondents requested a greater level of involvement in the process, and more detailed information about the proposals themselves.

Community care was the most prevalent area of commentary from respondents, with nearly 13% of all responses mentioning such issues in some way. There was some anxiety at the closure of local hospitals, as well as a desire for improved services in the community.

The potential risks of perceived fragmentation of care services, and a reduction or loss of local GP practices attracted some concern. There were worries that close

personal relationships between patients and doctors would be jeopardised, and many respondents wanted clarification on this issue.

There were also questions about specialised services, such as where and how provision for needs as diverse as speech and language therapy, rheumatology, ocular care and sexual health would be catered for. Respondents wanted clarification on the impact of the relocation and management of paediatric or neonatal services within the new hospital facilities.

The consultation process was used to voice complaint about current healthcare provision, focusing on areas of apparent practical shortcomings such as difficulties in travelling to existing services, perceived staffing limitations, and the quality of care received. There was a desire for more detailed information about what the change process would entail, and a perceived lack of a comprehensive understanding about the results of the process.

The proposed increase in high quality, patient-driven local community services was welcomed. There were some concerns that the proposals focused too heavily on buildings and finance at the expense of personnel, service quality and patient welfare. There was some feeling that the scope of the proposals was too great to be effectively implemented, and would eventually result in a regionally skewed or reduced service.

Respondents asked if there were sufficient staff numbers to accommodate the new roles established in the proposal, and whether training would be offered to meet this potential deficit. There was a desire for greater numbers of staff, and improvements in the quality of care offered and the skills available.

Comments regarding waiting lists, times and appointments primarily focused on issues with existing services. Fears were expressed over the ability of local services to cope with current or increased levels of demand.

Observations

Many respondents used the consultation process to raise concerns or seek clarification about aspects of the proposed changes that they felt would have a direct impact on themselves, their families and their community, and this occurred regardless of whether or not they supported the overall proposal.

These queries themselves could be thought of in two distinct ways:

- *What does it mean to me?* – whereby concerns addressed how changes might affect respondents personal circumstances
- *What does it mean for us?* – whereby 'us' is the community, the 'bigger picture' concerns

Future phases of the *Towards 2010* programme could proactively address these types of query in isolation to one another, by:

- Providing information that alleviates the concerns of those who are apprehensive about how proposals may impact their own health care
- Promoting activity on an ongoing basis that demonstrates how proposals are impacting on local health care provision in a positive way

Introduction

Towards 2010 – Investing in a Healthy Future is a partnership between the Local Authorities¹ and National Health Service (NHS)² organisations responsible for commissioning and delivering services across Sandwell and the heart of Birmingham.³ The *Towards 2010* programme is ambitious, with major changes proposed to the way in which health and social care services are provided for the 620,000 people living in the area, supported by an anticipated spend of up to £700m on new and improved buildings and equipment.

Two separate but linked consultations took place at the same time:

- *Towards 2010 – Investing in a Healthy Future* - consulted on the long-term vision and strategy for health and social care on behalf of all health and social care organisations across Sandwell and the heart of Birmingham
- *Shaping Hospital Services for the Future* - consulting on behalf of Sandwell and West Birmingham Hospitals Trust (SWBH), concerned with short- and medium-term changes to services⁴

This document reports responses to the ***Towards 2010: Investing in a Healthy Future*** consultation.⁵ A separate report is being prepared regarding the *Shaping Hospital Services* consultation.

¹ Birmingham City Council and Sandwell Metropolitan Borough Council.

² Heart of Birmingham Teaching Primary Care Trust (PCT), Sandwell PCT, Sandwell and West Birmingham Hospitals Trust (SWBH), Birmingham and Solihull Mental Health Trust, and Sandwell Mental Health NHS & Social Care Trust.

³ Covering the 10 wards of Aston, Handsworth Wood, Ladywood, Lozells and East Handsworth, Nechells, Soho, Sparkbrook, Springfield, Perry Bar, and Oscott.

⁴ The process of consultation is a requirement of Section 11 of the Health and Social Care Act 2001, which sets out the legal obligations of public authorities in respect of consultation.

⁵ This consultation was formally conducted by *Heart of Birmingham Teaching Primary Care Trust* on behalf of all the NHS organisations

1.1 Background

Activity prior to the consultation

The process for involving people

In November 2003, a public and service user strategy was developed, which outlined the range of stakeholders and the potential mechanisms that could be used to involve different stakeholders in Sandwell and Birmingham. To implement this strategy, patient and public involvement (PPI) leads, communications officers, and community development specialists from each of the partner organisations came together to agree how best to deliver the public and service user aspects of the programme and integrate this into their mainstream activities. Guidance was also obtained from the Department of Health publication *Strengthening Accountability: Involving Patients and the Public, Policy and Practice Guidance on Section 11 of the Health and Social Care Act 2001*.

As part of this process, a working group, the Wider Stakeholder Engagement (WiSE) Group, was established to champion public and service user involvement and shape the strategies and action plans for involving the public in the programme. Members included representatives from the voluntary sector, patient and public involvement forums, and local elected members. This group provided an ongoing means by which issues could be raised with, and by, stakeholders, and approaches tested.

Consultation activities carried out in advance of the public consultation

Given the diverse range of stakeholders, different methodologies were adopted to encourage wide participation. These ranged from giving information at community events, via news releases and on the 2010 website, through creating opportunities for debate at public meetings, to participation from patient groups in the development of the care pathways and in the shortlisting of options to be considered in the future.

A number of other key projects were carried out to gather the views of local people. A short discussion document, *Investing in a Healthy Future*, was prepared in November 2004. This outlined the rationale behind the programme and asked local people to comment on the improvements they would like to see in the future. Over

20,000 copies were circulated and more than 740 people responded. In addition, an analysis of the local patient surveys was undertaken to identify cross-cutting themes and areas for improvement.

Key findings from these exercises indicated that people from Sandwell and the heart of Birmingham wanted:

- More convenient and local services that would give them faster access to appointments
- Investment in better health and social care facilities
- Patient-focused care with health and social care staff that treated patients with dignity and respect
- Services with good public transport links and car parking services
- More information about health and social care services available
- Clean facilities that reduced hygiene problems and hospital acquired infections

These concerns were adopted as a central driver for the future direction of the programme. The option selected as the preferred solution for public consultation was accordingly designed to be the most effective way to address these issues.

Pre-consultation events

Over the weeks before the formal consultation started, a large number of informal pre-consultation events took place. These included meetings with interested groups, briefing sessions for MPs, councillors, the Joint Overview and Scrutiny Committee for Birmingham and Sandwell, and the three PPI Forums, as well as open days and events. Staff were kept informed through team briefings, newsletters, email and informal meetings. These events built on the pre-consultative work carried out over the previous three years and were designed both to test the consultation materials and to raise awareness of the imminent formal consultation process.

The WiSE Group met regularly throughout this period and was instrumental in producing the questionnaire used during the formal consultation, in partnership with the research team at **QUAD research**.

The consultation process

Public consultation began on 20 November 2006 and ran until 16 February 2007. The consultation ran in parallel with SWBH's consultation on its interim reconfiguration plans, *Shaping Hospital Services for the Future*. That consultation was extended to 15 March 2007 and the results will be reported separately

Consultation materials

The consultation materials consisted of a full consultation document, a summary version and an easy read version. An audio version of the summary document was also prepared, while the easy read version was translated into the nine most appropriate community languages for the area. A questionnaire, which was also translated, was inserted in all the documents to stimulate responses. Separate copies of the questionnaire were also printed and distributed.

A standard presentation for use at public meetings was prepared, together with a background briefing sheet and a list of frequently asked questions and answers.

All material was published on the website <http://www.towards2010swb.nhs.uk/> and the three organisations' internet and intranet sites. (A copy of the questionnaire is available in Appendix 1.)

Launch of consultation

At the start of the consultation, copies of the documents were sent to 1,800 individuals, organisations and groups, including MPs, councillors, schools and universities, libraries, places of worship, patient support groups, community groups, GP surgeries and opticians. An offer to meet with these groups was contained in a covering letter.

External communications

A total of 187 meetings were organised over the three months of the consultation period. These ranged from formal open public meetings to meetings with local community leaders and patient support groups. They also included drop-in sessions for members of the public to voice their concerns. Public meetings were advertised locally and on the programme website.

A monthly Stakeholder Update was produced and circulated to all councillors, MPs and other key stakeholders.

Details of the consultation were contained in the Patient Prospectuses published by each PCT and delivered to every household in each PCT's catchment area.

Speaking at regular meetings of community groups worked exceedingly well. Although often small in numbers of attendees, meetings allowed members of the consultation teams to reach a wide range of minority ethnic and community groups. These meetings were incredibly resource intensive for Board directors and the communications and engagement teams. Open invitation public meetings were less successful in producing significant numbers of attendees.

The Birmingham Evening Mail hosted a public debate in the African Caribbean Millennium Resource Centre on Dudley Road, Birmingham in January 2007. All questions asked during the debate were printed in the next edition of the Evening Mail.

Internal communications

All staff in the two PCTs and SWBH were informed of the consultation via email on 20 November and received regular email updates together with articles in each organisation's staff magazine. Every member of staff at SWBH received a copy of the summary document and of the questionnaire with their payslip at the end of December. A wide range of meetings was also held for staff, including department-specific and open briefing sessions.

Media coverage

Individual briefing sessions were held for the Editors of the Express and Star and the Evening Mail. John Adler, Chief Executive of SWBH, was interviewed on BBC Radio WM's Ed Doolan programme at the start of the consultation and Midlands Today ran a story at the start of consultation. During the consultation there were regular articles in the Evening Mail, Express and Star, Great Barr Observer, Sandwell Chronicle, and the local authority newspapers delivered to most households in Sandwell and Birmingham.

In addition, an advertorial on the consultation and including the questionnaire was printed over two pages of both the Sandwell Chronicle (circulation 98,000) and the Birmingham News (circulation 243,000). These publications are distributed to most households in these areas.

John Adler and Sandy Bradbrook, Chief Executive, Heart of Birmingham Teaching PCT, were interviewed on New Style Radio, which has a large African Caribbean audience. John Adler, Sandy Bradbrook, Jacky Chambers (Director of Public Health, Heart of Birmingham Teaching PCT), Diane Reeves (Director of Service Development, Sandwell PCT) and Hugh Bradby (Medical Director, SWBH) took part in an hour-long phone in and discussion on the Ed Doolan radio programme on 26 January. Ed Doolan also broadcast his programme from City Hospital on 23 February and devoted two hours of the programme to the planned changes.

1.2 Methodology

In this document, **QUAD research**⁶ reports on the data from the consultation process gathered from a questionnaire (distributed in paper copy, in local newspapers and online), public meetings, responses from stakeholder groups, responses by letter or email to the research team and other stakeholders, and a brief series of focus groups. **QUAD research** has also received petitions addressing the consultation – a discussion of these is provided in Section 2.4.

The research process benefits from this multi-method approach. Data provided from a range of research techniques (such as focus groups and questionnaires) serves both to strengthen the validity of the project and broaden its capacity to capture the varied responses to the consultation programme.

The data collection process yielded both quantitative (questionnaires) and qualitative (all formats) data. Quantitative data was analysed to produce demographic information about the respondents to the questionnaire, their support of different components of the *Towards 2010* programme, and to investigate the relative importance of certain aspects of services to them. A thematic approach was taken to analyse the qualitative data, with emerging themes being coded using a dedicated data coding matrix.

Reponses

It should be carefully noted that it is not possible to calculate a final figure of responses to the consultation for the following reasons:

- Full data was not received for all public meetings
- Focus group data cannot be quantified as individual responses from attendees, and a precise number for attendees was not provided for each focus group
- Formal responses were received from collectives
- Group responses were received from collectives

⁶ <http://www.quadresearch.co.uk>

Table 1 illustrates the responses to the consultation where single responses can be quantified. The grey sections illustrate where known responses are not equivalent units and therefore cannot be quantified in the same way.

Table 1 – Responses

Format data	No. responses
Questionnaire – paper	511
Questionnaire – online	22
Questionnaire – newspaper	42
Letters	13
Emails	13
Petitions	3,266
Public meetings	1,891 <i>known attendees</i>
Focus Groups	323 <i>approx participants</i>
Formal responses	18 <i>responses</i>
Group responses	23 <i>groups</i>

Questionnaires

Questionnaires were distributed widely by the consultation team (as described in the Background section). Printed copies of the questionnaire were returned by respondents using a “Freepost QUAD” address dedicated to the project. An online version of the questionnaire was designed by the research team using specialist online survey software. The URL link to this questionnaire was made available via the *Towards 2010* website.⁷

All paper responses were data entered into a statistical software package (SPSS)⁸, and online responses were downloaded into the same dataset. All data entry was subject to a rigorous data accuracy checking procedure.

A coding matrix was developed to interpret the qualitative data responses and this data was extracted from the data and coded as appropriate.

⁷ <http://www.towards2010swb.nhs.uk/>

⁸ SPSS: Statistical Package for the Social Sciences

Public meetings

The research team developed a template for use by consultation team staff attending the public meetings. The template was used to record the questions raised at public meetings, and the answers given, as well as any further comments made by members of the public. Completed templates were returned electronically to **QUAD research** for analysis.

A coding matrix was developed to interpret the qualitative data from public meetings. This was analysed using qualitative data analysis software (NVivo).

Responses from stakeholder groups

Responses regarding the consultation were received by letter or email from a variety of stakeholder individuals and groups, including members of the general public. Responses were forwarded to **QUAD research** for analysis.

Formal responses from key organisations have been analysed separately for the purposes of this report, and are presented in section 2.5.

Focus groups

A brief series of focus group sessions was held by the consultation team between September 2006 and January 2007. Findings from these focus groups have been written up in a separate report which is available in Annexe 1 to this document. Key findings from focus group data have been further analysed by the research team for the purpose of this report, and are included in the thematic analysis (Section 2.1).

Petitions

The research team received two petitions in response to the consultation. The issues raised in the petitions have been analysed and presented as part of the thematic analysis. In addition, a discussion of the petitions themselves is included in Section 2.4.

1.3 Caveat

Response rates

Despite the questionnaire being distributed very widely by the consultation team, there remained a relatively low response rate (575). It is possible that some people felt their views were adequately represented in the questioning at the public meetings or through group responses to the consultation. These views have been captured and are presented in this report.

It is important to approach interpretation of the quantitative data with some caution. Due to the relatively low response rate from the questionnaire, this data may not be a representative sample of the population. In addition, it is possible that people may have been more likely to complete the questionnaire (and also to attend public meetings) if they felt their experience of health care services would be directly and immediately impacted by the proposed changes. This might include people with long-term health conditions, disabilities, older people, and so on. This supposition appears to be borne out by apparent disparities in the respondent profiles (see Section 2.2). It is perhaps correct to say that the consultation process inevitably captured larger amounts of information from those who either have an explicit interest in the changes, or those who are resistant to them.

Presentation of data

Qualitative data presented in this report has been analysed by the research team. Emerging themes are presented according to the degree to which each individual theme was raised over the duration of the consultation. It is important to recognise that it is not possible to measure precisely the weighting of individual themes. This is because, while themes emerging from the questionnaires can be attributed as being raised by individuals, those from other data formats (public meetings, group responses, focus groups and so on) cannot. It is not possible, for example, for the research team to know how many attendees at a particular public meeting agreed with each of the questions (themes) raised.

Instead, themes are presented according to their emerging importance relative to one another (for a full explanation of this see Section 2.1.).

It should be noted that due to the connection between the two concurrent consultations, *Towards 2010* and *Shaping hospital services for the future*, it was sometimes difficult to separate comments that referred or were of relevance to both consultation processes. Comments have been left in the report for information where there is clear overlap between the two consultations.

Printing errors

Printing errors in the newspaper versions of questionnaires led to some responses to question four being marked as missing in the dataset. This does not inadvertently impact upon results presented, as the data was treated by SPSS as missing data, and the responses to these questions were therefore calculated as valid percentages rather than actual percentages.

The following sections of question four were printed incorrectly in the Sandwell Chronicle:

- Easier to use services
- Outpatients appointments in the community instead of the hospital
- Care provided in better building
- Services that create more local jobs

As a result, these questions were marked as missing in the dataset. However, the response rate from the newspaper was low (38 responses), and therefore had relatively little effect on the overall findings. Findings were calculated to a valid percentage, where appropriate, in order to take into account missing data.

There was a further printing error in the double-sided questionnaire (distributed in the SWBH staff magazine *Heartbeat*) in the following sections of question four:

- Easier to use services
- Outpatients appointments in the community instead of the hospital

As a result, these questions were marked as missing in the dataset. Again, the response rate from this format of the questionnaire was relatively low (34 responses).

1.4 About QUAD *research*

QUAD *research* is an independent research organisation based at the University of Warwick. **QUAD *research*** work to nationally agreed professional quality and ethical standards to ensure that all research is carried out in an independent, robust and ethically sound way.

Over the course of the consultation process, **QUAD *research*** have advised on the design and distribution of questionnaires, and provided tools for gathering data from aspects of the consultation process. **QUAD *research*** has full and independent editorial control over the production of this report.

1.5 Reporting

This report details a qualitative analysis of comments and free text responses to the consultation, using a thematic analysis. It also provides a quantitative analysis of responses to the consultation questionnaire.

Throughout this report quotations from respondents appear in *italics*. They are included as examples to illustrate particular points, and do not necessarily capture everything that has been written on the topic to which they relate.

2 Results

This results section is broken down into four parts:

- 2.1 – A **thematic analysis** of qualitative data received through all formats used in the consultation process (questionnaire, public meetings, focus groups, stakeholder responses)
- 2.2 – An analysis of the **quantitative data** received through the questionnaire
- 2.3 – Information about the **respondent demographics**, from the questionnaire, public meetings, and group responses
- 2.4 – A report on the **petitions** that have been received by the research team in response to the consultation
- 2.5 – An analysis of the **formal responses** received from key stakeholder organisations

2.1 Thematic analysis

In the following analysis, the emerging themes from the consultation are presented in order of their importance relative to one another. Themes that emerged from each of the different formats of data collection (questionnaire, public meetings, focus groups, stakeholder responses) are presented according to the total number of times that they appeared in each format. Where possible, the number of times a theme emerged within and across formats is provided in brackets.

The first section is a **discussion of overall themes** which discusses the way in which themes emerged across the different formats of data collection. This is followed by a more detailed **analysis of themes** in order of their relative importance. Finally, there is a brief section concerning the **ongoing reporting to respondents** which documents responses from question 9 in the questionnaire.

Throughout, examples are given in *italics* of some of the indicative and distinctive comments that have been given.

It is important to reiterate that the connection between the two concurrent consultations, *Towards 2010* and *Shaping hospital services for the future*, led to overlap of some comments across both consultations. Where this has happened, comments were left in the report for information.

2.1.1 Discussion of overall themes

Qualitative responses from all formats of data collection (questionnaires, public meetings and so on) used in the survey were categorised under key themes. The same code frame was used across all formats to analyse responses from public meetings, focus groups, groups, letters and emails. An individual response within any of these formats was assigned single or multiple code frames, according to the scope and complexity of the comment in question.

Analysis of the number of times themes arise in each format takes several forms: those areas which were particularly prevalent amongst the responses, those which were correspondingly scarce, and the ways in which these distributions differed across different formats. Unusually high or low incidences are also worthy of analysis, with specific instances from the various data cited where indicative.

This section of the report is a discussion of the way in which themes were raised according to the different formats of data collection. The first part of the section discusses the themes aggregated across all formats. Subsequent parts discuss the differing frequencies with which themes were raised within each format.

Themes aggregated across all formats

A combined total of the data from all formats reveals that comments relating to community care – both in its formalised meaning and in the more general sense of care being given to the community – comprised the most prevalent emerging theme (with 453 comments either fully or partially pertaining to it). The next highest numbers of comments were:

- Issues surrounding existing services (368)
- Transport and travel (358)
- Theory and process of developing the proposal (326)

There are several reasons for the dominance of certain themes within the responses. Specifically, the consultation process centres around a set of key proposals, for which a correspondingly large public reaction would be expected (as opposed to, say, hospital cleanliness, which is an issue common in public health discourse

outside the specific remit of the consultation). Therefore, it is perhaps unsurprising that themes of community care, and transport and travel feature highly among the responses, since the *Towards 2010* process features a proposed partial movement of services, both away from hospitals more generally and in the specific location of certain hospital services.

Public meeting data

Within data returned from public meetings, comments relating to the consultation process were the most prevalent theme (124). Proportionately, this was a higher ranking than within the aggregated totals. Similarly, comments relating to the involvement of the general public within the consultation process were more prevalent than within the sample as a whole (58). This data would appear to indicate that individuals attending public meetings – in other words, those already involved in the consultation – either wished to have further participation in the process themselves, or would have liked to have see it extended to involve greater numbers of people.

Attendees of public meetings also felt the involvement of healthcare professionals was important to the consultation process (24). This could potentially be due either to the presence of such professionals within the meetings, or due to a wider public desire for more consultation with such individuals.

Responses addressing quality of care issues occurred less in public meetings than amongst the aggregate totals. Contrastingly, the potential impact on A&E provision (38), location of the new hospital (37) and the possible effect on specialist services (33) featured more often. The quality and implementation of these services represent arguably the most practical manifestation of the potential change process being put forward and therefore it is perhaps unsurprising that such issues featured heavily among service users present at public meetings.

Focus groups

In the focus groups, issues regarding transport and travel (10) and re-location of existing services (9) were the most prevalent. Over half of the code frames used to

analyse the data were not featured at all among focus group responses, although as previously mentioned this is likely due to the low levels of data within this particular method of data collection.

Stakeholder responses

The postal (freepost) and email addresses to which completed questionnaires were returned were also used for open text responses in the form of letters and emails. These originated from both groups and individuals.

As with the survey population as a whole, themes of community care (25) and the consultation process itself (17) featured heavily among the group stakeholder responses. However, issues relating to transport and travel (17), staff skills (9), resources (8) and waiting lists (8), themes middle-to-highly ranking among the combined responses, were common among respondents. It is notable that whilst these operational issues were highly featured, comments pertaining to the theory and process of developing the proposal, the fourth most highly occurring theme within the overall totals, featured very rarely (3). As mentioned with regard to the public meeting data, it would seem likely that these issues are more relevant to people involved in the consultation process as they represent practical manifestations of a theoretical change.

Amongst letters and emails received from individual stakeholders, the possible impact on A&E services was the most prevalent theme (17 responses out of a total of 71 for the entire method of data collection). Its dominance here – greater than within the aggregated totals – can be partially ascribed to the MP of one of the areas covered by the proposals who invited his constituents to respond in writing regarding this specific issue. As with other consultation formats with low responses, further definitive analysis is difficult due to the indicative rather than representative nature of the data.

Questionnaire responses

The qualitative (free text) responses from questionnaires are considered here, broken down by specific questions.

Question 2 – ‘Are there any parts of the proposal you value most?’

In relation to specific areas of the proposal that most appealed to respondents, this question revealed two specific issues: those areas of change most needed because the *changes* would be valued, or because the *area which they are to change* is of current concern. It is not always easy to isolate the two, although specific comments will be used to illustrate key points.

Community care, as with other data collection methods, was the theme emerging most commonly within this question. With 156 responses, it featured nearly four times as often as the next highest (theory and process of developing the proposal, with 43). Analysis of the comments falling within this category points to a desire for more community-based services as well as services closer to home. Very few comments regarded increased community care as problematic, although the ways in which ‘community care’ is interpreted by respondents results in some variation in exactly what is covered by this term. Indeed, some support community care because they feel it will offer more local hospital care (“*The fact that there will be a brand new hospital and that we will have a lot of care at our local medical centre*”), whilst other responses prioritised care received outside hospital.

The theory and process for developing the proposal, the second most prevalent theme (43), was met with what might be best described as cautious optimism by respondents. The general aims of the proposal were largely supported, although the ways in which they were achieved and specific details involved were rather more problematic (“*Investment is good, whether this is the best way to spend the hundreds of millions remains to be seen*”).

Issues relating to staffing generally featured less often than amongst the overall sample.

Question 3 – ‘Are there any parts of the proposal you are concerned about?’

Transport and travel was the prevalent issue within this question (132), whilst issues relating to community care were stressed proportionally less than among the aggregate total (40). The corresponding displacement of these two themes within questions relating to specifically *valued* and *concerning* issues suggests a greater

level of support for community care aspects as opposed to proposals concerning transport provision.

The assertion that staffing numbers was seen by questionnaire respondents as a negative rather than positive theme is borne out within responses to this question (27). Comments focused on whether there would be sufficient staff to cover all of the channels of healthcare provision proposed ("*sufficient trained nurses and doctors to fill all these roles*"). Whilst staff skills and broader staffing issues featured more highly than within the general totals, relocation of staff and morale provoked as little response as within the overall survey population.

Themes relating to the location of services featured highly (location of new hospital being raised 47 times and (re)location of existing services occurring 42). This again supports the assertion that respondents concerns often focused around the practical implementation of theoretical proposals. As with the combined totals, themes pertaining to the theory and process of developing the proposal were common (79). The scheduling of the change process (17) is a specific area that appears more commonly to have concerned respondents than figures for the overall sample population would suggest.

Question 5 – ‘What else is important?’

It is first necessary to state that a degree of caution must be exercised when undertaking analysis of this question as it is not immediately clear whether respondents feel an issue is *negatively* or *positively* important. The themes of quality of care (56) and staffing (54) are again prevalent within responses to this question. Management, however, was felt to be the most important by the highest number of respondents to the question (75), a higher proportion than within the aggregate totals. An examination of the qualitative responses to this question suggests that guarded optimism is a common reaction, with specific caveats being widely cited as reasons against wholeheartedly accepting the proposal. These factors tend to be practical in nature, a possible reason why the theme of ongoing / future operational issues featured highly.

Question 7 – ‘Do you think changes to health and care services are needed in your local area? Why do you say this?’

399 people responded to this question: 293 with a ‘yes’, 56 with a ‘no’ and 48 who felt they were unsure (see Section 2.2).

Of those who felt that changes to health and care services were required within their local area, issues surrounding existing services ranked among the highest occurring themes (23). Similarly, themes centred on proposed additions or changes did not feature highly within responses to this question. What is perhaps more surprising is that three themes were *more* prevalent, arguably suggesting that their quality is currently felt to be particularly poor: management (53), quality of care (49) and community care (40).

Respondents who did *not* think changes were needed to their local health and care services focused their comments around issues surrounding existing services (26). This might indicate that they were happy with services as they stood, or were unconvinced by the need to modify them.

When questionnaire participants were unsure of the need to change local health and care provision, the same theme – issues surrounding existing services – featured most often (12). This could be attributed to satisfaction with the current provision, although the responses, being couched in terms of uncertainty, would perhaps point more towards a *resistance* to change, or a wariness of committing to the specific changes proposed.

Question 10 – ‘Please add any additional comments or concerns you may have.’

The final qualitative question to be analysed is also the broadest, giving respondents the opportunity to air any issues or suggestions not covered by previous sections. Comments broken down by themes yielded a more scattered picture than for many other parts of the questionnaire, although certain patterns do emerge.

Transport and travel was the most common emergent theme (36), with comments expressing anxiety over whether the new services would be easy to access (“I’m

slightly concerned about access to these scattered centres by public transport"; *"I feel that travel to the new hospital for a lot of patients will be too far"*). Others were concerned that public transport networks would not be sufficient.

The theme of theory and process of developing the proposal (32), which was consistently highly rated among every method of data collection, again featured strongly within this question. Comments within this specific context tended to stress the importance of accountability for the changes made (*"How long before trusts, patient care, etc. are subject to scrutiny?"*) as well as uncertainty that they will actually be put into place (*"I hope it all works well in practice"*).

2.1.2 Analysis of themes

This section provides a detailed analysis of themes in order of their relative importance. Table 2 below presents the themes, together with the number of times they came out during the consultation.

Table 2 – Themes

Theme	No. occurrences
Community care	453
Issues surrounding existing services	368
Transport and travel	358
Management	349
Theory and process of developing the proposal	326
Staffing issues	285
The consultation process	245
Issues surrounding proposed new specialist hospital	202
Quality of care	191
Financial issues	178
Impact on GP services	147
Impact on A&E	128
Waiting lists, waiting times and appointments	100
Impact on other specialised services	96
The change process	64
Long-term care	61
Impact on paediatric or neonatal services	31
IT resources	14

Community care (453)

At public meetings a number of questions were raised about how proposed community hospitals would work (*"Please describe a community hospital"*) and how they would operate, in terms of what types of services would be available (*"What treatments will be available in the community treatment centres and community hospitals"*). Many attendees asked whether the hospitals would be open or covered by doctors '24/7.' Many were also concerned about how the proposed services would impact on their current locality:

- *"Will primary care centres such as Percy Road stay the same?"*
- *"There seems to be a lack of Primary Care Centres in Perry Barr"*
- *"Will the Handsworth Wood Medical Centre move to Soho Road Health Centre"*
- *"We need a substantial health centre in Great Barr / Hamstead"*

Questionnaire respondents overall welcomed the proposed community care services (*"The opportunity to provide services which reflect the health community's needs"*). In particular, respondents welcomed services that would be made available both near to and within people's homes. There is a strong feeling of community from this group of respondents, and this is reflected in their positive attitude towards community-based treatment (*"Having more services within the community, closer to where people live and tailored more to their local needs"*). When asked what aspects of proposed changes were important to them, many respondents discussed the need for the elderly to receive preventative care, and care in their own homes; in particular, those older people who live alone. Respondents also welcomed 'round the clock' availability of services.

Some questionnaire respondents did raise concerns about proposed community care services. Some preferred the option of hospital treatment (*"I think some care is delivered best in hospital and this should not be moved to community"*) or felt that community services might be inferior (*"Do not want second class service in the community, should not be harder to get referrals to specialist services"*, *"Standard of care available at community centres and hospitals – will it be just nurses and trainee doctors"*). Some were wary of the availability of adequate resources and staffing (*"I'm not convinced that there are enough resources / specially trained people available to make this happen"*; *"Community outpatients appointments are fine if*

supported by the diagnostic facilities and skilled staff”), and some about the quality of service (“If huge health centres are to be used, this will lead to less efficient and more impersonal service”). Others were concerned about where services would be made available (“If 75 surgeries are being replaced by 24 PCCs will everyone be within walking distance of one?”). There was also some opposition to the provision of a chemist in new health centres (“I would like to take hospital issued prescriptions to the pharmacy of my choice and not have to use the hospital pharmacy”).

Responses received from groups also discussed the provision of community care services. Many welcomed community based treatment and care, although some had reservations. One group suggested that community facilities would be more resource intensive than traditional hospital care, and that facilities needed to be “comprehensive and inclusive of mental health, social services, appropriate housing etc.” Another, the Cystic Fibrosis Trust, raised the point that community care might not be appropriate for all conditions:

The Cystic Fibrosis Trust does recognise that the NHS does need to change and modernise to meet changing needs, and we do not wish to obstruct progress. However, in your summary of proposed changes you do highlight the overall desire of moving from hospital to community care. Whilst we know this is very important for many patients and services, it is not appropriate for CF care. Children with CF have to be looked after by specialists in a tertiary referral centre. Those who attend to their needs in the community should also be from the specialist team.

One group suggested that care in the community “is an idea that has not worked anywhere else in the country, why should it be effective here?” A further group put forward that community hospitals had not been successful in the past (“Why are we revisiting the past?”) and that “patients were transferred to acute hospitals so they could receive a full range of integrated care.” Another stated “Lacks real information on how health will integrate with Social care in delivering more community care.”

Issues surrounding existing services (368)

Many respondents attending public meetings had comments about the existing state of health and care services in their area, as well as concerns about how these services might be impacted upon as a result of the proposed changes.

With regard to the existing provision of services, several attendees felt that the standard of care offered by the doctor was not always sufficient:

- *“We’re not as happy with our GP since he has been in the new building. You can’t get to see him. Always having to see a locum – he only works about two days a week”*
- *“My doctor is great, brilliant – but the practice itself is rubbish. I can’t get through [by phone] – the practice is too big”*
- *“Communication problems at GP practices – how can GPs explain medication if they can’t communicate?”*

The issue of communication was also raised with specific regard to the existing provision of services to patients with special medical needs. In particular, many attendees mentioned the difficulties experienced by deaf patients in negotiating care pathways (*“[I] find it very difficult to lip-read doctors in hospitals. Their accent / lip patterns are a problem for me”, “Deaf people need to be involved in the design of the [new] buildings – there are barriers at the hospital at the moment”*).

This sense of a lack of involvement in the consultation and change process was echoed elsewhere in public meetings, with attendees posing a high number of questions as to the exact implications of the proposal:

- *“Will the new mortuary be sold off?”*
- *“What will happen to the intermediate beds, such as those at Leasowes?”*
- *“Which GPs and services will be provided in which locations?”*
- *“So most people will continue going to services where they are?”*

Attendees of these meetings felt they needed a greater level of information on how the proposed changes would affect their receipt of healthcare in their local areas. This perceived lack of openness within the consultation process led many respondents to doubt the potential effectiveness of the change (*“Why can’t they*

refurbish the existing buildings? This would be better use of resources”; “We have already lost two hospitals, are we going to lose Sandwell Hospital too?”).

The relocation of services from their existing state also featured heavily within responses obtained through the questionnaire format. Respondents were particularly concerned about the re-siting of A&E services (*“The proposal to relocate A and E from City Hospital seems that it will be further away from City centre and my home address”*) and maintaining existing hospital facilities (*“Rationalisation of existing sites and use of recently built facilities [...] need more efficient use of existing sites”; “Keeping Sandwell Hospital functioning fully as it does now”*). However, the fact that a wide range of care services were also cited among people’s fears of the changes could arguably be associated with the perceived lack of information about the details of what they would entail.

Relocation of services was also discussed in a number of letters received by the research team as part of the consultation process. These expressed concerns that key services remain local, in particular, A&E services.

Transport and travel (358)

Transport and travel issues were raised at both public meetings and through the questionnaire, relating to transport infrastructure, public transport networks, cost of public transport, parking, travel to A&E and transport of patients between sites.

Travel implications for patients, healthcare staff and visitors was a major concern, given the proposed location of the new hospital, the relocation of many of the existing services at hospitals and the new sites for health centres in the community. Questions were raised about how the elderly, parents and children, and the disabled would travel distances, especially if they do not own cars. Concerns were also expressed about travel during busy traffic times, travel in emergencies and travel for aftercare.

Some respondents discussed poor transport infrastructure in the area, which is reflected in traffic problems and congested roads. This poor infrastructure might potentially hinder ambulances, and provide poor road systems and unreliable transport links to proposed new services. Respondents were worried that cost of

public transport might be an obstacle for those unable to afford bus fares. Issues related to parking at the proposed new hospital for staff and patients, especially the disabled, as well as parking costs were of concern to many respondents.

Some comments reflected fears regarding the potential time required to transport patients to A&E, the risk for patients' safety involved, travel routes for ambulances, as well as choices of the hospital to which a patient is taken. Responses showed apprehension about arrangements for the transfer of patients between hospital sites, especially for children and the implications this might have for parents. Some comments suggested that the travel implications of the proposals were contradictory to the proposed advantages of local health care and service provision, where people are expected to travel less and not more. There was a sense that this needed clarification to the general public in terms of the relocation of GP clinics, relocation of services at existing hospitals and the location of the proposed new acute hospital.

Recommendations put forward by respondents involved coordinating with transport service providers to expand and enhance the public transport networks to ease the travel for patients, providing them with relevant travel information, road plans and signposting. Upgrading the transport infrastructure and examining the Department for Transport's projections for road usage were felt to be important in defining the implications of the plans for where the proposed new hospital and A&E services should be located. Suggestions were made to reduce the cost of public transport and parking fees, and for making allowance for a large parking space at the proposed new hospital site. Parking facilities' proximity was seen as especially important for the elderly and disabled. It was argued that all issues related to transport of patients to A&E needed to be studied relative to the new locations of A&E services. Transport of patients between sites ought to be addressed, recognising the need for a coherent medical care plan and providing for risk assessment.

Some group responses echoed the concerns about the transport times required to move patients between hospitals. One group stated that some elderly people were concerned about the potential transport issues regarding the proposed new sites. Another asked if the public transport infrastructure would be developed in line with proposed new services, and whether road networks were prepared for changes.

Letters and emails received through the consultation raised issues relating to transport and travel. Many suggested that heavy traffic would hinder the carriage of patients to proposed A&E sites, as well as making travel time difficult for many patients and their visitors. The additional cost of using public transport was also discussed, with one respondent asking if public transport users had been considered *“especially at night in this area (perceived as ‘greater risk’) during reduced transport time – i.e. after 6.00pm”*. Concerns about transport times, public transport infrastructure and the cost of parking were raised in the focus groups.

Management (349)

Comments relating to management covered a wide range of issues, meaning that comprehensive analysis of the themes contained within is sometimes difficult. However, the public meeting responses were in many ways indicative, with many of the comments or queries being couched in terms of uncertainty:

- *“Who will run the new community hospital?”*
- *“If anything goes wrong who will be responsible?”*
- *“You mention ‘home care’ in your proposals, what considerations are being made?”*
- *“Will the community hospitals be able to cope, will they have the facilities and services needed for the future?”*

In particular, comments such as the last one quoted above were common, attendees questioning whether the shift from hospitals to care in the community would be manageable. The impact on staffing also emerged as a prevalent theme (*“If radiographers are spread all over the place, won’t it take even longer to get the results?”*, *“If 2010 proposes that people are discharged sooner from hospital, won’t this create extra burden on carers?”*).

Group participants were also anxious for management to be accountable on a larger scale:

- *“What actions are being taken to ensure that services are in place when things change?”*
- *“Who will decide who gets treated where?”*

- *“Will core services still be delivered? Will there be a Service Level Agreement to ensure this happens?”*

Amongst the questionnaire data, ongoing and future operational issues were often cited as areas of importance for respondents. Reflecting the emphasis elsewhere on the practical receipt of care, participants felt that hygiene needed to be improved (*“More health checks on wards, stop bugs in hospitals”, “The prevention of superbugs. The fact that they are in hospitals will stop people wanting to go there”*). Effective management of schedules was also widely referred to, particularly in terms of delays in care (*“Ability to access these services quickly when needed”, “Quicker communication between professionals – cutting out unnecessary overlap”*).

Whilst questionnaire respondents particularly valued the importance of new resources being introduced to health and care services, they were also critical of the ways in which they were managed. Many comments referred specifically to the provision of beds:

- *“Potential loss of overall bed numbers, and concerns that funding may not be enough to support the community ideas and treating people more at home”*
- *“Huge reduction in beds in acute care – even with increased primary [care] I cannot see how 600 / 700 beds will be enough”*
- *“You cut enough beds at existing hospitals, so I can’t imagine where you are going with buildings, let alone beds”*

Management was also a common reason for questionnaire respondents feeling that changes were needed to health and care services in their local area. Effective coordination of current services was felt to be lacking (*“Services remain fragmented”, “There is not enough true joined-up working yet. Some of it is illusory”*).

Within the group responses, resource management was also a recurring theme. One group felt that there was a lack of information regarding who would manage resources within the community hospitals. Others shared concerns, expressed elsewhere, that there would not be sufficient beds within the proposed new hospital system.

Theory and process of developing the proposal (326)

This section involves the emerging discussion of the theoretical base of developing the proposals and the process from which they evolved.

Questionnaire respondents discussed the value of the proposal being founded on delivering local community services that were patient driven and of high quality. Urgent care centres and larger health centres were favoured by many who hoped that mergers of services will provide quicker services and improve primary care.

Some respondents expressed concern that there was an emphasis in the proposals on the buildings and finance, rather than on personnel, quality of services and patients' welfare:

- *"This project is back to front – you've started with buildings and not service delivery"*
- *"Money is the only consideration that [has] been taken, not clinical need"*
- *"Overall it seems with these proposals that there is too much emphasis on facilities and services and not enough on personnel"*
- *"Health is not always top priority"*

The motivations behind the proposals and its focal points were also questioned in terms of being driven by political or government targets rather than people (*"The proposals focus on Government targets for surgery and childcare. Little is addressed on medical needs and long term illness"*, *"Is the consultation about trying to convince the public that it is the right direction?"*, *"What is important is the reason for change is better care – not politics"*) or otherwise for financial reasons and not better patient care (*"Things only change to cut budgets and overall spending"*). Based on this, many respondents had reservations that the decision to implement the proposals had already been taken, regardless of people's opinions (*"What if most people say they are against the proposals?"* *"Decisions have already been made"*, *"These consultation response forms seem to offer you the answers that you want to get"*).

The scope of the proposals was also questioned in terms of ambition and reality, and potential for materialising as planned (*"Too big a change."*, *"Concerns about the reality of the proposals – concerned only part will be in place"*, *"Concerns that the*

ambitious proposals do become a reality"). Some comments expressed optimism in better health care if the proposals could really be put to action.

There was also expressed fear that the focus of the changes would be of benefit only to people in Birmingham:

- *"New services are Birmingham based"*
- *"I am extremely concerned that all the proposals focus on benefiting the people in Birmingham. Sandwell residents are being treated as an afterthought"*
- *"As far as I can see you are concentrating on inner city areas and circled around Great Barr."*
- *"Everything is attached to Smethwick area and not enough for Sandwell"*

Suggestions were also made about studying the changing demographics of the population and responding to its evolving needs, given the projected rising percentage of elderly within the population. The fact that some of the existing healthcare buildings are new or renovated (such as the new A&E department in Sandwell), where huge expenditures have already been invested, led to questions about proposals that involve giving them up (*"Why is so much money spent then the site is abandoned?"*)

Earlier plans based on previous consultations raised queries in terms of their relevance to the proposals in the new consultation process (*"What happened to the radical plan?"*). Respondents suggested that much could be learnt from past experience, and there were questions around whether the new model was tried successfully elsewhere (*"The shift from hospital to community based services has been tried before with mental health services and has a bad reputation. Has this model been tried successfully elsewhere?"*, *"Is there another area where this has been well received and executed?"*)

Staffing issues (285)

Within public meetings concerns were raised about how the proposed changes to healthcare provision would impact upon the (re-)allocation of staff (*"Who will be*

delivering the various services?") and whether there would be enough staffing to cope with the new roles established:

- *"Having doctors at both sites and staff shortage, we can't cope with two hospitals, how are we going to cope with three hospitals?"*
- *"Will there be extra staff needed as a result of 2010 or will we be expected to spread round existing staff?"*
- *"Are we also having a big shift in resources i.e. nurses?"*

Staff training was also an issue repeatedly raised amongst those attending such meetings. Again, the changes in job responsibilities led many to query whether sufficient training would be offered (*"Has there been any consideration re: training staff to up-skill them to work in the specialties / special care centres?"*). Language barriers were additionally cited as a key area in which it was felt staff needed greater levels of training, both in terms of communicating in other languages (*"...How can GPs explain medicine if they can't communicate?"*) and to patients with special needs (*"Need to do deaf awareness training for all staff – e.g. nurses start shouting when they are told their patient is deaf!"*).

The willingness of staff to adapt to changes in their roles was questioned by some participants (*"Are consultants happy to come out into the community?"*). Staff morale was cited as a potential side-effect of this (*"Staff can be reluctant to change, so what are the plans to support the changes and provide options?"*). The other major factor felt by public meeting attendees to affect staff morale was the physical process of changing hospital buildings.

For questionnaire respondents, staffing issues were commonly raised as concerns or anxieties. The quality of care provided by staff was a particularly prevalent theme:

- *"Good, caring, highly-qualified GPs and supporting staff i.e. nurses and receptionists"*
- *"Community outpatient appointments are fine if supported by the diagnostic facilities and skilled staff"*
- *"Do we really have enough specifically qualified staff to support the changes in job descriptions, potential retraining and ongoing support?"*

For these respondents, the focus lay on the practical, frontline implications of the theoretical changes put forward in the proposal. The quality of care provided to them

by staff was felt to be intrinsically bound up in two other issues: staff skills and staffing numbers.

In line with this prioritisation of frontline, face-to-face receipt of care, many comments focused on the ability of care practitioners to relate to the general public (*"Communication and people who really want to do a caring job and speak clearly!"*). Therefore, as well as their ability to deal with the range of medical care needed (*"Someone who understands their illness or disability"*), medical workers' skill with patients from a variety of different cultural backgrounds was important to respondents (*"Culturally trained staff and professional"*, *"More female GPs in local surgery for women"*).

The number of staff was commonly expressed as a concern within the questionnaire responses, with a high level of cynicism regarding the existence of funding levels to ensure sufficient levels of staff:

- *"...Also if more work is to be put into general practice, will funding be available for extra staff?"*
- *"Where is the money coming from? Where are the NHS staff coming from seeing as we have no staff and no jobs for new doctors or nurses?"*

Responses received from groups also repeatedly raised the issue of staffing numbers and skills. Many felt there were not currently enough staff to manage existing services, so questioned whether there would be sufficient staff to cope with the proposed changes.

One group repeatedly referred to staffing issues, commenting on how health and care services could be made better. They felt greater numbers of doctors, nurses, childcare professionals and reception staff were required to make the system run smoothly (*"By having more doctors and healthcare professionals. So people can be seen quickly and treated as quickly as possible"*).

A number of the group responses focused on the importance on having sufficiently trained staff to deal with a range of specialist care provision. As one response states, *"[specialist] care should only be given by a specialist team"*. Another stressed the importance of considering existing staff skills when re-allocating staff for new or reconfigured roles.

Overall, respondents felt that both more, and better trained, staff were required to ensure the proposed changes operated effectively and efficiently. Training was required both to ensure healthcare needs were dealt with, but also to meet the cultural and personal needs of individuals using the services.

Staffing issues were also raised by focus group participants. Participants called for services that were culturally appropriate to their needs (*"What are the PCT doing to recruit medical and healthcare professionals from the Chinese community? We need more culturally sensitive services!"*, *"Please improve interpreting for hospital visits"*), and welcomed proposed improvements to the perceived poor quality of existing services.

The consultation process (245)

There was a good deal of discussion about the consultation process itself at the public meetings. Some attendees asked if the consultation was a 'done deal' or if findings would be acted upon (*"This all sounds cut and dried, are these decisions already made?"*, *"What if most people say they are against these proposals?"*). This concern was echoed by questionnaire respondents (*"It is not a consultation, it is a foregone conclusion"*). Conversely, one public meeting attendee suggested that *"Generally people feel over-consulted"*.

Some attendees felt that more information needed to be provided about the proposals (*"You will need to run a public information campaign"*, *"Proposals need to be explained in more understandable wording"*).

Many attendees asked how health care professionals were, or were going to be, consulted about proposals, and what their feelings were:

- *"What feedback have you had from surgeons and consultants?"*
- *"What's the feeling amongst GPs about care within the community and moving to grouped practices?"*
- *"How are we communicating to staff whose role will change when they have to work out in the community?"*
- *"Staff in specific services will want to know the implications for them – when will the details be known?"*

Similar points were raised by questionnaire respondents (*“Concerned that NHS staff are not all on board with this. If everyone pulled together this could work”*).

A number of questions were also raised at public meetings about how social services and the voluntary and community sector were being involved in the changes. Questions were also asked about the support of local Trusts for the proposals.

Questionnaire respondents expressed concern about the general public’s involvement in the proposals, with some respondents feeling that their opinions may go unheard (*“Please listen if we say we would like smaller well equipped clean friendly well run hospitals”*, *“No one listens”*) or unspoken (*“[Ensure] people with communication problems have a voice”*).

One group respondent emphasised the importance of maintaining communication with the public and staff: *“It is our opinion that good two way communication with both staff and the public on a regular ongoing basis and at least six monthly [...] is the key to the success of this project”*, while others underlined the importance of full ongoing consultation and communication with staff.

Issues surrounding proposed new specialist hospital (202)

Group responses to issues surrounding the proposed new specialist hospital were notable for their level of *questions* rather than *concerns* – in other words, attendees did not feel they had enough information to effectively comment further:

- *“Where is the site in Smethwick? It’s important to know this information”*
- *“What will be the bed capacity of the new acute hospital?”*
- *“...In terms of the size of the new hospital, has this already been finalised?”*

A large proportion of these queries centred on the location of the proposed new hospital. When issues were raised, many were similarly based around negative reactions to the siting of the new facility:

- *“Proposed site of new hospital based on land availability, best fit for serving ‘whole’ of Sandwell and West Birmingham. Configuration of services is not determined by the needs of any specific community of interest!”*
- *“New hospital in Smethwick – it’s absolutely ridiculous”*
- *“Why is the new hospital in Smethwick? There are problems with transport, it would be at least two bus journeys from here”*

Other attendees were concerned that the proposed new hospital would be too small to be effective (*“I am concerned that departments in the new acute hospital will be smaller than at present in City and Sandwell”*) and that it would not be well designed:

“You say that the hospital will be prestigious, modern and architecturally exciting. I am concerned that the new hospital will look uninspiring and more like a warehouse.”

For questionnaire respondents, the proposed location of the proposed new hospital was the issue causing most contention, with some feeling their area had been overlooked in favour of other regions:

- *“Lack of services for the residents of Sandwell Borough, particularly West Bromwich, Wednesbury”*
- *“The siting of the specialist hospital. The problem with the proposed site is [it] is at the southern edge of the area. This will disadvantage people living in the north of the area”*
- *“The position of the hospital in Smethwick. This seems to be a bias towards Birmingham”*

For others, the location was contentious for practical issues of transport and travel rather than any perceived geographical bias:

- *“The [proposed] site does not have good public transport links with the rest of the area. The roads in the area of the site suffer traffic congestion”*
- *“Geographic location of ‘specialist hospital’ will make travel for patients and visitors difficult. Not everyone has own transport and public transport ‘running against the grain’ of radical main roads is poor”*
- *“I would never go to a hospital in Smethwick. This is a dreadful idea. What about the distances needed to travel from outlying areas?”*

However, it should be noted that, for a number of questionnaire respondents, the proposal of a new hospital was valued (*“New hospital facilities would be welcome”; “The fact that there will be a brand new hospital and that we will have a lot of care at our local medical centre”*).

Some group responses mirrored the fears expressed elsewhere that the location of the new hospital would not effectively serve the entire region. Others expressed anxiety at the lack of information available about the facility, together with concerns whether there would be sufficient finances to cover the proposed design.

Quality of Care (191)

At public meetings, questions were raised asking whether the proposals would lead to an improvement in the quality of care. Some respondents reported poor quality of care in their area, whether in GP surgeries or hospitals. This was echoed in questionnaire responses, with some respondents welcoming the potential improvement in quality of care that proposed changes may bring. The reasons for this potential increase are put down to better accessibility (*“Round the clock services”, “I would like to see more GPs having more quality time with patients”*), better facilities, better staffing and locally available services.

Many welcomed the proposals as potentially addressing the current poor health status and care services in the locality (*“People’s health status in Sandwell is terrible”, “Care services appear to be non-existent”*). Many said that better services are required, with current services inefficient and slow.

Respondents also raised some potential threats to quality of care. One suggested there might be a *“fragmentation of specialists and the PCTs not [...] organised or competent to deliver.”* Another was concerned that a lack of commitment from social services would have a negative impact on community-based care (*“The outcome of this will be as of now – bed-blocking by patients waiting for community beds as elderly relatives struggle to cope at home”*).

Many respondents also mentioned cleanliness and hygiene within hospitals as being of particular importance.

Financial issues (178)

Public meeting questions addressed the costs of both building the proposed new hospital and providing proposed services. Some simply wanted to know the true cost of the proposals (*"How will the new venture be funded?"*, *"How much is all this going to cost?"*), where exactly it was to be spent (*"Is the figure of £700 million just for the acute hospital"*, *"Will the PCTs be getting more or less money with these new health care plans?"*) while some were cautious that the proposed investment might not be sufficient (*"£700 million is not enough"*). Many raised questions about the proposals being a private finance initiative (PFI):

- *"I understand this will be funded though PFI, isn't that more expensive?"*
- *"Is PFI the cheapest or dearest way forward?"*
- *"What are the guarantees that this model is stable?"*

Questionnaire respondents raised similar issues. While many welcomed the investment in the areas health care provision (*"Any type of investment in the health of Sandwell's people is a good investment – it's about time!"*), some felt that the money would be better spent on existing buildings and services (*"If the money was spent on the hospitals we already have [...] we would have the best hospital services"*), or that the funding model was not sustainable, or might lead to cutbacks in other services. Some respondents were sceptical about the benefits of PFIs (*"Nothing will be reinvested for the patient, all the money will go to the investors"*), some were cautious about whether the proposed investment masked cutbacks (*"Things only change to cut budgets and overall spending. Most changes are made for financial reasons not to provide better patient care."*)

Group responses received also discussed financial implications of the proposals. One group questioned the expense of buying land for the new hospital and satellite community hospitals, when there is, they suggested, existing land that could be redeveloped. Another group suggested that the finances remained unclear, and that management of the financing needed clarification. One group also questioned the amount of money left for building the proposed new hospital once other proposed investments had been carried out.

Impact on GP services (147)

There was concern among many public meeting attendees that they would lose their existing GPs. In particular, there were numerous comments about having a close relationship with current GPs, having been with a family doctor for many years, seeing ones 'own' GP, and so on (*"If GP practices group together in more modern health centres, will patients be forced to change doctor? Very worried about this."*)

Other attendees were worried about the proposed location of their primary care services under the proposals:

- *"Is the intention to decrease the number of GPs in Sandwell"*
- *"Are GPs going to change in Mobarak Health Centre as we never seem to receive the continuity of care?"*
- *"When all the GPs move to the Wednesbury Town Centre – can you still see your own GP?"*
- *"Dr [name removed] surgery is moving [...] He's a great doctor and we wouldn't want him to move."*

A number of questionnaire respondents welcomed the impact of the proposals on GP services, in terms of potential improved quality of care, accessibility, resources and modernisation. However, some expressed concerns about losing familiar surroundings and staff (*"You never see the same person twice and reception staff who don't know you"*).

Impact on A&E (128)

At public meetings questions focused on the potential relocation of A&E services. Specific concerns were raised about the moving of such services away from Sandwell (*"Will A&E no longer be at Sandwell? If not, what was the point in building a brand new centre there?"*). More generally, however, the time it would take to reach the new A&E sites caused greatest levels of anxiety:

- *"I live in Wednesbury. The A&E will just be in one hospital? It's a long way for something like a heart attack"*
- *"If there was a major accident in Great Barr, I do not believe that an ambulance would make it to A&E in Smethwick"*

- *“What about stabbings and shootings that currently go to City, could the extra distance mean life or death?”*

For questionnaire respondents, both closure and relocation of A&E facilities were again the issues provoking most reaction. The potential closure of Sandwell remained a strong theme:

“Yes, I think it would be criminal to close the A&E in Sandwell. It is a new building with equipment which local people donated hard-earned money to serve this area of Sandwell”

More generally, participants questioned the ability of the area’s health system to cope with reduced A&E services. Opinion was rather more divided on the problems associated with relocating existing A&E departments. However, this can at least partly be ascribed to individuals feeling their particular area was not being granted sufficient services, or other areas were benefiting at its expense.

For some group respondents, waiting times were highly stressed, whatever the exact configuration of A&E services the proposals resulted in (*“Deal with emergencies quicker”; “...cut waiting time at A&E”*).

The potential impact of the proposal upon A&E services generated a relatively large number of responses in the form of letters and emails. Many of these responses were very similar in nature, due in part to an organised campaign by a local MP (*“Whatever the outcome of the Towards 2010 consultation, I believe that there must be an Accident and Emergency unit in the borough of Sandwell”*). However, much of the rest of the correspondence received echoed similar sentiments, with a particular emphasis on the travel time required to new A&E sites:

- *“It has been reassuring to have Sandwell Hospital emergency department so close – but what might happen if we had to travel 20 – 25 minutes further?”*
- *“If this [a proposed new ‘super-hospital’ at Winson Green]” is to be our new A&E unit it means that people from our own area, from Charlemont Farm and from Wednesbury, as well as people from Blackheath and Rowley Regis, having to travel many more miles through some of the most congested roads in the area to get emergency treatment”*

Waiting lists, waiting times and appointments (100)

The issue of waiting lists, waiting times and appointment systems was strongly raised as a key concern and an essential area where changes should take place as an outcome of the proposals.

Responses about why improvements in health and care services are needed in local areas addressed the current problems experienced in contacting GPs and getting quick appointments on desired days, due to busy phone lines and awkward opening times. Other problems mentioned included difficult access to specialists' appointments, long waiting lists and waiting times to get services, in addition to the poor customer service attitude of receptionists in communicating with patients. Local provision of services was feared to impose a risk of increasing waiting times due to increased pressure on medical centres. Reduced single-handed practices posed the risk of aggravating the current problem:

“Reducing 70 to 24 Primary Care Centres seems illogical? We can barely get through [by phone] as it stands with having less practices surely this situation is going to be made worse.”

Responses also pointed to unacceptable waiting times in A&E services and at emergency times when trying to access doctors or consultants. Suggested solutions included out-of-hours services through a 24/7 system for access to health care, where patients could be seen on the same day for quicker assessment and treatment. The need to respect patients' dignity and morale by ensuring doctors spend enough time with each patient, providing proper communication and care, was highlighted. Some responses reflected concerns about whether the new changes will help cut the waiting lists, speed up referrals and access to outpatient appointments, making appointment times more flexible and reducing waiting times. Other suggestions put forward included designing appointment systems that provide access to updated information on availability of appointment times, which can help people make informed choices about where to seek health services. Facilities to ease waiting times for children at hospitals were proposed to reduce the tension for parents awaiting appointments.

Impact on other specialised services (96)

Public meeting attendees asked questions about a variety of specialised services and the impact that the proposals would have on these. These included mental health, palliative care, diabetes, Speech and Language therapy, rheumatology, eye clinics, cancer and sexual health. In the main, questions around these services centred on plans for their provision and location under the proposed new services. Attendees asked if specialists would still practice from hospitals, or if they would be available in the community.

Questionnaire respondents had similar concerns, asking about plans for palliative care, mental health, dementia care, ophthalmic services, therapy services, physiotherapy, rheumatology, chiropody, audiology and diabetes. Several respondents also asked where the eye centre / clinic / hospital will be located. One respondent commented *“Do not want second class service in community, should not be harder to get referrals to specialist services.”*

One group response discussed the importance of some specialist services being provided by specialist teams, with many years experience of dealing with specific conditions.

The Change Process (64)

Responses to the consultation showed a clear interest in the improvements proposed, but there were questions about whether spending a lot of money on health care would work because of the many administrative expenses involved:

- *“Everyone wants good service but...much of the money is wasted on administration and inefficient use of existing facilities”*
- *“It horrifies me that the more hands-on staff required generates more administration services, which, in my opinion, diverts cashflow to unnecessary needs and sources”*

Concerns were raised about the current fragmentation of services between primary and secondary care (*“poor communication between 1st and 2nd care”*). In addition, the lack of joined-up working between health care and social care was seen as an important issue which *“cripples coordinated care”* in managing the change process

as well as in future operations. Respondents suggested that those managing the change process needed to identify and take into account patient needs (*“correct needs analysis to ensure patients know pathways to follow to receive appropriate care”*), the effective involvement of all parties, and ensure that all the parts of the system work together efficiently.

An important issue raised was the transition process between the interim changes and the long-term changes. Comments emphasised the need to make sure there is a smooth transfer of care from the hospitals to the community facilities, where the community services should be in place first before finalising the shift (*“We would accept this hospital if the community centres were in place first”*). Keeping the public informed about the changes as they happen was seen as essential.

Some comments approached the tangibility of the change process, and how it had to be realistic, well-communicated and properly planned. It was argued that issues such as care in homes and other consequences of the reduced hospital visits and shorter stays had to be given proper consideration. At the macro level, some comments touched on the NHS operations, its systems and bureaucracy, expressing the need for an organised, efficient and effective approach:

- *“There is too much bureaucracy in the NHS....there is no point putting systems in place that don’t provide services to the community that they need”*
- *“There are too many targets in the healthcare system. There should be more prioritisation and more emphasis on effectiveness of treatment”*
- *“I know care in the community can work when it is implemented properly”*

There were many queries regarding who was in charge of managing the change process, to whom the responsibility and accountability of it went and who would manage the new facilities (*“if anything goes wrong who is going to be responsible”, “who will the new centres belong to?”, “are the people who are working on this model local people?”*). Concerns about the commitment of all parties to the changes, including hospitals and GPs, were raised. These comments advocated the need for proper monitoring of the changes and interim review as they evolve, and making sure that the project is completed in a proper form (*“will there be evaluation after the facilities are built?”, “2013 is a long way away – how can we be sure that the project will be completed?”*).

The scheduling of the change process with its timescales and pace were important issues highlighted in the consultation process. Some comments proposed that the problems are clear in the current system, and questioned the long waiting time for the changes to be in place (*"pace of change of slow, so money wasted"*, *"do it quickly please"*, *"why wait for 2010 when there are problems we know?"*).

The scheduling of details of the changes, including the training plans of the staff involved, was highlighted and people want to be informed about this. In addition, some comments pointed out the risk that the planned timescales are not realistically achievable:

- *"Is the timescale achievable for the community and hospital services to be in place?"*
- *"We have been through community hospitals before! My biggest fear is the timescales; it took six years to build Warley Health Centre", "No evidence that this is possible – or even practical – in the next ten years"*

Long-term care (61)

Questions were asked at public meetings about the long-term care of the elderly and terminally ill patients. Some attendees suggested that the needs of these groups were not adequately addressed. Conversely, many questionnaire respondents welcomed the potential improvements for long-term health patients.

There was some discussion around the impact of newly-located services on the elderly who currently have to use public transport or prohibitively expensive taxis to gain access to care. One respondent stated that it is *"aftercare and the elderly who appear to be most vulnerable"*; another described the elderly as *"neglected"*. Intermediate community beds should not, it was suggested, be used as temporary care for elderly patients who require a different kind of specialist care.

Impact on paediatric or neonatal services (31)

There was some discussion around maternity services at public meetings, with attendees asking about the impact of the proposals on existing services. Concerns were raised that community maternity services would be unable to cope when faced

with complicated births. One attendee asked how the PCTs were using the plans to tackle health inequalities such as infant mortality.

One questionnaire respondent had concerns about travel implications with children, in terms of new locations and parking facilities. Another felt that their current use of Birmingham Children's Hospital was fine. Some respondents welcomed the proposals, as they felt they will improve accessibility and efficiency.

One group respondent discussed the impact of proposals on children suffering from Cystic Fibrosis, explaining that these patients require segregation, and intensive and ongoing medical intervention.

IT resources (14)

There were a few comments on the provision of IT resources. These discussions dealt with the IT skills needs of staff, the need for adequate IT systems / infrastructure for new resources (including compatible systems across primary and secondary care facilities, and social care), less paper-based operations and more electronic-based records.

2.1.3 Ongoing reporting to respondents

Question 9 – ‘As we progress with our plans (following consultation), what things would you like us to report upon to demonstrate progress?’

Responses to this question fell into two main groups: those specifying the method or format in which they wished to be informed, and a larger number detailing the areas of service provision on which they wanted to be updated.

Amongst the first group, comments primarily related to the frequency of progress reporting. The desire for information was such that, in a large number of cases, respondents wished to be kept informed as often as significant changes were made (*“Keep us updated as things happen”, “Every single one”*). A smaller number of respondents specified time periods in which they wanted interim reports to be produced.

Many respondents wished to be informed on a very broad range of progress (*“Anything we need to know”, “Everything”*). A similar proportion of the sample requested specific, detailed information, grounded against statistical or benchmarked criteria. For instance, one response requested information on the:

“financial situation, whether deadlines and targets (e.g. reduction in acute bed days) are being met. In particular, can the PCTs deliver on their promises they will reduce hospital admissions.”

As in other areas of the survey, comments such as these regarding finance were particularly prevalent, with the potential closure of existing services and staffing being the next most contentious issues. Another respondent more simply required *“factual stats (none political)”*.

The suspicion of political or ‘hidden’ agendas within the proposal was a theme within a smaller number of responses, for whom the consultation process was met with differing levels of mistrust. Whilst comments such as *“Let people know the truth”* were comparatively rare, phrases such as *“full consultation with local people”* and *“we need to be aware of the situation”* suggest a wider lack of faith in the reporting progress.

Overall, respondents to this question demonstrated a desire for both a wider and deeper set of information on the process of change and the ways in which it would come to affect them.

2.2 Quantitative data from questionnaires

Quantitative data from questionnaires was inputted into an SPSS⁹ database for the purpose of analysis. Results from this analysis are presented here along with, where appropriate, a discussion of the findings. Additional figures for the data presented are available in Appendix 2.

Respondents' overall support of proposals and changes

Respondents were asked if they supported the overall proposals in the *Towards 2010* consultation, as well as if they felt changes to health and care services were relevant to their needs and needed in their local area.

Some clear areas of support emerge from this set of questions. Most significantly, 73.2% of respondents supported the overall proposals. In addition, 69.3% thought changes to services are needed in their local area, and 45.8% thought changes will provide the health and social care services important to them.

It is also noticeable from the results that many respondents were either unsure or perhaps unclear or non-committal, as to their feelings about their support of these aspects of the proposals. Understanding the actual reasons for this uncertainty is, unfortunately, outside of the capacity of this research project. However, possible explanations may be: respondents were merely being indecisive; respondents felt they lacked adequate information and / knowledge to pledge their support (or otherwise); respondents were being deliberately non-committal until they were able to experience some of the proposed changes in action.

Respondents' support of overall proposals to spend extra resources in Sandwell and the Heart of Birmingham

Nearly three quarters (73.2%) of respondents supported the proposal overall: 11.7% did not. There was a relatively high level of uncertainty, with 15% unsure of their position. (Figure 1 in Appendix 2.)

⁹ SPSS: Statistical Package for the Social Sciences

Respondents view on the need for changes to health care services in their local area

Respondents were asked if they thought changes to health and care services were needed in their local area. 69.3% of respondents agreed that they were: 12.5% did not. Again, there was some degree of uncertainty, with nearly a fifth (18.2%) unsure of their position. (Figure 2 in Appendix 2.)

Respondents were asked to comment on why they did or did not think changes were needed in their local area. The data from this question has been included in the thematic analysis in Section 2.1. In addition, some of the key findings are also presented here.

The key themes raised by those respondents who **did** think that changes were needed were (in order of frequency):

- Quality of care – changes were welcomed by those who thought that the current quality of care provided is insufficient. Some respondents pointed out that people's health status in the locality is poor, that care is fragmented, and that provision is often inefficient and slow
- Community care – respondents welcomed the proposals to increase the provision of care in the community. This included better access at convenient times (*"More access to services at times convenient to an individual"*), and more home support (*"Not enough home visiting nurses to cope with demand"*, *"Home visits when needed"*)
- Improved resources and services – the age, condition and lack of adequate skilled staffing and facilities in current buildings led to many respondents welcoming the proposed new build (*"We want bright, clean, modern buildings"*, *"Improve facilities and staff levels"*, *"All our local hospitals have bad reputations, people are frightened of going INTO hospital!"*)
- Waiting lists and appointments – access to GP appointments and hospital waiting times could be improved by the proposed new services (*"Making an appointment with my doctor is a nightmare, many calls have to be made before I get any success"*, *"Having to travel to a hospital for minor injuries and waiting hours for treatment"*)
- GP services – it was felt that there is a need for improved GP services, in terms of quantity and access

- Funding – proposed additional funding is timely (*“Underfinanced for many years”*) and current systems inefficient and costly (*“Services need modernising and streamlining”*)
- Management – services were considered to be fragmented, lacking in coordination, communication and efficiency (*“We need a more ‘joined-up’ service”*)
- Transport and travel – many respondents felt that the proposed services will be located more conveniently for them. (This contrasts with the responses given below, where respondents stated that travel will be more *inconvenient*; this perhaps reflects an understandable tendency for many respondents to support aspects of the changes most suitable for themselves.)

The key themes raised by those respondents who **did not** think that changes are needed were (in order of frequency):

- Existing services are fine as they are – respondents’ experiences with their local services were positive, and they were reluctant to change this (*“If it’s not broke, don’t fix it”*)
- Transport to proposed new hospital - some respondents also felt that plans may jeopardise services that are currently conveniently located (*“Everything is near to my home”*), or that the proposed will be inconvenient to reach by public transport (*“The planned site of the new hospital is too difficult to reach, especially by those who have to use public transport”*)
- Proposals may not improve overall quality of care (*“The proposals are simply about cost cutting and do nothing to improve care”*)
- Perceived cost cutting – some respondents believed the proposals are designed to cut budgets, rather than improve care

The key themes raised by those respondents who were **not sure** that changes are needed were (in order of frequency):

- Existing services are fine as they are – as above, many respondents felt their needs are met by existing services (*“We already have very good service from Sandwell hospital”, “I have been satisfied with care I’ve received both at City hospital and my GP”*)
- Change – there was a general resistance to change amongst some respondents (*“Change creates confusion amongst patients and staff”, “Unsure if changes will be for the better?”*)

- Proposals are a 'done deal' – there was some cynicism as to whether decisions have been made regardless of the consultation process:

“Because what we say or think will not make a difference. There’s an agenda the government has and they’ll have their way. The rest is unimportant. It just looks and sounds good. Decisions have already been made regardless of what any of us think.”

Respondents’ view on whether proposed changes will provide the health and social care services that are important to them

Respondents were asked if they thought the changes will provide the health and social care services important to them. 45.8% of respondents thought they would: 18.8% thought they wouldn't. Over a third (35.4%) of respondents were unsure of whether the proposals would provide the services that were of consequence to them. (Figure 3 in Appendix 2.)

Importance of services and aspects of services

Respondents were asked to rate a range of 15 services and aspects of services according to their perceived level of importance, and these were attributed a figure: not important (1), slightly important (2), important (3), and very important (4).

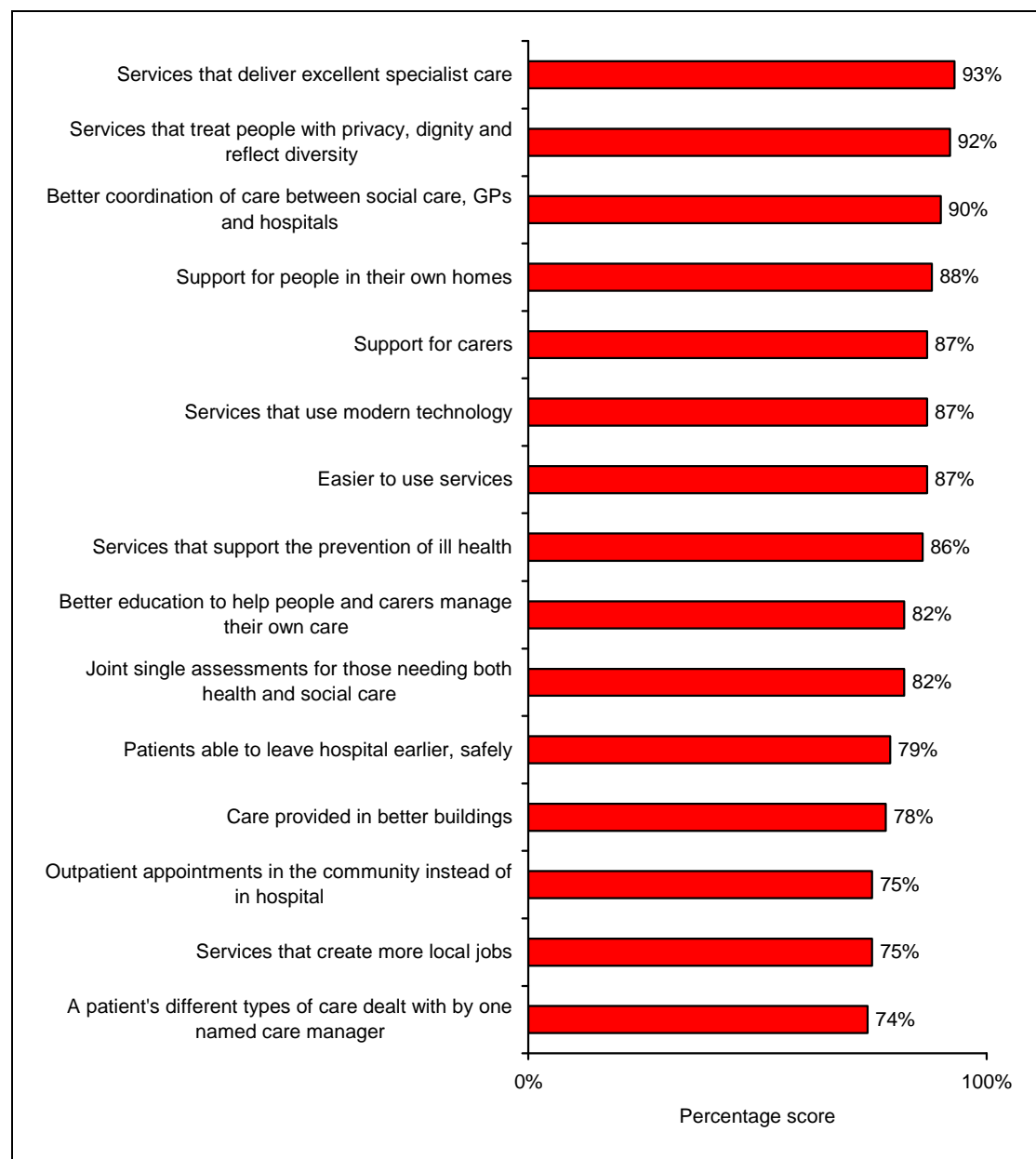
A mean was calculated for each service / aspect of service: the higher the mean, the more importance given to the service by respondents. This mean was converted to a percentage to indicate level of importance in a percentage format: the higher the percentage, the more importance given to the service by respondents. These calculations are presented in Figure 4 below. (Figures 4.1 – 4.5 detailing the spread of responses for each individual service / aspect of service are available in Appendix 2.)

Respondents placed most importance on services delivering excellent specialist care, with a mean score of 93%. Services treating people with privacy, dignity and reflecting diversity were the second most valued (92%) and better coordination of care between social care, GPs and hospital was valued third highest (90%). It could be argued that the focus of these values was on the quality of care provided, placing the theme higher than among that returned from qualitative data.

Outpatient appointments being offered in the community instead of hospital was the factor rated as not important by the most respondents (9.9%), with patients' different care types being dealt with by a single named care manager (9.1%) and services creating more local jobs (8.2%) also rated important.

Conversely, community care issues, which generated the highest level of reaction among the qualitative sections of the data, were featured comparatively lower within the importance levels analysed here. Improved support for people in their own homes was ranked fourth, with 88% valuing it as important, and outpatient appointments in the community rather than hospitals was ranked thirteenth (75%).

Figure 4 - Importance of improvements to healthcare provision (by % importance)



Respondent profiles

In order to understand the profile of respondents, the questionnaire gathered a series of quantitative data, which explored respondents' health status and experience of health care over the past two years.

Respondents with disabilities

Respondents were asked if they considered themselves to have a disability. 25.5% of respondents self-declared as having a disability: the approximate national figure (measured 2005) is 18%.¹⁰ This discrepancy could suggest that people with disabilities were more likely to respond to the consultation. This is to be expected, as people with disabilities may be increasingly likely to make use of local health care services, and therefore have a vested interest in any proposed changes. (Figure 5 in Appendix 2.)

Respondents with long-term health conditions

Respondents were asked if they considered themselves to have a long term health condition, such as diabetes or asthma. 40.3% of respondents considered themselves to have a long-term health condition, compared to the national and local averages of 18% and 20% respectively. Again, this discrepancy could suggest that people with long-term health conditions may be increasingly likely to make use of local health care services, and therefore are more likely to respond to the consultation. (Figure 6 in Appendix 2.)

Experience of ill-health in the past 2 years

Respondents were asked if, in the past two years, they, a member of their household, or an individual they care for had: visited a family doctor; been treated in hospital; stayed overnight in a hospital; or stayed in a nursing / care home.

Nearly one in five respondents had visited a family doctor in the past two years. Over one third had stayed overnight in a hospital¹¹. (Figure 7 in Appendix 2.)

¹⁰ Employers' Forum on Disability (2007) *Disability in the UK*. Available online at <http://www.employers-forum.co.uk/www/guests/info/statistics.html>.

¹¹ Hospital Episode Statistics 2005/06 for Sandwell PCT and Heart of Birmingham PCT suggest that this figure is expected.

2.3 Respondent demographics

This section presents data relating to the demographics of respondents according to the different consultation formats.

Questionnaire respondents

The questionnaire gathered information about respondents in terms of gender, age, ethnicity, and geographical location.

Gender

Nearly twice as many women (64.1%) as men (35.2%) responded to the questionnaire. (Figure 8 in Appendix 2.)

Age

65.7% of respondents were aged 45 or over: only 12% of respondents were less than 30 years old. This is perhaps to be expected; with older members of the population being more concerned about their health care than younger members, and therefore more likely to respond to the questionnaire. It is also possible that older people may have more experience of health care systems, and are potentially more resistant to change. (Figure 9 in Appendix 2.)

Ethnicity

Although the ethnicity of respondents does to some extent reflect the ethnic diversity of the population across the consultation area compared to that of the UK as a whole, it is still not wholly representative of the population of the area. A previous report established:

The overall ethnic diversity in Sandwell and West Birmingham is 27 per cent more than that seen in the nation as a whole, with 64 per cent of the population white, compared to 91 per cent nationally.¹²

¹² Sandwell and West Birmingham Health and Social Care System (2004) *Towards 2010 – Building a Future Together*. Strategic Outline Case, April 2004.

73.7% of overall respondents to the questionnaire were White – British, Irish or other White background (nearly 10% more than the representative figure). However, in terms of the findings of the project as a whole, the diversity of the population is well represented in the data from public meetings. (Figure 10 in Appendix 2.)

Public meeting respondents

Data was gathered during public meetings by representatives from the *Towards 2010* consultation programme. Representatives recorded the questions raised by each audience, the answers given to those questions, as well as some basic information about the meeting itself (type of meeting, date and location) and its audience (number attending, type of attendees). It was not possible to capture detailed demographic details of each attendee due to the open, drop-in nature of meetings. Data was not received from all the public meetings held. In total, the research team received data from 100 public meetings.

Meetings held were categorised in terms of their primary audience type and, if appropriate, the specific remit of the group organising the session. It must be noted that, for some meetings, insufficient information was available to place them within a category. Similarly, some meetings may fall into more than one category – for instance, general public meetings of which the main attendees were elderly people, or people from ethnic groups. In order to provide a more detailed overview of meetings, in these instances groups were categorised under the relevant specialist headings.

Meetings run by residents' associations, neighbourhood forums, or other local interest groups were the most commonly held (22). Groups attended by health workers represented the next most prevalent (20). This includes staff from various services, of which care support groups were a strong component (5).

Meetings specifically organised, or primarily attended, by elderly people comprised the next most prevalent meeting type (12). As noted previously, this includes general public meetings at which the attendance was largely made up of the elderly.

Group respondents

Table 3 is a table of all the group responses received by **QUAD research**. Groups were of two “types” – health-related or community groups. Group responses have been submitted by:

- Forwarding to **QUAD research** from the consultation team
- Received directly through **QUAD research** freepost address
- As part of the questionnaire (Question 11 asked respondents to state if they were responding on behalf of a group – these questionnaires were analysed separately from those submitted by individuals)

Table 3: Group responses

Group name	Group type
George Salter High School	Community group
Great Barr Over 60's Club	Community group
International Malayan and Borneo Veterans	Community group
Sandwell Council of Voluntary Organisations	Community group
Sandwell Early Years Parental Support Service, 'Early Steps'	Community group
Sandwell Partnership Forum	Community group
Yemeni elders	Community group
Yemeni Women's Group	Community group
Yemeni Youth forum	Community group
African Caribbean Health Improvement Service Group	Health-related
Carers Sandwell: Carers Advice & Resource Establishment, Sandwell	Health-related
City Hospital Supporters Group	Health-related
Cystic Fibrosis Trust / Regional Fundraising Branch Chair	Health-related
Cystic Fibrosis Trust Group	Health-related
Portland Eye Care	Health-related
Slater Paediatric Unit	Health-related
Speech and Language Therapy Department	Health-related
Speech and Language Therapy Group	Health-related
Upper G.I. Blues	Health-related

Focus group respondents

Two sets of focus groups were carried out by the consultation team, and results reported by to **QUAD research**:

- Older People's Consultation,
Location: The Bordesley Centre, Camp Hill, Birmingham
Date: 14 February 2007
Participants: approx 150 elders living in Heart of Birmingham location from a wide range of support organisations covering all ethnic groups across region
- 2010 pre-consultation focus groups
Dates: Sept 2006 – Jan 2007
Participants: 173 members of the public resident within Heart of Birmingham tPCTs boundaries.

2.4 Petitions

QUAD research has received two petitions in response to the consultation, from:

- Upper G.I.Blues (3,237 signatures)
- Responses to Tom Watson, Member of Parliament for West Bromwich East (20 letters, 9 emails)

Upper G.I.Blues petition

Upper G.I.Blues is a Hospitals Charitable Trust raising awareness of, and funding research into, upper gastro-intestinal cancers. **QUAD research** received letters from Upper G.I.Blues on 20 and 22 February 2007, which included a total of **3,237 signatories** to the following statement:

“After attending Public Consultation meetings, and listening to the comments of both NHS users and providers our positions has hardened against the proposed Super Hospital for our region. We would prefer that the two existing sites, Sandwell General & City Hospital, Birmingham be improved, rebuilt and refurbished, with full services for both acute and recuperative care at both sites. We believe that any disruption that takes place during a building program will be overcome by later benefits for patients in the region.

“We the undersigned, whilst recognising the need for a Super Hospital for the region believe the proposed site to be wrong. We believe that a new hospital central to the area, e.g. the rebuilding of Sandwell General or the replacement of Edward Street Hospitals in West Bromwich, with their already existing public transport bus, Metro and rail links and their central location to be a preferred option.”

A letter included with the petitions asked that the signatories were filed as ‘*objections to the program for 2010.*’ The key objections raised by the letter were:

- Opposition to the proposed Super Hospital
- Full A&E services available at both existing sites
- Concerned that the proposal program for care in the community will not work
- Proposed costings are flawed

- Objections to rebuilding on existing sites are overplayed.

The Upper G.I.Blues petition included a letter which outlined the opposition to the proposed *Towards 2010* changes. A detailed analysis of the information provided has been carried out, and the emerging themes have been included in the thematic analysis in Section 2.1.

Responses to Tom Watson, Member of Parliament for West Bromwich East

Over the course of the consultation, **QUAD research** received 20 letters and 9 emails in response to a letter to constituents from Tom Watson, Member of Parliament for West Bromwich East. In his letter, Mr Watson drew attention to the ways in which constituents could express their views on the *Towards 2010* consultation:

A number of people tell me that they are happy for community groups and elected members to represent their views on the details, as long as the pledge to keep A&E in Sandwell is met. If you share this view, then simply email your name and address or send views by post to "Freepost Quad (2010)" to towards2010@swbh.nhs.uk with this sentence:

"Whatever the outcome of the Towards 2010 consultation, I believe that there must be an Accident and Emergency unit in the borough of Sandwell"

In the main, the 20 letters and emails received in response to Mr Watson's letter contained only the sentence given above. Any additional views given have been analysed and are included in the thematic analysis in Section 2.1.

2.5 Formal responses

Formal responses were received from a range of NHS and statutory organisations. A summary of the responses, their support and some particular points raised within them (this is not comprehensive) is provided here. Formal responses have been divided into the following headings according to their authors:

- Primary Care Trusts
- NHS Trusts
- Local Authorities
- Clinical / Medical

Full text of the formal responses is available in Annexe 2, together with a numbered table that corresponds to the numbers given each response below.

Summary of all formal responses

Overall support was given for the proposals within all but one of the formal responses received. Particular praise was proffered for proposed changes to community care provision and increased levels of localised care. In addition, a series of caveats were expressed, and these have been summarised in this section of the report.

Many formal respondents felt that the consultation did not effectively address the issue of communication, and expressed a desire for this process to be extended in two ways. Firstly, the level of groups' involvement with the consultation process was often felt to be limited. Secondly, respondents wished for more regular, and more detailed, publicly available information about the changes. This should include accurate figures on the levels of cost and investment involved in the process. Some felt the consultation documents were unclear, or that the proposals did not go into a sufficient level of detail about specific areas of service provision. Maintaining and extending the degree of consultation was felt to be necessary in order to ensure a smooth and comprehensive process of change.

The impact of the proposed changes upon specific local areas was a further shared area of concern. Formal respondents requested a greater level of information concerning the impact of service relocation, particularly in terms of patient numbers.

Managing any shift in demand was felt to be crucial, as was establishing sufficient bed availability and effective transport networks.

Several groups felt that the consultation documents did not integrate care services with a sufficient degree of cohesion. In particular, mental health care was often felt to be disconnected to other areas of the proposal. Formal respondents suggested a greater focus on liaison arrangements across care providers.

Primary Care Trusts

1 Birmingham East and North Primary Care Trust

The Trust were supportive of the developments outlined on the consultation paper, particularly the proposal to offer increased local and community care. An emphasis was stressed on the importance of efficient management of timescales and resources during the transition to localised services.

In addition, the Trust also felt that effective communication methods must be established and maintained in order to keep the public informed of the changes.

2 Dudley Primary Care Trust

The Trust offered support for the proposal.

3 South Birmingham Primary Care Trust

South Birmingham Primary Care Trust valued the aims and approach of the proposal, particularly its involvement of a wide range of local stakeholders. The Trust encouraged the continued participation of such groups, particularly PCT and practice-based commissioners local to the area.

4 Walsall Teaching Primary Care Trust

The Board was fully supportive of the proposal document, considering it to be well constructed and coherent.

NHS Trusts

5 Birmingham and Solihull Mental Health NHS Trust

Birmingham and Solihull Mental Health NHS Trust offered complete endorsement of the proposals, particularly praising the provisions for mental health, emergency care and social inclusion in the context of community-based services.

6 Birmingham Women's Health Care NHS Trust

The Trust welcomed the planned development of services set out in the proposal document, including those areas relating specifically to changes in neonatal unit designation. There was a desire for greater information about changes to maternity care, particularly the management of transferring high-risk pregnancies from Sandwell to City Hospital.

7 The Dudley Group of Hospitals NHS Trust

The Trust expressed doubt over the shift from hospital- to community-based care, pointing to a lack of evidence that such a change would offer any reduction in care costs. Concerns were also raised that reconfigured services would be able to respond to current levels of demand, as well as the impact upon Trusts outside of Sandwell. The Group indicated a desire to be involved in examining the details of the changes.

8 Heart of England NHS Foundation Trust

Concerns expressed by the Heart of England NHS Foundation Trust focussed on the impact of the proposed changes upon the care local to the area. Particularly, the proposed changes to surgery and neonatal care were seen to have the potential to increase patient flow in the Heart of England area, and a review of both current services and proposed recommendations was suggested. Support was indicated for community-based elements of the model, although the risks associated with Private Finance Initiatives were highlighted.

9 The Royal Orthopaedic Hospitals NHS Trust

The Trust offered support for the proposals, particularly commending the emphasis on public development of healthier lifestyles, community and localised care.

Whilst support was indicated for wider community provision, the Trust expressed a view that highly specialised services, and those requiring inpatient care, should continue to be delivered from an acute provider site. A desire was expressed for the development of partnership arrangements in order to ensure specialist orthopaedic work was provided in viable and effective environments.

Similarly, the Trust wished to be kept informed about the level of cost and investment involved in the proposed new facilities, requesting transparency concerning any implications of such investment.

10 Sandwell Mental Health NHS and Social Care Trust

The Sandwell Mental Health NHS and Social Care Trust valued the shift of resources into community care as a means to provide improved treatment, care and support for mental health and learning disabilities. However, more detailed information was felt to be necessary, particularly with regard to proposed resources and staffing levels involved in future mental health provision. Additionally, there was a sense that mental health was not sufficiently connected to other areas of the proposal, particularly in terms of resources.

The process of implementing the proposed changes was also raised as a specific issue, with the Trust keen that community services be put into place before the development of a new hospital. Good public transport links and housing development, particularly for the elderly, were also cited as areas in which continuity of provision was important.

11 University Hospital Birmingham NHS Foundation Trust (UHBFT)

In similar with responses from other Trusts, the University Hospital Birmingham NHS Foundation Trust focussed its commentary around the potential impact of changes upon its area of care provision. Whilst the Trust felt that there was usually sufficient data provided to support the changes proposed, it did not feel it had been sufficiently involved in the proposal process. In particular, the Trust expressed a desire to discuss the specific impact on patient numbers across specialist care, as well as within Accident and Emergency services. It was felt that the relocation of City Hospital, in particular, would reduce the number of beds required within outpatient care, as well as for general care, at the University Hospital Birmingham.

Doubts were also expressed over the proposed numbers of beds suggested for inpatient care and surgery, although again a lack of information was indicated as a possible cause for this. The Trust urgently requested clarification on how the proposals would impact on the numbers of patients, and their location, within the area.

Local Authorities

12 Birmingham City Council

These bodies offered broad support for the proposals, with the exception of a series of specific caveats.

Concerns were expressed about two interlinked but separate consultation processes being run at once. The Council felt that this had led to a degree of confusion about

the exact nature of each document, with interim proposals taking precedence over more long-term plans. In addition, the timescale was noted as problematic.

Support for the proposed new hospital was proffered on the basis that the suggested site would not be subsequently relocated. Concern was expressed that enough work was being done to ensure sufficient investment in viable public transport networks. The proposed reduction in beds also caused anxiety, the Council feeling it to be crucial that any changes in provision or capacity were effectively managed in order to avoid high bed occupancy. Assurances were also requested that financial resources would be managed efficaciously.

The transport of urgent care patients between sites was another area of concern, the Council asking for reassurances that any relocation would not prove detrimental to patient safety. It was suggested that the relocation of primary care be managed more efficiently in order to minimise administrative costs and maximise appointment flexibility. Concerns were expressed that patients would have to travel further to visit their GP, and that relocated services would become increasingly impersonal.

Resource management and flexibility were also cited with regard to community care provision. The shift towards community provision was considered by the Council to be potentially expensive and requiring a high level of resource management. The Council wished to be reassured that any financial costs would be fairly and adequately allocated.

With regard to an ongoing commitment to public health, the Council wished to see an increased engagement between Health Authorities and Local Authorities, and with wider local authority departments. In addition, it was felt that an increased provision of transport, housing and access to health education were all of paramount importance in improving the health of residents.

The retention of full Accident and Emergency provision at the proposed new hospital was seen as essential, due to its proximity to Birmingham City Centre. It was also seen as important that easily understandable information about the distinction between Accident and Emergency and urgent care was widely disseminated.

The Council supported the proposal to help patients manage their own long-term conditions, although any consequent reduction in hospital admissions must be

supported by a continuing district hospital model of acute care. Investment in admissions monitoring through active case management was commended, although caution expressed that sufficient levels of staffing and finance were provided to guarantee such an investment.

Concerns were expressed that the proposed model of planned care overstated the level of control patients would have over the process. Significant levels of negotiation were seen to be required in order to successfully implement this proposal.

An increase in community services for children and young people would require an increased involvement with the Birmingham Children's Hospital, as well as providing an opportunity for closer partnership working with agencies such as the Local Authority Children and Family Department.

Proposals for mental health services were seen by the Council as disappointingly vague, and the lack of an explicit commitment to develop learning disability services was highlighted. A suggestion was made for a greater focus on creating liaison arrangements between acute and community services. It was felt that greater attention needed to be paid to mental health services within the proposal.

The impact of the proposals across the region was also considered. Employment and employment promotion were cited as particular areas in which young people may become engaged with the process.

Across all areas of care provision, the Council requested that it be kept sufficiently informed of any changes made, and that the general public be at all times engaged in an open and ongoing process of dialogue about the change process.

13 Sandwell Metropolitan Borough Council

The Council found considerable merit within the proposal, and acknowledged the factors it felt had led to its development. However, the consultation document was felt to be unclear, with the proposal not specified to a sufficient degree of detail.

In particular, the perceived reducing of Accident and Emergency facilities in the area was cited as a subject which required effective communication with the public. It was felt that not doing so risked successful adherence to the project timetable.

Similarly, it was felt that information concerning the relocation of emergency care and the reconfiguration of care pathways was lacking in clarity. Assurances were sought that communication and training were provided to all relevant NHS employees in order to ensure an effective implementation of any new system. In particular, the assessment of patients leading to service allocation was highlighted as an area of central importance.

The Council expressed concern at the pace of the change process, particularly in terms of the relocation and reorganisation of existing services. Doubts were expressed as to whether the health service could effectively cope with all of the demands of the proposal.

Whilst work in pursuing a joint health and social agenda was recognised and commended, the Council felt that this process must be enhanced and strengthened in order to ensure effective management and quality patient care. Similarly, the full engagement of GPs was regarded as critical in ensuring effective service provision and implementation of the proposals. Details were also requested concerning the ways in which the voluntary sector would be enabled to compete fairly with other health care providers.

Measures to address a perceived deficit in satisfactory palliative care was recognised. The Council's members were, however, equally keen to ensure that the proposals allow services and professionals to work together to continue to meet the needs of patients with terminal illnesses.

The Council expressed support for the proposed site of the new hospital, although highlighted a need to be mindful of the scale of such a building project. Potential disruption to the local area caused by the site was cited as a possible challenge, as well as the timely acquisition of sites for proposed community facilities.

Further assurances were requested that public transport networks were effectively networked and developed at an early stage. Mental health needs, additionally, were felt to be insufficiently well defined, with further clarification being sought.

In particular, the Council highlighted the financial stresses and challenges of such a large-scale project, whilst remarking upon the importance of maintaining service stability throughout the change process.

Clinical / Medical

14 Birmingham Local Pharmaceutical Committee

The committee welcomed the proposals, particularly their aim to modernise the delivery of primary care services. It was felt that the potential contribution of pharmacists to the delivery of the consultation's aims was not always sufficiently expressed in the proposal document.

Concern was expressed that the proposed changes to primary care provision, particularly the relocation of GP services, would disrupt or destabilise the community pharmacy network. Careful consideration of any such relocation was requested, with the Committee and contractors being kept fully informed at all stages of the proposals process.

15 Sandwell Local Pharmaceutical Committee

The Committee welcomed the moves to modernise primary care provision. However, it was felt that the role that community pharmacy could potentially play in improving healthcare provision was understated. In particular, possibilities for capitalising on current successes were highlighted, such as the Minor Ailments Scheme.

Additionally, the Committee also cautioned against destabilising current pharmacy networks through pharmacies becoming isolated from their main sources of prescriptions. This may occur through the proposed relocations of GP practices.

16 Sandwell and West Birmingham Hospitals NHS Trust Academic Department of Gynaecological Oncology

The Group did not feel it could support the surgical configuration as presented in the proposal. In addition, it felt that the proposed allocation of surgeons covering City Hospital would significantly degrade the quality of the gynae-oncology service. The Group also considered the development of pelvic surgery in the area to be at risk of being adversely affected.

17 Sandwell and West Birmingham Patient and Public Involvement (PPI) Forum

Hospital services being offered through community care was a move welcomed by the Forum. However, a high level of concern was expressed that there would be sufficient financial measures in place to ensure the service could be fully implemented and sustained. Any support for the proposals would be invalid in the instance of any further cuts to the proposed funding.

The Forum also felt that community services should be better supported and connected within and across Sandwell and Birmingham. In order to ensure comprehensive services, sufficient finances would need to be demonstrated for increased staffing and training. Greater evidence was also requested for the existence of comprehensive Partnerships that would effectively provide a holistic care service. Ongoing communication with both staff and the public was required at a frequency of at least every six months.

Potential moves to reduce bed capacity were understood, although sufficient back-up facilities were felt to be necessary in order to ensure the existence of as many beds in the community as at present. This would include 24 hour nursing. The Forum would accordingly require the Trust to place its full Emergency Planning Strategies in the public domain.

Staff involvement and monitoring was felt to be crucial to the success of the proposal. Levels of staff morale, attendance, recruitment and training should be shared with patients, staff and the public.

It was also felt that full planning and consultation should be provided in order to ensure a comprehensive and effective public transport network.

18 Sandwell Local Medical Committee

The committee welcomed the proposal. Reservations were expressed regarding the management of resources throughout the change process. Specifically, sustained investment must be made in any enhanced primary care services, ensuring that quality of service is maintained despite increases in workload. This would include ensuring sufficient staffing levels. The Committee expressed particular concern that retiring GP principals were replaced on an individual case basis. However, it was felt that staffing within all disciplines must be fully supported in terms of recruitment, training, integration and retention.

It was also regarded as crucial that patients, and the Committee, were kept involved during the change process.

3 Discussion

In order to thoroughly understand the results of the research, it is necessary to understand the connections between the nature of the consultation process and the responses it provoked. Whilst the paper and online questionnaires allowed respondents specific opportunities to respond in terms of optimism or concern, other response formats produced a more open response. For instance, public meetings by definition allow individuals the opportunity to voice concerns or raise queries about aspects of the proposals. Using a multi-method approach such as the one made use of in this consultation helps to minimise the potential impact of such trends. However, although it is relatively easy to quantify the occurrence of commentary on particular themes, it is more difficult to accurately weight the data in terms of the exact character of the comments – whether they are complaints, concerns, praise, and so on.

However, it is important to remember that it *is* possible to quantify some important aspects of the data; for instance, 73.2% of questionnaire respondents supported the overall proposals. Similarly, 69.3% thought current local services need to be changed, and 45.8% that the changes would provide the health and social care services important to them. The delivery of excellent specialist care was the potential improvement respondents attached with the most importance (with a mean percentage score of 93%).

It is also possible to reach some general conclusions about the qualitative data provided by the survey. Broadly speaking, the consultation process was used by respondents in three main ways: firstly, in order to rate particular aspects of the proposal, either positively or negatively; secondly, to similarly rate current areas of healthcare provision, again in terms of support or complaint; and finally, in order to question or query aspects of the consultation process.

As previously suggested, although the consultation returned a high level of negative responses – particularly within the areas of relocation of existing services, transport and travel, and management – other areas provoked a more positive reaction. Many respondents supported the theory behind the process and the need for change, if not the exact ways in which the change was to be implemented. To some extent this can be ascribed to certain themes being particularly emotive, with areas in which the

theoretical process could potentially impact upon the personal navigation of care pathways being key examples of this.

Respondents also used the consultation process as an opportunity to voice complaint about current healthcare provision. These often focused around areas of apparent practical shortcomings, particularly difficulties in traveling to existing services, perceived staffing limitations, and the quality of care received.

Finally, participants often expressed their reaction in terms of questions and queries rather than negative or positive comments. A consistent theme across consultation methods was the desire for more, and more detailed, information about what the change process would entail. Much of the cynicism expressed within the data, primarily over the motivating factors behind the consultation process as well as its ability to effect significant change, could arguably be attributed to a perceived lack of a comprehensive understanding about the results of the process.

Key themes

Categorising the combined totals from all of these research methods results suggests that community care was the most prevalent area of commentary from respondents. Nearly 13% of all responses fully or partially mentioned such issues in some way. However, as a theme it is important to note that 'community care' captured two distinct key attitudes: individuals expressing anxiety at the closure of local hospitals, and those indicating a desire for improved services in the community.

Comments about existing services was the next most prevalent theme. Again, two inter-related but specific themes emerge in particular from this data. Firstly, respondents often expressed a preference for changes to current healthcare provision. Secondly, many individuals were concerned about the precise implications of the change process, particularly in terms of the relocation of existing services. Formal respondents were also concerned about the impact of such a shift on service resources in their local areas.

Responses relating to issues of transport and travel comprised the third most prevalent category, emerging as a particular area of concern for those responding to questionnaires. In particular, travel time to potentially relocated A&E services caused

anxiety, as well as the need to establish efficient transport networks in the area. Participants often phrased their reactions in the form of questions, indicating a desire for more - and more specific - information on the accessibility of potentially relocated services.

Comments about management covered a wide range of issues, although again many respondents indicated a desire for a greater level of knowledge about how the proposed changes would be run. Shifts in care provision, particularly relocation of staff and increases in community care, were often met with doubts about their effectiveness. Many respondents also pointed to perceived problems with existing management systems, particularly resource management, as reasons for change being needed to the current provision of health and care services in their local area.

With regard to the theory and process of developing the proposal, respondents often discussed the value of the proposed increase in high quality, patient-driven local community services. However, concerns were raised that the proposals focused too heavily on buildings and finance at the expense of personnel, service quality and patient welfare. Others felt that the scope of the proposals was too great to be effectively implemented, with a degree of cynicism that they would eventually result in a regionally skewed or reduced service.

Commentary on staffing issues centred on the potential impact of the relocation of services on personnel. Public meeting attendees particularly raised the issue of whether there would be sufficient staff numbers to accommodate the new roles established in the proposal, and whether training would be offered to meet this potential deficit. Across all response formats, the focus was on the practical implications of the theoretical aspects of the proposal, including desired improvements to the number of staff, the quality of care they offered, and the skills they possessed.

Public meetings were also the venue for considerable discussion about the consultation process itself. Some attendees were concerned that it was already a foregone conclusion, and that public involvement was likely to have little effect. Respondents across all formats requested a greater level of involvement in the process, and more detailed information about the proposals themselves. The level of communication with healthcare professionals, social services, and the voluntary and community sectors was also questioned. Many formal respondents from within such

organisations requested a greater degree of involvement in the consultation process, as well as more detailed information about how the changes would affect their particular area of care provision.

Participants referring to the proposed new hospital were likely to respond in terms of questions rather than concerns, again wishing for more information about the location of the site and what services it would provide. Once details of the location were made available, many public meeting attendees and questionnaire respondents reacted negatively to it, particularly for reasons of transport and travel. However, a large proportion of questionnaire respondents welcomed the proposal of a new hospital.

As elsewhere, quality of care comments fell into two broad themes: respondents communicating complaints about the current provision of care, and those asking whether the proposals would lead to an improved quality of care. Current care quality was most often defined in terms of existing local health status, hospital cleanliness, waiting lists, and service accessibility. Respondents also voiced concern about the potential risks of perceived fragmentation of care services.

Financial issues caused respondents to question both the precise allocation of funds within the proposal and whether it would be enough to cover the entire programme. Many were sceptical about the use of the Private Finance Initiative. Clarification was requested across formats as to the details of the proposal.

The potential impact on GP services was framed by many respondents in terms of a reduction or loss of local GP practices, with close personal relationships between patients and doctors often cited as a reason for this concern.

A&E services, as with other areas of proposed relocation, proved a particularly emotive issue. The potential closure of services at Sandwell was a common theme within all response methods. Respondents also questioned the ability of relocated A&E facilities to cope successfully with the greater traveling time required.

Comments regarding waiting lists, times and appointments primarily focused on issues with existing services, suggesting patient dissatisfaction with the current organisation of care. With specific regard to the proposals, fears were expressed over the ability of local services to cope with current or increased levels of demand.

Respondents who commented on the potential impact on specialised services focused on the relocation of care, asking questions about where and how provision for needs as diverse as speech and language therapy, rheumatology, ocular care and sexual health would be catered for. With the formal responses, concern was expressed that community-based pharmaceutical care would not be disrupted by the relocation of GP services.

The change process, whilst commented on comparatively infrequently, was an issue on which respondents had clear concerns. In particular, the managing and pacing of any transition, together with a desire for effectively 'joined-up' services, were recurring themes. Formal respondents also indicated concern that diverse forms of care provision were integrated in a cohesive manner.

Patients within the sample for whom long-term, paediatric or neonatal care was an issue of specific concern voiced concern that their needs were not being sufficiently considered. The impact of relocation on these services was often voiced as a concern, as well as their management within the new hospital facilities.

4 Observations

It is important to capitalise on the benefits of the independent research process and the findings presented therein. As stated in the discussion section, there is considerable support for the proposals. However, the nature of the consultation process unavoidably means that many more queries, concerns and criticisms are raised than endorsements. There was, for example, no 'show of hands' for support of the proposals at public meetings. Likewise, it was always unlikely that anyone would contact the research team by letter to praise and support the proposals: formal responses aside, this indeed did not happen.

It is clear that a large number of respondents to the consultation used the process to raise concerns or seek clarification about aspects of the proposed changes that they felt would have a direct impact on themselves, their families and their community, and this occurred regardless of whether or not they supported the overall proposal (which nearly three-quarters of questionnaire respondents did).

These concerns themselves could be thought of in two distinct ways:

- *What does it mean to me?* – whereby concerns addressed how changes might affect respondents personal circumstances (whether these be visiting family members in hospital, caring for elderly relatives, themselves having a disability and so on)
- *What does it mean for us?* – whereby 'us' is the community. These are the 'bigger picture' concerns (about, for example, how health care provision will work, numbers of skilled staff available, siting of the new hospital and so on)

It might be productive for future phases of the *Towards 2010* programme, whilst appreciating that these concerns are interrelated, to proactively address them in isolation to one another.

This might take the form of providing information that alleviates the concerns of those who are apprehensive about how proposals may impact their own health care. For example: locations of new services could be made known as soon as possible; changes to provision of specialist operations could be made known directly to those affected by them; successes in negotiating developments in transport infrastructure in partnership with local transport facilitators could be made known to the population;

family doctors could reassure elderly patients about their ongoing primary care in revised locations; and ambulance services could make known potential transit times to revised A&E departments from locations where the population may be impacted by changes.

Similarly, information could be provided on an ongoing basis that demonstrates how proposals are impacting on local health care provision in a positive way. For example: success stories and best practice could be promoted through local media; success stories could be disseminated at the point of care (such as posters promoting reduced waiting times in GP surgeries); new services could be disseminated through local primary care services, and specialised services proactively promoted to those known to be impacted by them; examples could be shared with the population of where similar models of care have been successful within other health care settings; and information could be disseminated on all aspects of changes at community level.

Appendices

Appendix 1: Questionnaire

Towards 2010: *Investing in a Healthy Future*

Major changes are being suggested to the way health and social care services are provided for the people of Sandwell and the Heart of Birmingham. We are very keen to get the views of the public about these changes. (If you are under 16 years of age, please ensure your parent / guardian signs the statement at the end of the questionnaire, otherwise we will not be allowed to consider your views).

Please spend just **5 minutes** completing the following questions. Once completed post in an envelope (no stamp required) to: **'FREEPOST QUAD (2010)'** no later than **16th February 2007**. You can also fill in this questionnaire online at www.towards2010swb.nhs.uk.

Q1 Do you support our overall proposals to spend extra resources in Sandwell and the Heart of Birmingham?

☐ Yes ☐ No ☐ Unsure

Q2 Are there any parts of the proposal you value most?

Q3 Are there any parts of the proposal you are concerned about?

Q4 How important are the following to you?

	Not important	Slightly important	Important	Very important
Better coordination of care between social care, GPs and hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easier to use services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient appointments in the community instead of in hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services that treat people with privacy, dignity and reflect diversity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services that deliver excellent specialist care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services that use modern technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care provided in better buildings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services that create more local jobs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A patient's different types of care dealt with by one named care manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients able to leave hospital earlier, safely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Better education to help people and carers manage their own care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support for people in their own homes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services that support the prevention of ill health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint single assessments for those needing both health and social care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support for carers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q5 What else is important to you?

Q6 Do you think changes to health and care services are needed in your local area?

☐ Yes ☐ No ☐ Not sure

Q7 Why do you say this?

Q8 Do you think the changes we want to make will provide the health and social care services that are important to you?

☐ Yes ☐ No ☐ Not sure

Q9 As we progress with our plans (following consultation), what things would you like us to report upon to demonstrate progress?

Q10 Please add here any additional comments or concerns you may have.

So that we know the kinds of people that filled in the questionnaire, please answer the following questions. This will help us see whether we have had responses from all parts of our local community.

Q11 If you are responding on behalf of a group, please tell us the *name* of the group and the *number of people* in the group. (Once complete go to Q19)

Q12 Gender

☐ Male ☐ Female ☐ Prefer not to say

Q13 Age (If under 16yrs, ensure your parent / guardian signs the statement at the end of the questionnaire)

☐ Under 16 yrs ☐ 25 - 30 yrs ☐ 41 - 44 yrs
☐ 16 - 20 yrs ☐ 31 - 34 yrs ☐ 45 - 64 yrs
☐ 21 - 24 yrs ☐ 35 - 40 yrs ☐ 65 yrs and over

Q14 Postcode (This will only be used to see which neighbourhoods we are getting responses from)

Q15 Would you consider yourself to have a disability?

☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

Q16 Would you consider yourself to have a long term health condition (such as diabetes or asthma)?

☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

Q17 In the past 2 years, have you, a member of your household, or an individual you care for experienced any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Visited a family doctor | <input type="checkbox"/> Stayed overnight in a hospital |
| <input type="checkbox"/> Treated in a hospital | <input type="checkbox"/> Stayed in a nursing / care home |

Q18 Ethnicity (Tick one only)

- | | |
|---|--|
| <input type="checkbox"/> White - British | <input type="checkbox"/> Asian or Asian British - Pakistani |
| <input type="checkbox"/> White - Irish | <input type="checkbox"/> Asian or Asian British - Bangladeshi |
| <input type="checkbox"/> White - other white background | <input type="checkbox"/> Asian or Asian British - other Asian background |
| <input type="checkbox"/> Mixed - White and Black Caribbean | <input type="checkbox"/> Black or Black British - Caribbean |
| <input type="checkbox"/> Mixed - White and Black African | <input type="checkbox"/> Black or Black British - African |
| <input type="checkbox"/> Mixed - White and Asian | <input type="checkbox"/> Black or Black British - Other Black background |
| <input type="checkbox"/> Mixed - White and other background | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Asian or Asian British - Indian | <input type="checkbox"/> Other (please specify below) |
-

If you would like to receive a copy of the report setting out the results of the independent analysis of responses to the consultation, please fill in your contact details below. This section will be detached from the questionnaire immediately upon receipt.

Q19

Name / organisation	_____
Address (including postcode)	_____
Telephone number	_____
Email address	_____

If you would like more copies of the questionnaire, a version translated into a language other than English, or more copies of the consultation document, please go to our website at www.towards2010swb.nhs.uk, email us at towards2010@swbh.nhs.uk, call us on 0121 507 5939, or write to us at FREEPOST QUAD (2010).

Q21 Parental / guardian consent: As parent / guardian I give consent for the responses to this questionnaire to be included within the consultation analysis (*Sign below*)

Appendix 2: Tables

Figure 1 - Support for overall proposals to spend extra resources in Sandwell and Heart of Birmingham

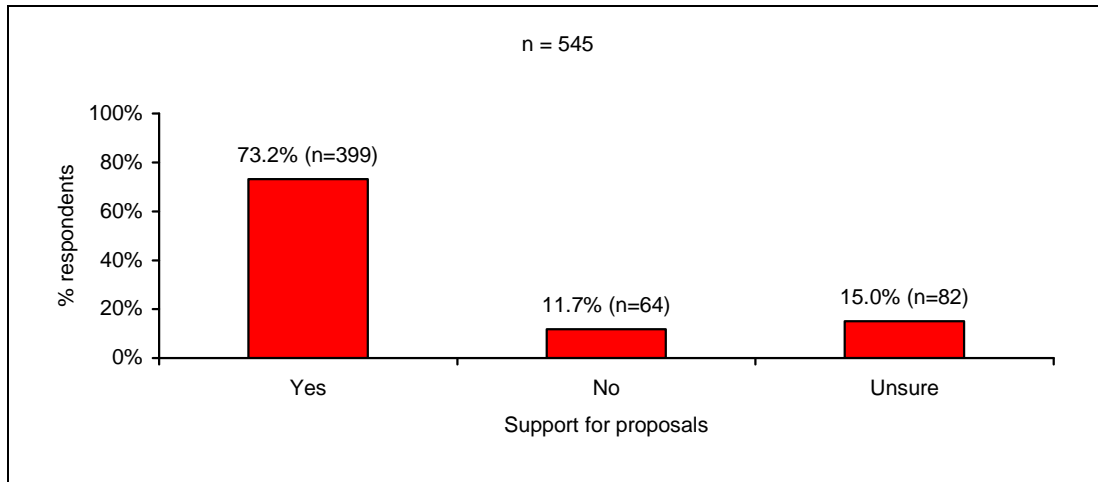


Figure 2 - Change is needed in my local area

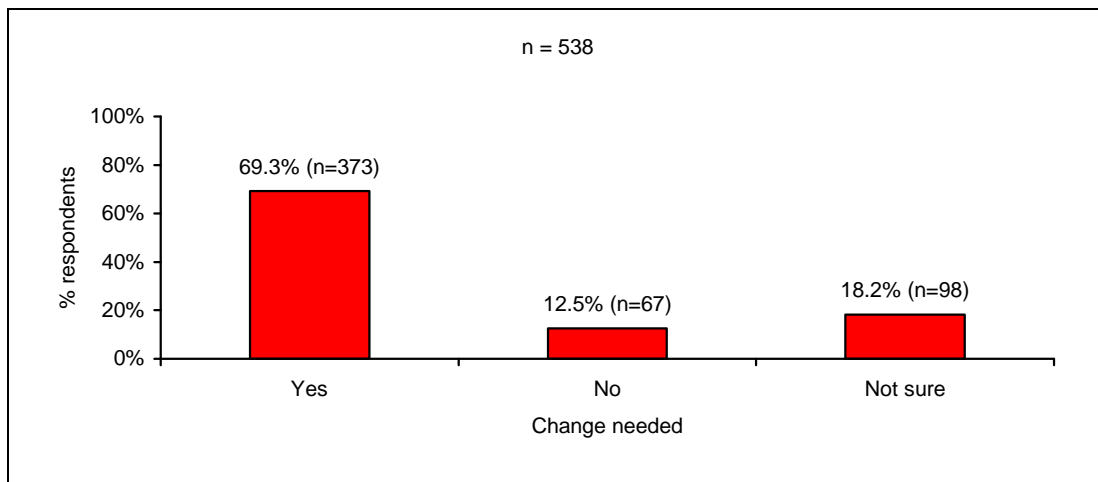


Figure 3 - Changes made will provide the health and care services that are important

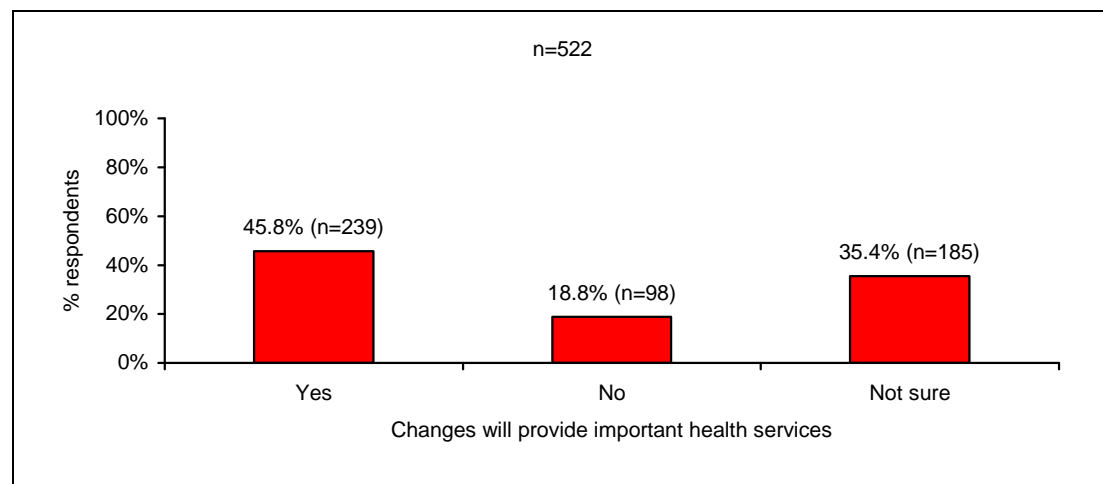


Figure 4.1 - Services that deliver excellent specialist care

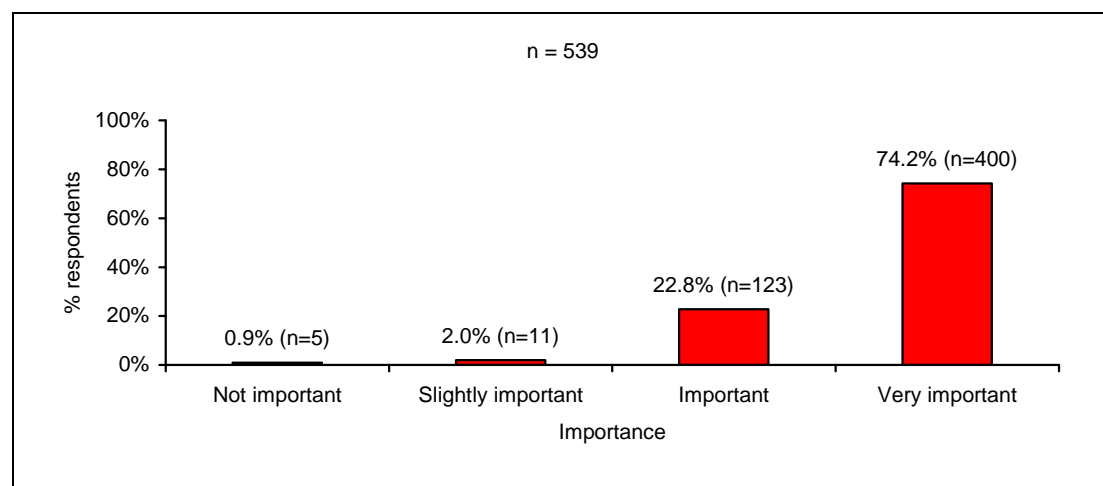


Figure 4.2 - Services that treat people with privacy, dignity and reflect diversity

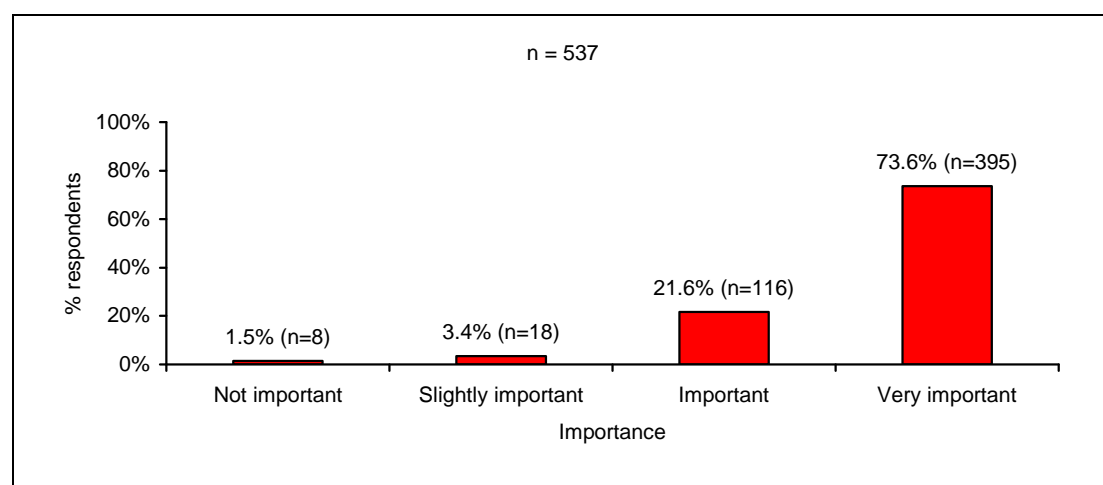


Figure 4.3 - Better coordination of care between social care, GPs and hospitals

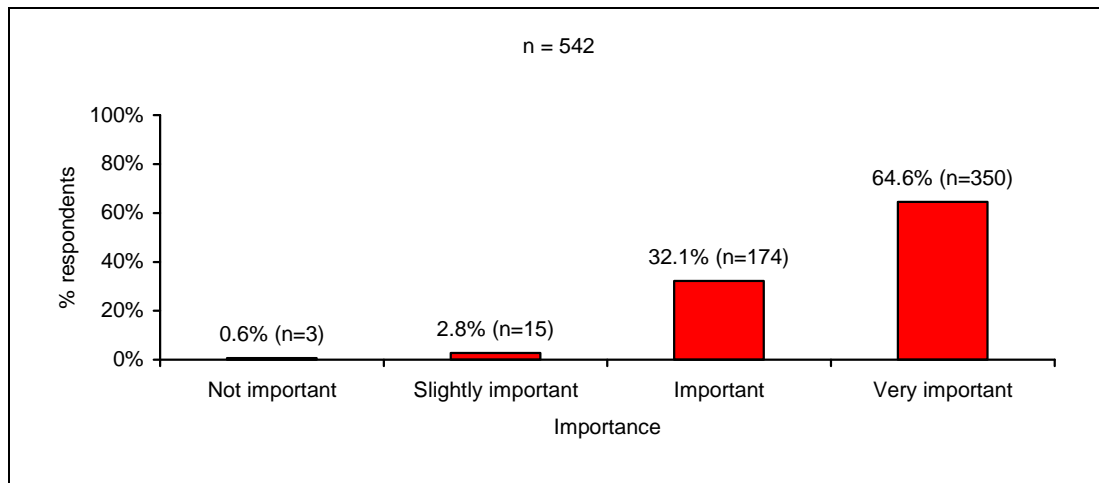


Figure 4.4 – Support for people in their own homes

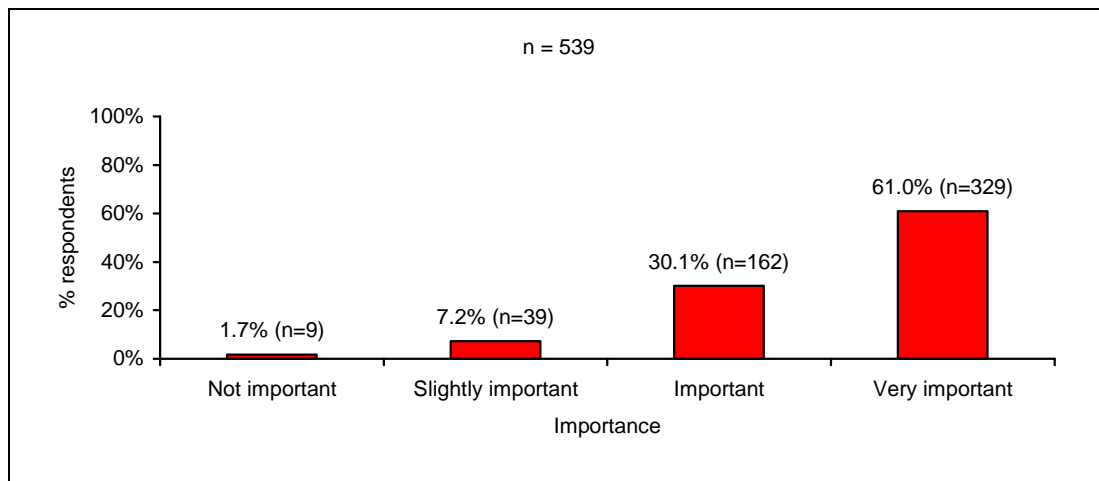


Figure 4.5 - Support for carers

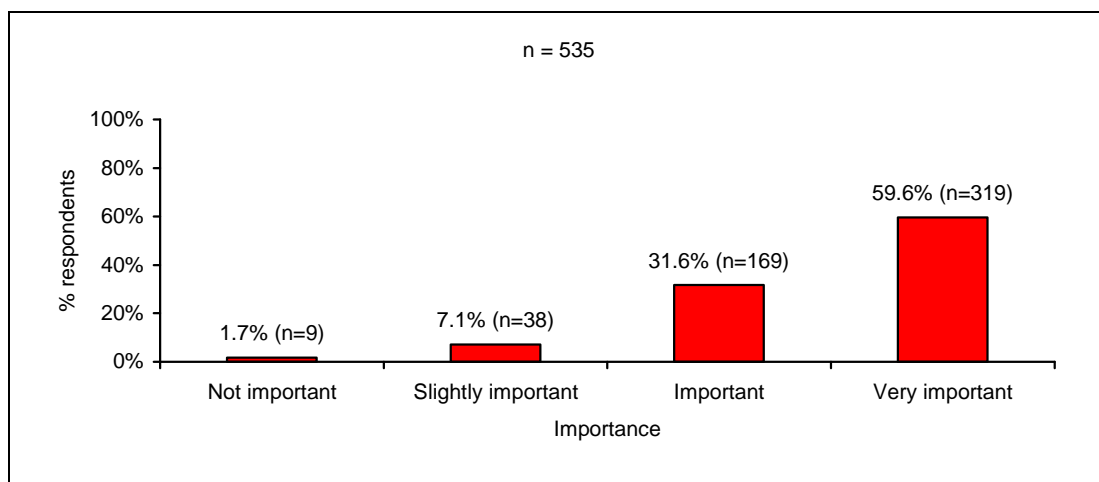


Figure 4.6 – Services that use modern technology

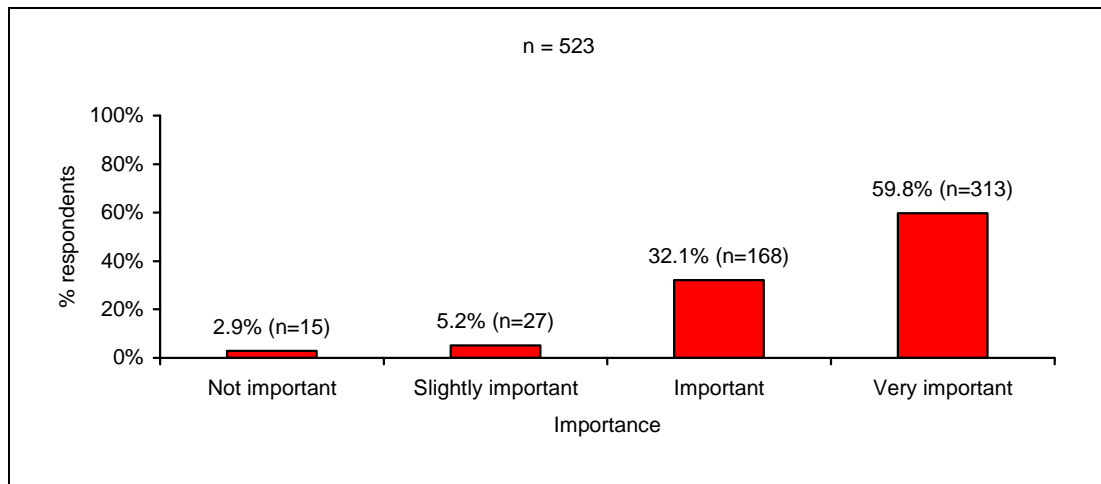


Figure 4.7 – Easier to use services

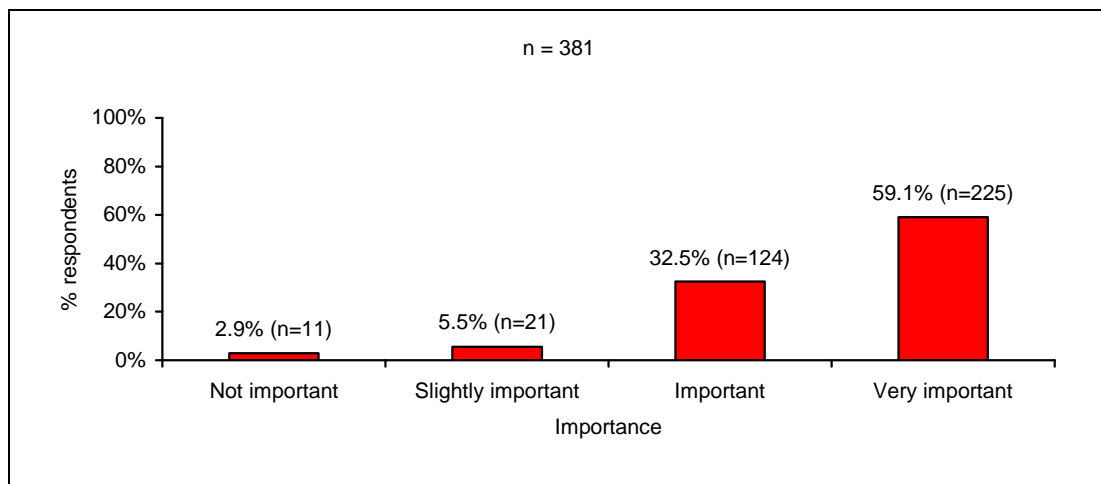


Figure 4.8 – Services that support the prevention of ill health

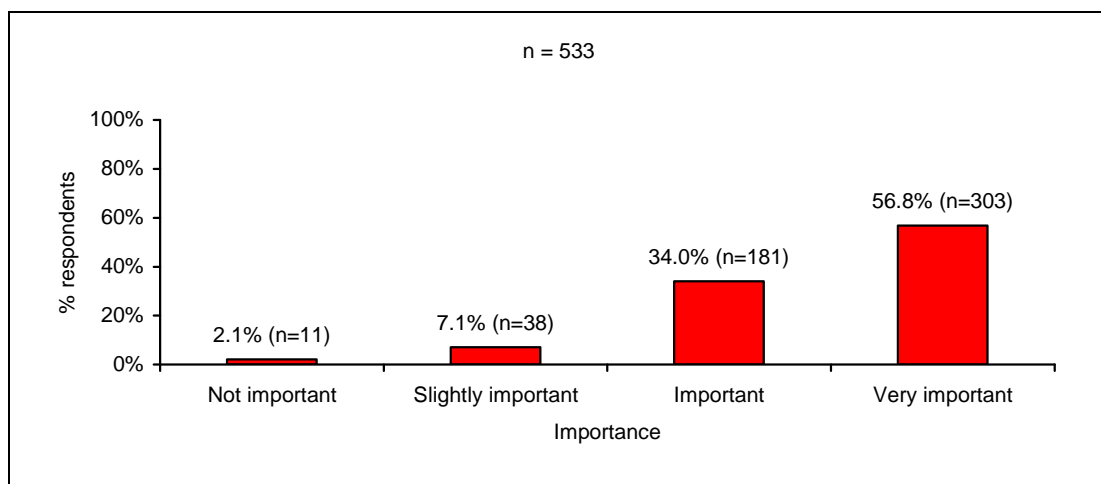


Figure 4.9 – Better education to help people and carers manage their own care

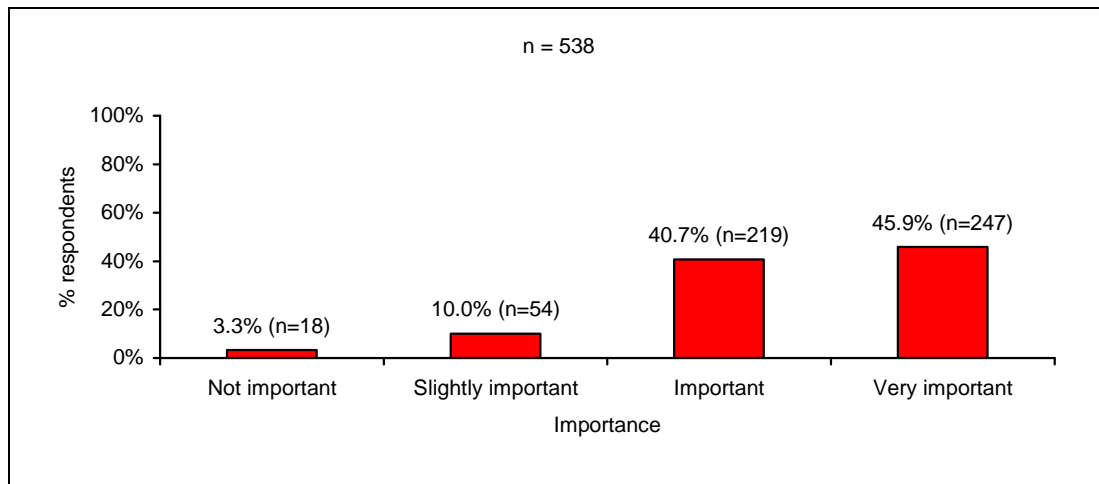


Figure 4.10 - Joint single assessments for those needing both health and social care

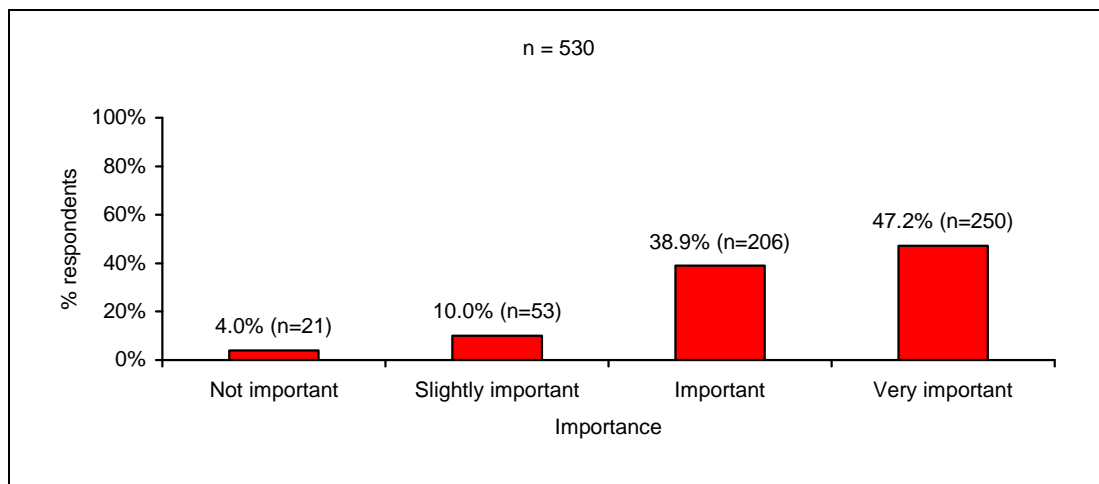


Figure 4.11 – Patients able to leave hospital earlier, safely

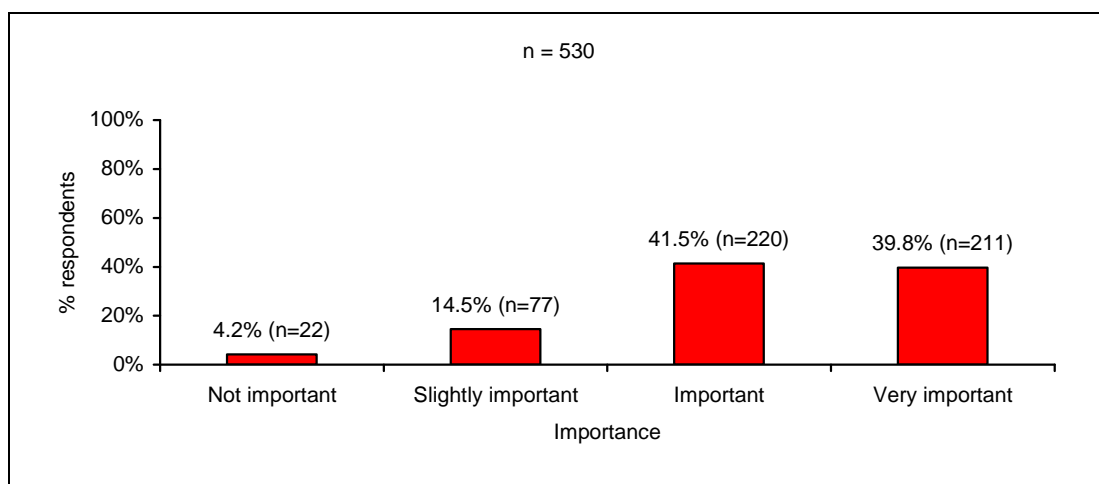


Figure 4.12 – Care provided in better buildings

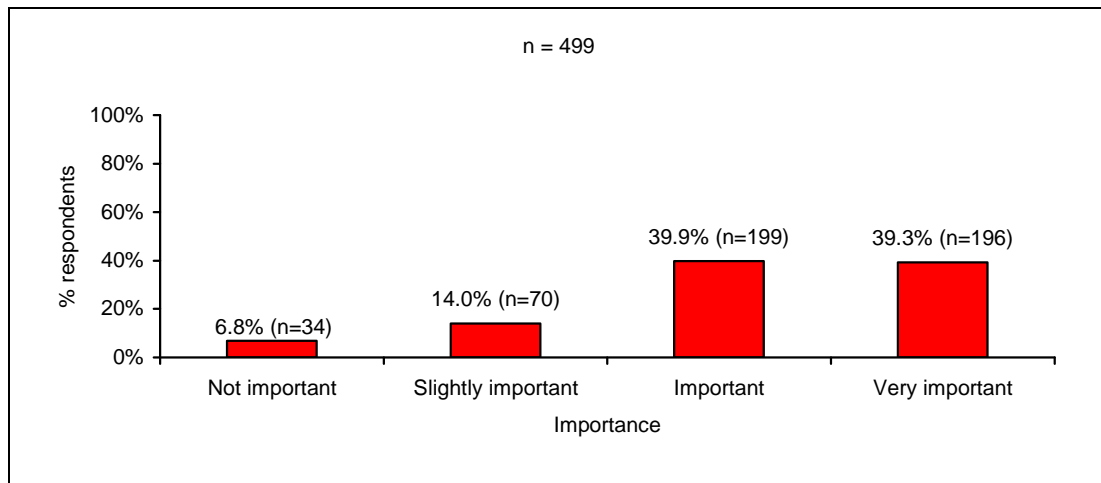


Figure 4.13 – Outpatient appointments in the community instead of in hospital

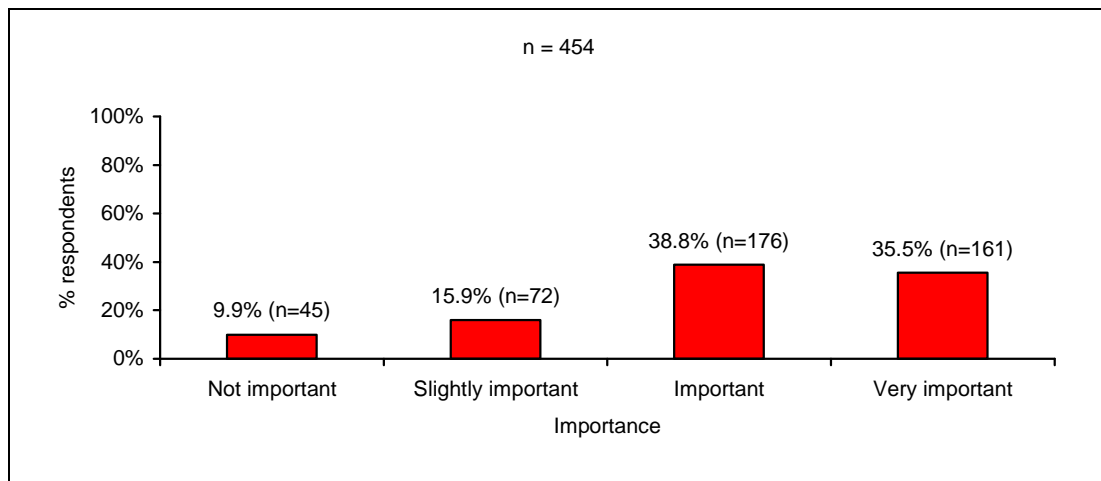


Figure 4.14 - Services that create more local jobs

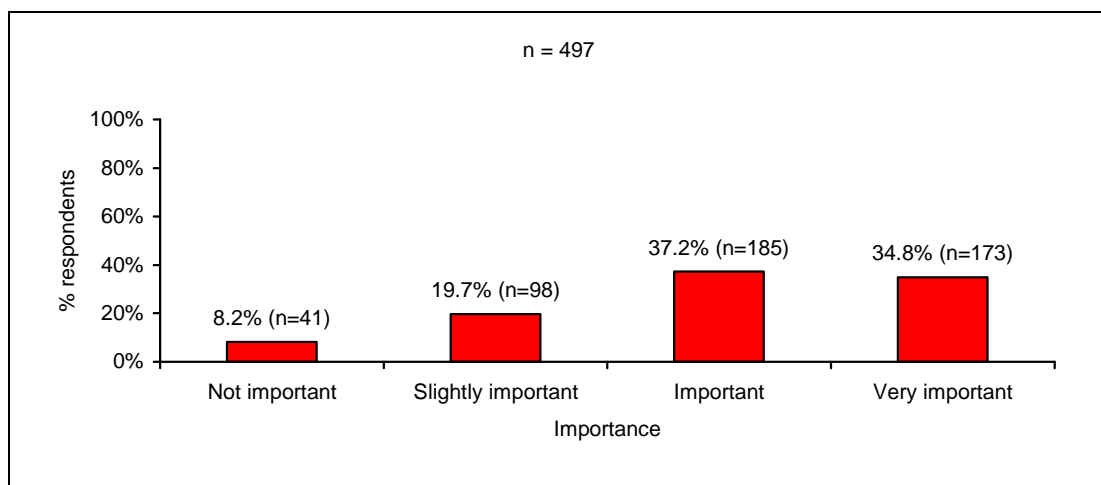


Figure 4.15 - A patient's different types of care dealt with by one named care manager

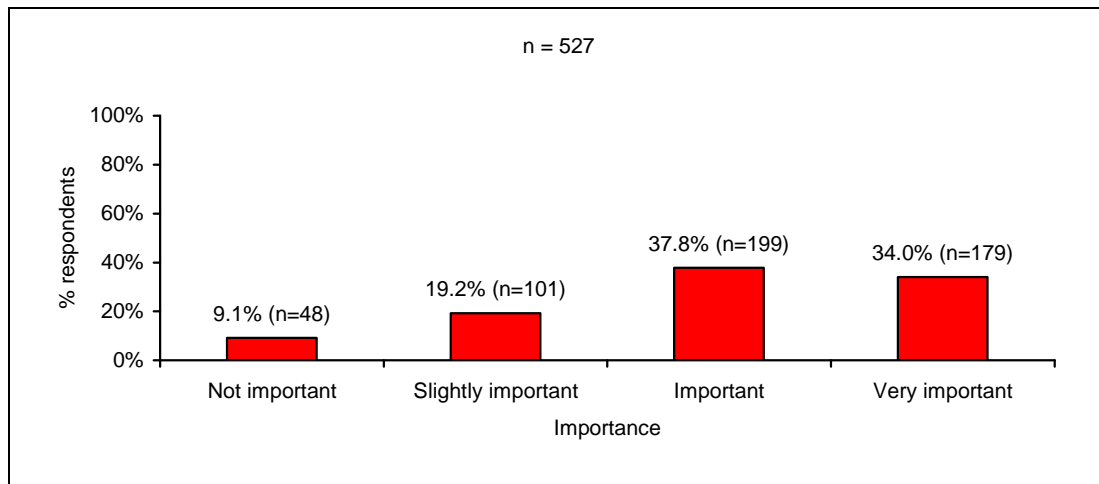


Figure 5 - Respondents considering themselves disabled

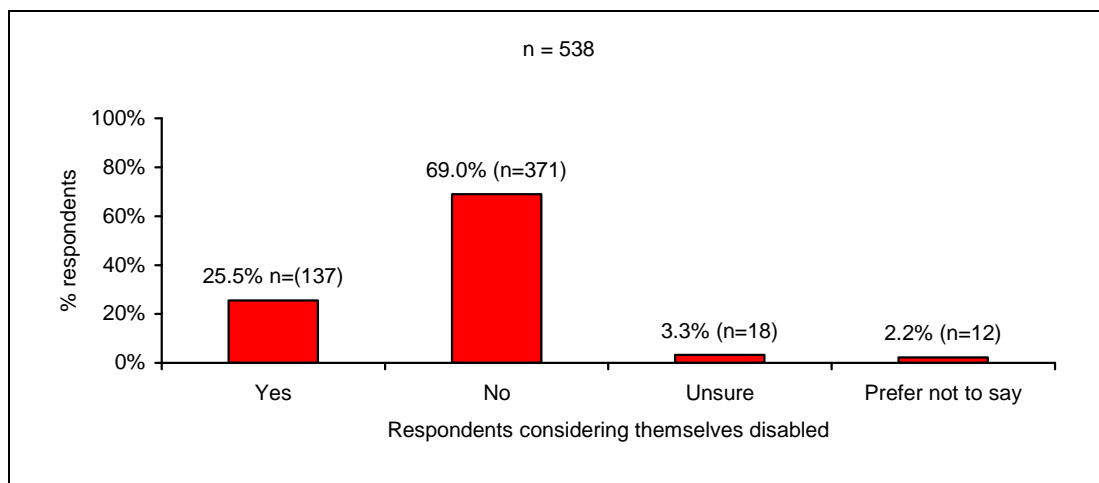


Figure 6 - Respondents considering themselves to have long-term health conditions

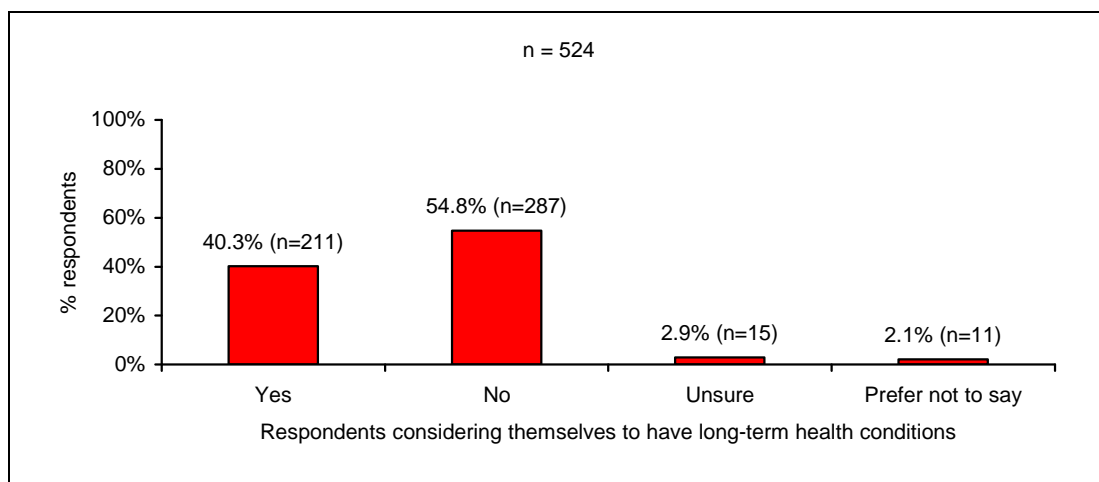
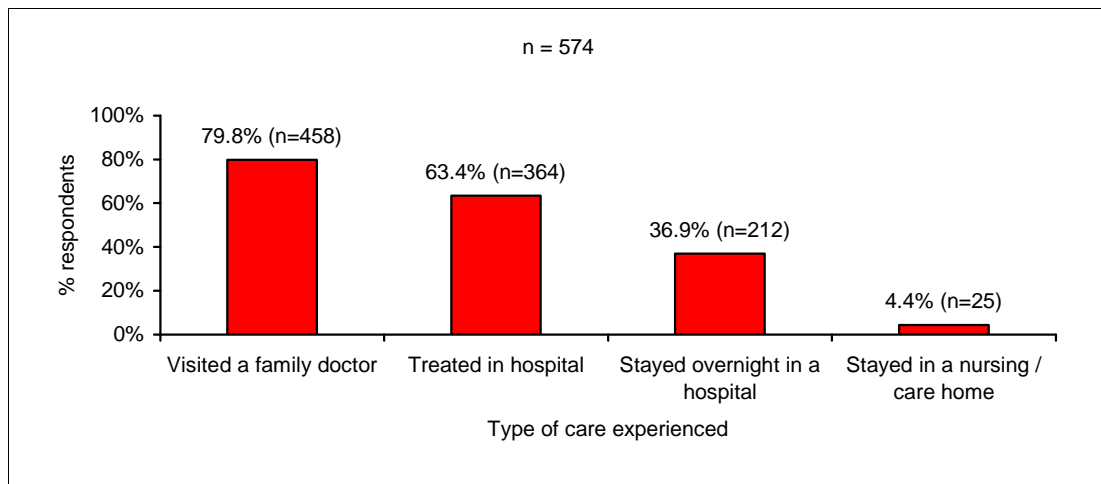


Figure 7 - Ill-health experienced in the last two years



(Please note: respondents could select multiple options for this question.)

Figure 8 – Gender

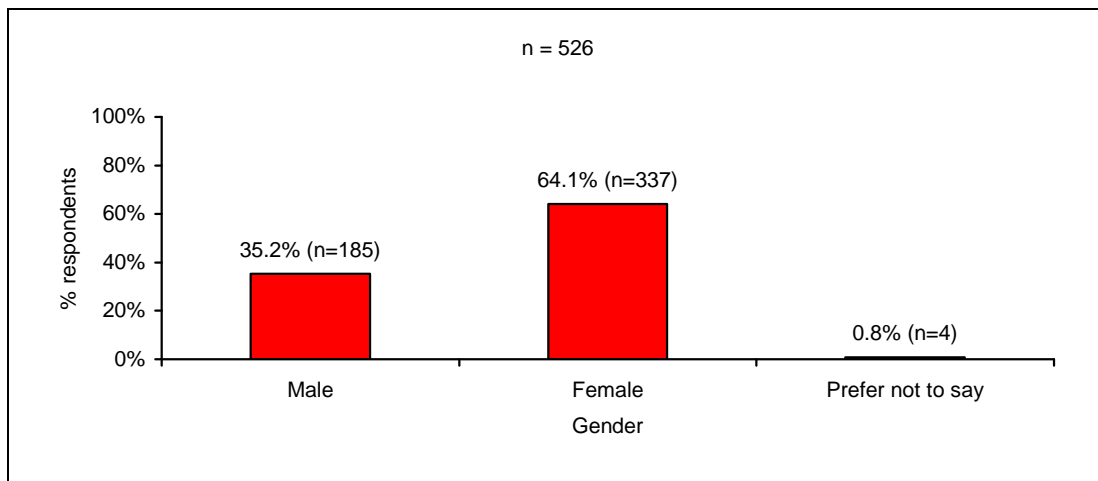


Figure 9 - Age

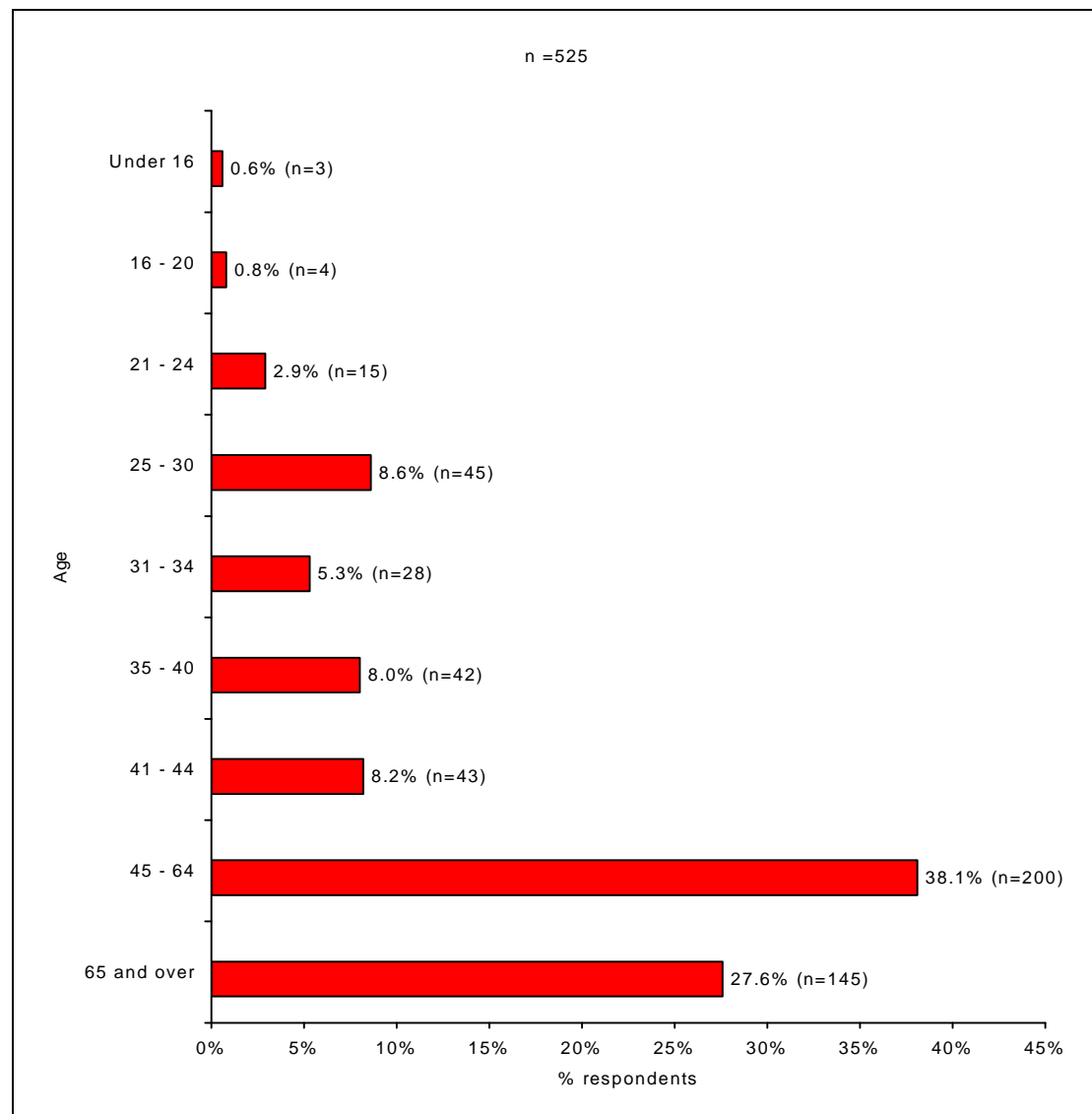
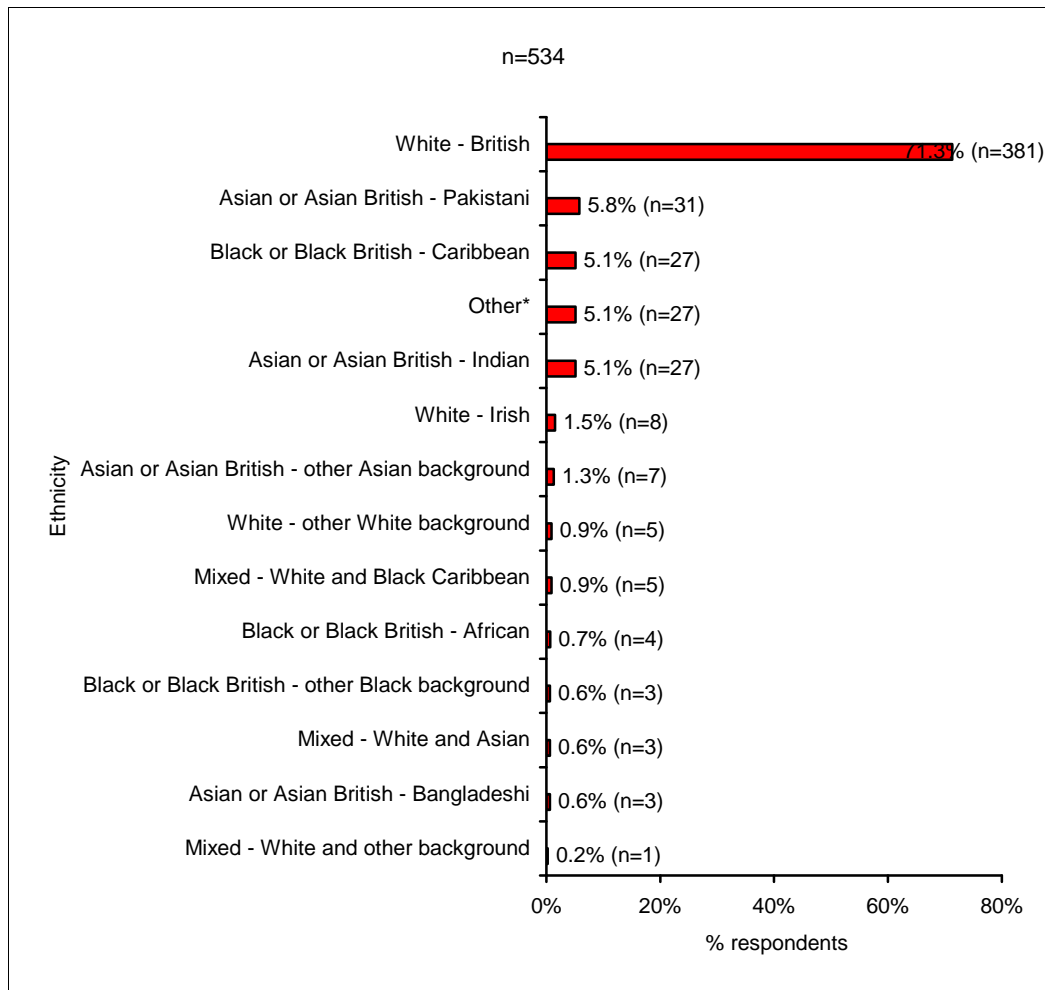


Figure 10 – Ethnicity



*19 respondents gave their ethnicity as *White English*. There was also one of each of the following: *British – African*, *African Asian British Citizen*, *African (Somali)*, *Arab (Middle East)*, *English*, *Muslim*, *White Welsh*.

Annexe 1 – Focus Group report

The Focus Group report is available as Annexe 1 provided separately to this document.

Annexe 2 – Formal Responses

Reproductions of all formal responses received are available as Annexe 2 provided separately to this document.

Sandwell and the Heart of Birmingham Health and Social Care Community



Towards 2010 - Investing in a healthy future

Summary

***Public consultation
20 November 2006 to 16 February 2007***





Introduction to Towards 2010

The health and social care services in your area need to change for the better. You can help us make this happen.

Towards 2010 is an exciting partnership between the NHS and the councils in Sandwell and Birmingham. We want to improve your health and that of everyone in your neighbourhood by:

- Bringing care closer to home and into local communities
- Providing high quality care in high quality places
- Making Sandwell and the heart of Birmingham healthier places to live and work

Why do we need to change?

There are three strong reasons why we need to change:

- People in Sandwell and the heart of Birmingham tend to have worse health than in many other parts of England
- Local people want health and social care services to provide care and treatment more quickly, closer to their homes and in better surroundings
- Our staff want to make better use of their skills so they can improve the care they provide.

Many of our buildings are coming towards the end of their useful lives and will have to be replaced soon. This gives us a once in a generation opportunity to redesign health and social care services so they meet the needs of local people in the most effective way, rather than just carrying on as we are now.

What changes should we make to services?

We have developed proposals for major changes to the way health and social care services are provided across Sandwell and the heart of Birmingham. We think this plan of action, called Towards 2010, is the best way to meet the needs of local people. It fits closely with the Government's latest thinking about what the NHS and social care should do.

We have been thinking in a new way about how services should be organised. We believe care should be provided as close to home as possible, with people having to travel only if it is not clinically safe or cost effective to deliver services in their home or community. This means moving away from a system where we mainly wait until people are ill and then care for them in large hospitals. But we do want to be able to call upon the specialist skills of a large hospital when needed. We are clear that having more services in the community would reduce the need for hospital beds.





Towards 2010 - Investing in a Healthy Future

The changes would require substantial additional investment, so by 2013 we would spend around £50 million extra a year on these enhanced services. This would be less than half of the extra money we expect to have available. In addition, we would switch spending from hospitals to community services. As a result we would by 2013 have reduced spending on specialist hospital care by around £65 million (a reduction of more than 10%) and increased spending in the community by the same amount.

Our proposals are ambitious and draw from experience elsewhere. We intend to test each major new service development and learn from pilots being run nationally to look at how services can best be moved into the community before we implement new models of care widely.

What difference would the changes to services make?

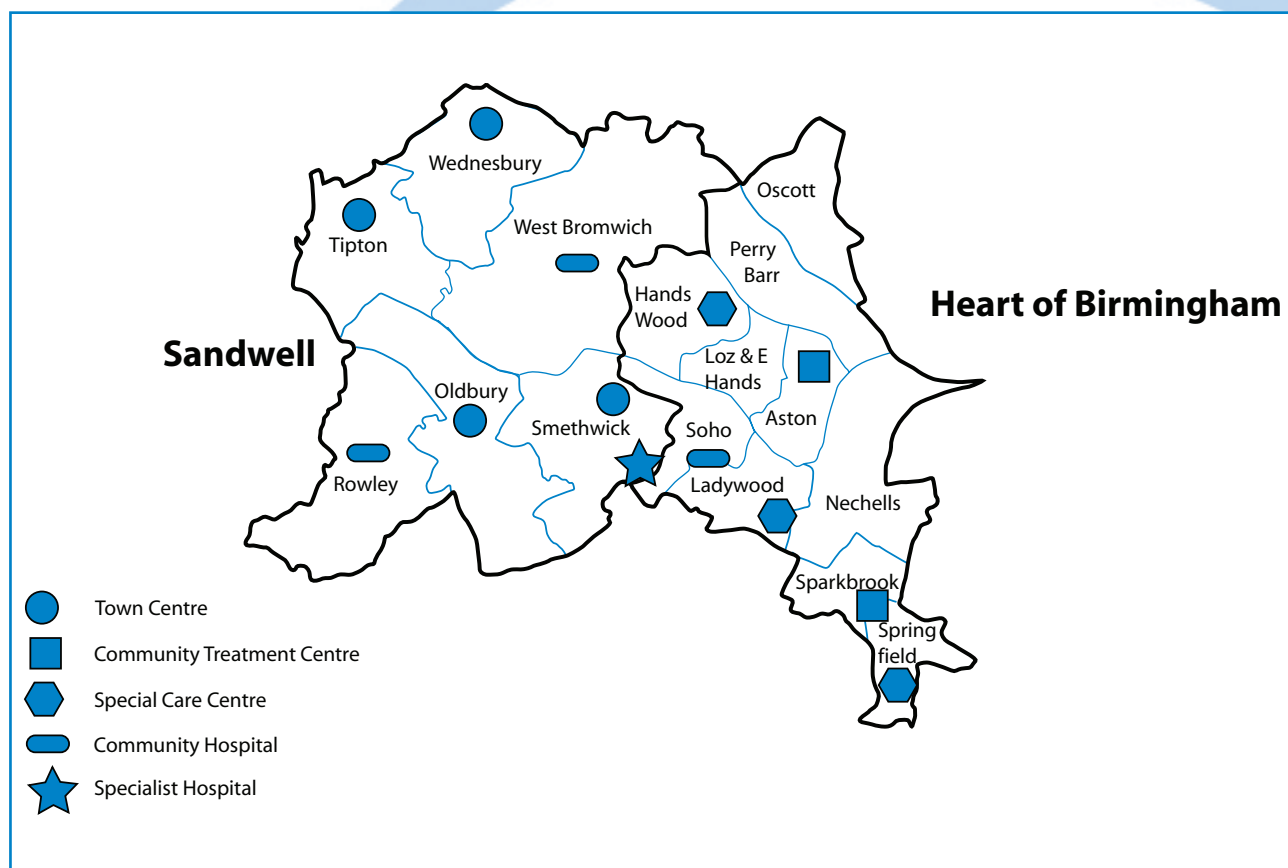
The changes would have a significant impact on many areas of service:

- We would do more to encourage people to stay healthy, helping them to stop smoking and adopt healthier lifestyles
- We would bring GPs together into new larger health centres, where they could offer a wider range of services in close connection with social care and other community services
- We would deliver most diagnostic services from 'community hospitals' or 'community treatment centres', so most people could have tests done locally rather than having to travel to a specialist hospital
- We would open a number of urgent care centres, where people with minor injuries and illnesses be treated quickly and locally, while developing a new state-of-the-art A&E for those people requiring specialist care
- We would be involved more actively with people who have a long-term health condition in order to help them maintain independence, using telecare and rapid response teams to deal with crises locally where possible without the need for them to go to a specialist hospital
- We would deliver most outpatient appointments and specialist consultations in people's local communities and would use the latest techniques to ensure people recovered quickly and so needed to spend only the shortest time in hospital
- We would provide a range of intermediate care beds in the community, so people could recover or receive respite care closer to home rather than having to stay in a specialist hospital
- We would open a new state-of-the-art specialist hospital, able to provide the most up to date treatments in the best possible environment



What buildings would the new services need?

We want to provide better health and social care services in Sandwell and the heart of Birmingham. To do this, we think we need to have:



- A range of **round-the-clock services** to provide care for people in their own homes
- Up to **40 new or refurbished large health centres** offering a wide range of GP and community care services, many run jointly with social care. You might also be able to see a chemist, optician or dentist there
- New '**community hospitals**' and '**community treatment centres**' (using existing buildings where possible) in West Bromwich (on the current Sandwell General Hospital site), Rowley Regis Hospital, Ladywood (on the current City Hospital site), Aston / Perry Barr and Sparkbrook/Springfield. These would offer a wide range of community services, including outpatient appointments, diagnostic tests and minor surgery



Towards 2010 - Investing in a Healthy Future

- A new, 21st century **specialist hospital** in the Smethwick area offering a full range of medical, surgical and women's and children's services on one site. This would work with the Birmingham Treatment Centre on the City Hospital site in Ladywood offering outpatient appointments, diagnostic tests and day surgery

The new specialist hospital and the community hospitals will cost around £495million to build, with the new and refurbished health centres costing a further £200 million. As well as these one-off costs, we will by 2012 invest around an extra £50 million a year in better community services. This will be split roughly equally between two of the NHS organisations – Sandwell PCT and Heart of Birmingham Teaching PCT.

How would we make it happen?

We need to know what you think of our plans, so we can be sure we design health and social care services that meet your needs in the future.

The system of health and social care is complex and there are many links between different services. We need to make sure new services were in place and fully operational before we started to close down old services or reduce capacity. We would develop a detailed plan for the transition from the way services are organised now to how they needed to be in the future. The changes would then be put in place over a number of years, with the aim of completing the programme in 2013.

We would ensure our plans were designed to allow as much flexibility as possible, giving us the opportunity to adjust them in the light of experience and changes in the local context. We would also check our progress against our plans by carrying out a rigorous external review before making key decisions. The strategic health authority, NHS West Midlands, would be closely involved in this process to ensure our plans were robust and provide reassurance to our stakeholders.

While we work towards building the new major hospital, we will need to deliver some specialist services from one or other of City Hospital or Sandwell General Hospital. These include emergency surgery, children's inpatient beds and intensive care for the very youngest babies. This will allow us to provide better services than if we try to run two general hospitals right up until the day the new hospital in the Smethwick area is ready to open. To make this happen, we are separately asking for your views on changes to some services. Details of these proposals are set out in a separate consultation document, ***Shaping Hospital Services for the Future***. Copies of this document can be obtained from www.swbh.nhs.uk or telephoning 0121 507 5940 or emailing consultation@swbh.nhs.uk. That separate consultation has the same start and end date as the consultation on the proposals set out here.





Towards 2010 - Investing in a Healthy Future

Your views matter

But before any of this happens, we need to know whether you support our proposals. We also want your views about which aspects of the suggested new services are most important to you and how we could improve our plans further.

We need your help to make this plan happen. We want to know what you think:

- Do you think changes to health and social care services are needed in your local area? Why?
- Do you support our overall proposals for how to spend £50 million a year of extra resources across Sandwell and the Heart of Birmingham?
- What are the most important health and social care issues for you?
- Are there any particular services you value most?
- Are there any services you are particularly concerned about?
- How can our plans be improved to better meet your needs?
- As we progress with our plans (following consultation), what things would you like us to measure and report upon to demonstrate progress ?

Who is going to make this change happen?

The organisations behind this consultation are:

- Heart of Birmingham Teaching Primary Care Trust (PCT)
- Sandwell PCT
- Sandwell & West Birmingham Hospitals NHS Trust (which runs City Hospital in Winson Green, Sandwell General Hospital in West Bromwich and Rowley Regis Hospital)

They have developed the proposals with these other organisations:

- Birmingham City Council
- Sandwell Metropolitan Borough Council
- Birmingham & Solihull Mental Health NHS Trust
- Sandwell Mental Health NHS & Social Care Trust
- West Midlands Ambulance Trust

A huge amount of background research and material supporting this summary is available online. This is a summary based on our main consultation document which is available on www.towards2010swb.nhs.uk or you can write to us at FREEPOST QUAD (2010) (you do not need a stamp) and we'll send you a copy. We will also be speaking at lots of public meetings over the next few months. Contact us to find one near where you live.

Please call 0121 507 5939 or email us at towards2010swb@nhs.uk to order:

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- o More copies of this document translated into other languages

www.towards2010swb.nhs.uk



Bengali:

স্যান্ডওয়েল এবং বার্মিংহামের কেন্দ্রে, স্বাস্থ্য ও সামাজিক পরিষেবাগুলির ক্ষেত্রে যে পরিবর্তনগুলি হয়েছে, তা এই ডকুমেন্টটিতে দেওয়া হয়েছে। আপনি যদি বাংলাতে এর একটি সারসর্ম পোতে চান, তাহলে অনুগ্রহ করে, 0121 507 5303 নাম্বারে ফোন করুন।

Arabic:

يتعلق هذا المستند بالتغييرات التي سيتم إجراؤها على الخدمات الاجتماعية والصحية في "ساندويل" ووسط مدينة برمنجهام. إذا كنت تود الحصول على ملخص باللغة العربية فترجو الاتصال بنا على الرقم 0121 507 5303.

Cantonese:

本文檔的內容是關於桑德維爾和伯明罕中部地區個人和社會服務的變化。如果您需要中文版本的摘要，請致電 0121 507 5303。

French:

Ce document porte sur les changements relatifs à la santé et aux services sociaux à Sandwell et au cœur de Birmingham. Si vous souhaitez recevoir un résumé en **français**, veuillez téléphoner au 0121 507 5303.

Polish:

Ten dokument opisuje zmiany w służbie zdrowia i opiece społecznej w Sandwell oraz w centrum Birmingham. Jeżeli chcieliby Państwo otrzymać jego streszczenie po **polsku**, prosimy o kontakt pod numerem telefonu: 0121 507 5303.

Somali:

Dokumentigaan wuxuu ku saabsan yahay waxyaabaha laga beddelay adeegyada caafimaadka iyo bulshada ee Sandwell iyo wadnaha Birmingham. Haddii aad jeceshay in lagu soo koobo af **Soomali** fadlan soo wac 0121 507 5303.

Urdu:

یہ دستاویز سینڈ ویل اور برٹ آف برمنگھم میں صحت اور سماجی خدمات میں تبدیلیوں کے بارے میں ہے۔ اگر آپ کو اس کا خلاصہ اردو زبان میں درکار ہو تو براہ کرم 0121 507 5303 پر فون کریں۔

આ દસ્તાવેજ સેન્ડવેલ અને બર્મિંગહામની જિલ્લાના સ્વાસ્થ્ય અને સામાજિક સેવામાં ફેરફાર બાબતનો છે.

ਇਹ ਦਸਤਾਵੇਜ਼ ਸੈਂਡਵੈਲ ਅਤੇ ਹਰਟ ਆਫ ਬਰਮਿੰਘਮ ਵਿੱਚ ਸਿਹਤ ਅਤੇ ਸਮਾਜਕ ਸੇਵਾਵਾਂ (Social Services) ਵਿੱਚ ਆਈਆਂ ਤਬਦੀਲੀਆਂ ਬਾਰੇ ਹੈ। ਜੇ ਤੁਸੀਂ ਇਸਦਾ ਸਾਰ-ਅੰਸ਼ ਪੰਜਾਬੀ ਵਿੱਚ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0121 507 5303 ਤੇ ਕਾਲ ਕਰੋ।



www.towards2010swb.nhs.uk



APPENDIX 21b – OUTLINE COMMUNICATIONS AND ENGAGEMENT PLAN

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

Development of the Midland Metropolitan Hospital

Communications Strategy

1 Background

Developing a new hospital for Sandwell and West Birmingham has been the subject of debate and discussion for several years. Government approval for the Outline Business Case in July 2014 has re-established the commitment to open the Midland Metropolitan Hospital on Grove Lane in Smethwick in 2018.

This communications strategy identifies how patients, the public, staff and stakeholders will be informed of and engaged with the Trust's transformational changes taking place to deliver services fit for the future, of which the new hospital is a vital part.

The development of the hospital is part of the Right Care Right Here programme of service change and delivery led by Sandwell and West Birmingham Clinical Commissioning Group, supported by local health and social care partners. This strategy complements the Right Care Right Here communications strategy describing the communications activity that focusses on developments that are part of the pathway towards the opening of the Midland Metropolitan Hospital.

There is significant transformational change required to the Trust's existing services so that the operating model for the Midland Metropolitan Hospital works. A range of transformation change projects are being and will be implemented across the organisation in conjunction with partners, supported by communications and engagement plans so that staff and stakeholders are fully engaged and involved in the implementation and delivery of these plans.

2 Aims

The communications strategy aims to ensure that staff, the public, patients and stakeholders are well-informed about Sandwell and West Birmingham Hospital NHS Trust's plans to change and develop health care services in partnership with health and social care organisations that support delivery of the new Midland Metropolitan Hospital.

3 Objectives

- To provide Sandwell and West Birmingham patients and the public with a range of opportunities to find out about the journey towards developing a new hospital in 2018 and how they can get involved
- For stakeholders to understand that the development of the Midland Metropolitan Hospital is part of the Right Care Right Here plan to reshape local health services to meet the needs of the population, and has had wide engagement from the public and partners in the plans
- To produce a range of material in different formats that illustrates the service changes taking place and what services will be provided from where
- To raise awareness of the opportunities for people to be involved in the implementation of changes to local health services such as design elements of the new hospital and what services are going elsewhere

- To use new and existing communications methods to raise awareness of the service developments, and the development of the Midland Metropolitan Hospital, fully utilising the Trust's and partner's communications channels

4 Key messages

The development of the Midland Met Hospital is part of a wider plan to reshape local health services (Right Care Right Here) to meet the needs of the Sandwell and West Birmingham population now and in the future.

The Midland Metropolitan Hospital will concentrate services for the sickest patients on a single site bringing together complex surgery, inpatient care and accident and emergency services.

The majority of patient services provided by Sandwell & West Birmingham Hospitals NHS Trust will take place outside the Midland Metropolitan Hospital including the provision of intermediate care beds, urgent care, outpatient appointments, day case surgery and community services.

Additional services are being added in the community including more services at Rowley Regis Hospital following engagement with the local population during February and March 2015.

City Hospital and Sandwell General Hospital will still be well-used for patient care.

In getting ready for the Midland Metropolitan Hospital we are already transforming services, bringing some together on a single site ahead of the 2018 opening date of the new hospital in order to improve quality, and developing more services in the community.

5 Stakeholders

Stakeholders have been mapped out and will be communicated to in a range of different ways and are grouped as follows:

- Sandwell & West Birmingham Hospitals NHS Trust workforce – current employees including bank staff, as well as partners who subcontract with the organisation, future staff including clinicians in training, interns and apprentices
- Transport providers – West Midlands Ambulance Service, public transport providers, private taxi firms, community transport, local authority transport planners
- Primary Care - local GPs need communication and engagement through our existing channels as well as through the support of the Clinical Commissioning Groups, dentists, pharmacists, optometrists
- Other health providers – neighbouring acute hospitals, community services providers, mental health trusts
- Third sector – voluntary groups, social enterprises, community networks, community groups representing minorities, patient groups, HealthWatch
- Commissioners – Clinical Commissioning Groups and NHS England

- Social care – Birmingham and Sandwell Council social care leads, council leaders and chief officers, social care teams, care providers
- Medical Schools and education providers – as well as the education providers who we work with to train clinicians, local schools and colleges are a route for communication to young people and parents, as well as further and higher education facilities. Local and regional education networks
- Local councillors and MPs – reflecting election changes as appropriate, health and wellbeing board members, scrutiny committee members
- Local, regional, national and trade media – managed through the Trust’s external communications team with opportunities for national media interest in the new hospital
- Patients, members and the public – Sandwell & West Birmingham Hospitals NHS Trust’s patients who attend for care are able to read and pass on information about service changes, as well as using our existing communications channels. Our 8400 members receive regular news about the Trust
- Volunteers – The Trust works with volunteering organisations to support patients and is expanding this work over the next three years
- NHS England, Trust Development Authority, Care Quality Commission, Department of Health

6 Communications activities taken place in 2015

Significant activity has taken place within the community and with stakeholders about the Right Care Right Here programme, the development of the Midland Metropolitan Hospital and how services will need to continue to change to meet the needs of Sandwell and West Birmingham patients. The Treasury announcement of approval for the OBC in summer 2014 was widely communicated internally and externally firmly putting the new hospital back on the map. In 2015 activities have already commenced to engage with stakeholders and the public.

Between 12 January and 20 March the Trust worked with Sandwell and West Birmingham Clinical Commissioning Group to engage patients and the public in proposed changes to emergency surgical assessment and interventional cardiology, planning bringing these services onto a single site ahead of the Midland Metropolitan Hospital opening. The engagement activity was wide, clearly positioning service changes as part of the Right Care Right Here programme, and established the new Midland Metropolitan Hospital as a key part of the change programme. Staff engagement events were also held.

Sandwell and West Birmingham Clinical Commissioning Group held a public listening exercise around urgent care services between January and March to seek views on current urgent and emergency care provision and to gain feedback over how these services could or should change in the future.

Between February and March 2015 Sandwell & West Birmingham Hospitals NHS Trust led a public engagement exercise to seek views from the local population about potential new services to be provided out of Rowley Regis Hospital. Trust staff contributed to the engagement exercise.

7 Sandwell & West Birmingham Hospitals NHS Trust channels of communication

The Trust has a range of well-established communications mechanisms for use internally and externally. Key messages about the development of the Midland Metropolitan Hospital will be included within these channels as appropriate.

Channel	Frequency	Content
'Heartbeat' Internal newspaper for staff	Bi-monthly	Include regular article on service developments relating to Right Care Right Here and new hospital
'Connect' Internal intranet site for staff	Continual	Develop a Midland Metropolitan Hospital page for staff FAQs
Trust screensavers On internal staff computers	As required	Use for milestone announcements including invitation to attend engagement exhibitions
Hot Topics briefings Internal briefing	Monthly	Senior team briefings to team leaders to include milestone announcements and regular updates
GP bulletin For GPs within the Sandwell and West Birmingham area	Monthly	Electronic bulletin to GPs, to include regular updates
'Wellbeing' Public magazine aimed at patients and members	Twice-yearly	Include planning application engagement activity and promote exhibitions and public events, as well as service changes
Trust website External	Continual	Includes detailed section on new hospital that will be developed along with separate project website
Social media – Trust presence	Continual	Use of social media to promote public and staff opportunities to find out about service changes and new hospital developments
Media relations	As required	Link to milestone announcements

8 Milestones and activity

Dates / Milestones	Communications theme	Communications activity planned
May and June 2015 Community engagement programme (joint with bidder) for planning application	Public consultation for planning application – shared communications and engagement plan with Trust and bidder	Leaflet distribution to local households Stakeholder letter to invite consultation Series of exhibitions at the Trust and in the community Launch new hospital website Briefing meetings for councillors and MPs Resident newsletter Press release Social media links to website Update content on Trust website Trust Heartbeat internal newsletter E-bulletin to Trust public members Trust Wellbeing public newsletter published and distributed
May 2015 Feedback to the public on listening events	Publication of public feedback on Rowley, Right Care Right Here cardiology and	Publish on Trust website, RCRH website, CCG website Rowley Regis Hospital newsletter distributed to local residents Social media alerts to raise awareness of public feedback

	surgical assessment changes, and urgent care responses	responses
June 2015 Annual General Meeting	Public questions in Annual General Meeting	Press advertising, posters, social media, press releases to promote public Annual General Meeting
July 2015 Receipt of final bid	Confirm that final bid has been received	Press statement, publish on Trust and project website
July 2015 Site maps for Rowley, City and Sandwell Hospitals	Understanding of the remaining estate and which services will be located where	Trust website, internal staff channels
October 2015 Planning approval	New hospital gets planning permission	Press release, promotion on social media, use of Trust internal and external channels to alert staff and stakeholders
December 2015 Financial close	Completion of procurement process for new hospital	Press release, promotion on social media, use of Trust internal and external channels to alert staff and stakeholders, Website banners, stakeholder newsletters, letter to stakeholders
January 2016 Work begins on site	Following site clearance, construction work begins	Website and social media updates
2016 – 2018 Ongoing construction work	Site developments continue. Service and team moves taking place throughout	Share progress with staff identifying service changes as appropriate. Partner engagement on clinical pathways, especially transport providers (public and ambulance).
2018 Hospital ready for opening	Service location changes. Benefits of single site for acute care.	Local resident household delivery of new hospital and where to go for what services. Replicate on website. Staff and GP hospital tours. Press release, Opening / launch event. Arrange public open days within first six months.

9 Evaluation and testing

Detailed annual plans for communications activity are in development to fit with the Right Care Right Here communications strategy. The stakeholder mapping has taken place and will be kept updated with contacts as positions change.

The communications strategy will be evaluated through:

- Volume of responses to public and staff engagement activity around service developments
- Web analytics on Trust and project website pages, and Trust intranet
- Social media engagement and forwards
- Public and staff attendance at exhibitions and open days

- Stakeholder surveys about the Right Care Right Here programme and knowledge of Midland Metropolitan Hospital plans
- Engagement with stakeholders at briefing events

The communications strategy will be reviewed by December 2015 to ensure communications activity for the years ahead has been fully identified.

APPENDIX 21c – LETTERS OF SUPPORT FROM COMMISSIONERS

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case

Email: paul.taylor@westmidlands.nhs.uk
Direct line: 0121 695 2429

30 January 2009

St Chad's Court
213 Hagley Road
Edgbaston
Birmingham
B16 9RG
DX: 709310 Birmingham 25

Tel: 0121 695 2222

Fax: 0121 695 2427

John Adler
Chief Executive
Sandwell & West Birmingham Hospitals NHS
Trust
City Hospital
Dudley Road
Birmingham
B18 7QH

Dear John

**SHA Board Approval of the Towards 2010 Programme Acute Hospitals
Development Outline Business Case (Submission Version 2)**

I am pleased to confirm that the SHA at its board meeting on 27th January 2009 approved the above outline business case.

The approval was subject to the following actions for which I was given delegated responsibility:

- To review the OBC prior to the issuing of the OJEU notice to ensure it remains affordable and value for money. This is because there will be a delay of approximately a year whilst the land is purchased.
- To review the Public Sector Comparator on an annual basis to ensure it has been updated.
- To review the qualitative assessment of the scheme at key stages in the lifecycle of the project to ensure the continued value for money of the scheme.

I will now formally submit the outline business case to the DH for their approval.

Yours sincerely



Paul Taylor
Interim Director of Finance and Capacity

Chairman: Elisabeth Buggins CBE DL
Interim Chief Executive: Peter Shanahan

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 5461
Fax: 020 7210 5824

John Adler
Chief Executive
Sandwell & West Birmingham NHS Trust

14 August 2009

Dear John,

DH approval of Outline Business Case:

I am writing to you to confirm the Department of Health's approval of the Outline Business Case to redevelop the Trust's sites onto a single new site in the Grove Lane area of Smethwick. This approval clears the way for the Trust to begin the process of negotiating the acquisition of the land that is necessary for the new buildings, and the process of applying for a compulsory purchase order, should this prove necessary.

There are however a number of important matters that I need to draw to your attention.

Firstly, the Treasury has not yet considered the Outline Business Case. Their reason for not doing so was because they considered that the scheme parameters, particularly scheme cost, would be firmer once the trust has made progress with negotiating the acquisition of land and when it has worked up its procurement documentation. Treasury officials have advised that they intend to consider the case immediately prior to launch of the procurement.

This means that approval of the Outline Business Case is not complete and the Treasury will require an updated business case when the Trust has completed the arrangements to acquire the land. DH will liaise with both the Trust and the Treasury on the timing and arrangements for procuring the Treasury's approval in due course.

Secondly, the Treasury may apply conditions to its approval over and above those applied by the Department of Health, which are summarised below:

- 1) The procurement documentation and any application for a compulsory purchase order will need to be approved by DH Capital Investment Branch/Private Finance Unit officials and DH Estates prior to procurement.
- 2) In developing the scheme further, the Trust should note that the capital cost should not vary, in real terms, from the current estimates of £432 million for construction and £22 million for land. Any increase of 10% or more would precipitate a requirement to have the Outline Business Case re-approved.
- 3) The plans must also remain affordable to the trust in revenue terms. The Trust should note in particular that the normalised revenue unitary charge of the scheme must not exceed 12.5% of the trust's turnover, and a real-terms increase of 5% or more in the revenue costs of the scheme would precipitate a requirement to have the Outline Business Case re-approved.

In the time between now and submission of the business case to the Treasury, the Trust should not just look carefully at scheme costs, but also continually update its income projections to ensure affordability. The trust should also ensure that the scheme is likely to remain within the financial parameters that Monitor may apply, should the Trust become an Foundation Trust.

Should, you or your team, require any further information concerning this approval, or on progressing the scheme in general, please refer to Ben Masterson on 0113 2545550 or ben.masterson@dh.gsi.gov.uk.

I would like to wish you and your team every success in the further development of this scheme.

A handwritten signature in black ink, appearing to read 'R. Alexander', is positioned above the printed name.

Bob Alexander
Director of NHS Finance

cc David Flory
 Peter Coates
 Andrew Stubbings
 Ben Masterson
 Peter Spilsbury (West Midlands SHA)

Heart of Birmingham

Teaching Primary Care Trust

KM/GS/10102602

26th October 2010

Mr John Adler
Chief Executive
Sandwell and West Birmingham Hospitals NHS Trust
City Hospital
Dudley Road
Birmingham B18 7QH

Bartholomew House
142 Hagley Road
Birmingham
B16 9PA

Tel: 0121 255 0700
Fax: 0121 224 4601

Dear John

I am writing to set out the PCT's wholehearted support for the project to develop a new Acute Hospital on the Grove Lane site as part of the overall changes envisaged by the Right Care, Right Here Programme, and as set out in the revised Outline Business Case (OBC).

Over the past 18 months, the RCRH partners have worked closely together to reassess the Right Care, Right Here Programme in the light of the changed financial environment. This reassessment has been incorporated in the revised OBC. In addition, in the light of the changes to commissioning arrangements proposed in the recent White Paper, we have consulted with GP commissioners.

The PCT Board considered the revised OBC at its meeting on 14th October 2010 and confirmed their support, noting in particular:

- That the forecasts of workload made within the OBC are consistent with the PCT's Commissioning Plans for future years.
- The models of care and planned level of facilities to be developed in the acute hospital are consistent with the future plans of the local health economy and reflect a reasonable approach to planning the performance requirements of the scheme.
- The income levels forecast by the Trust to arise from us as a consequence of the proposed levels of activity are agreed within the long term financial plans of the PCT.
- The PCT agrees with the principle that transitional finance support will be required and understands the nature of the costs described in the revised Outline Business Case. The scale and timing of the transitional financial support will be subject to the annual contracting process and overall affordability, understanding the need to support the restructuring of services as we move towards the opening of the new hospital.
- The PCT is committed to the "Principles for the provision of Out of Hospital Services" agreed by the Right Care, Right Here Partnership Board. The PCT's procurement (*strategy/approach*) provides for services to be commissioned through a process of managed change for a period of time. Once the new pattern of services is established, services may be subject to competitive processes in line with normal commissioning policy at the time. These principles are consistent with the approach that we expect to



E-mail: info@hobtpct.nhs.uk
Web: www.hobtpct.nhs.uk

Ranjit Sondhi - Chairman
Kevin McGee - Chief Executive

be taken by GP commissioners.

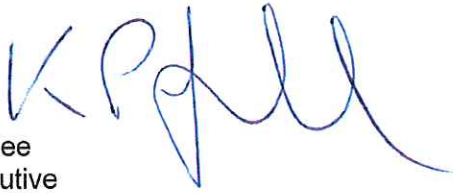
- The PCT would wish to input into the determination and design of the new hospital recognising the link between these issues and health and well being outcomes for patients.

Heart of Birmingham tPCT Board has a joint plan with Sandwell PCT and Sandwell and West Birmingham NHS Trust to transform the health system so as to make a significant contribution to reducing the health inequalities presently experienced by our populations. Bringing care closer to people's homes and providing them with a modern fit-for purpose Acute Hospital are two components of this plan. The OBC is therefore vital for improving the health of our population.

I can also confirm that the PCT is progressing those elements of the overall Right Care Right Here Programme in relation to the Primary and Community Care developments for Heart in line with the agreed Programme.

We look forward to the revised OBC being granted approval to enable the Trust to commence work on the next stages of the project, and the delivery of this much needed investment in local health facilities.

Yours sincerely



Kevin McGee
Chief Executive

Kingston House
438 High Street
West Bromwich
B70 9LD

Telephone: 0845 155 0500

Facsimile: 0121 612 1410

Website: www.sandwell-pct.nhs.uk

→ GS
SANDWELL & WEST BIRMINGHAM
HOSPITALS NHS TRUST
- 2 NOV 2010
RECEIVED
DIRECTOR OF FACILITIES

Mr John Adler
Chief Executive
Sandwell and West Birmingham Hospital
Birmingham City Hospital
Dudley Road
Birmingham
West Midlands
B18 7QH

27th October 2010

Dear John,

I am writing to set out the PCT's wholehearted support for the project to develop a new Acute Hospital on the Grove Lane site as part of the overall changes envisaged by the Right Care, Right Here Programme, and as set out in the revised Outline Business Case (OBC).

Over the past 18 months, the RCRH partners have worked closely together to reassess the Right Care, Right Here Programme in the light of the changed financial environment. This reassessment has been incorporated in the revised OBC. In addition, in the light of the changes to commissioning arrangements proposed in the recent White Paper, we have consulted with GP commissioners.

The PCT Board considered the revised OBC at their meeting on 30th September 2010 and confirmed their support, noting in particular:

- That the forecasts of workload made within the OBC are consistent with the PCT's Commissioning Plans for future years.
- The models of care and planned level of facilities to be developed in the acute hospital are consistent with the future plans of the local health economy, and reflect a reasonable approach to planning the performance requirements of the scheme.
- The income levels forecast by the Trust to arise from us as a consequence of the proposed levels of activity are agreed within the long term financial plans of the PCT.
- The PCT agrees with the principle that transitional finance support will be required and understands the nature of the costs described in the revised Outline

Chair
Chief Executive

Richard Nugent
Robert Bacon

Business Case. The scale and timing of the transitional financial support will be subject to the annual contracting process and overall affordability, understanding the need to support the restructuring of services as we move towards the opening of the new hospital.


- The PCT is committed to the "Principles for the provision of Out of Hospital Services" agreed by the Right Care, Right Here Partnership Board. The PCT's procurement (*strategy/approach*) provides for services to be commissioned through a process of managed change for a period of time. Once the new pattern of services is established, services may be subject to competitive processes in line with normal commissioning policy at the time. These principles are consistent with the approach that we expect to be taken by GP commissioners.
- The PCT would wish to input into the determination and design of the new hospital recognising the link between these issues and health and well being outcomes for patients.

The Sandwell PCT Board has a joint plan with Heart of Birmingham PCT and Sandwell and West Birmingham NHS Trust to transform the health system so as to make a significant contribution to reducing the health inequalities presently experienced by our populations. Bringing care closer to people's homes and providing them with a modern fit-for purpose Acute Hospital are two components of this plan. The OBC is therefore vital for improving the health of our population.

I can also confirm that the PCT is progressing those elements of the overall Right Care Right Here Programme in relation to the Primary and Community Care developments for Sandwell in line with the agreed Programme.

We look forward to the revised OBC being granted approval to enable the Trust to commence work on the next stages of the project, and the delivery of this much needed investment in local health facilities.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'R. Bacon', written over a horizontal line.

Robert Bacon
Chief Executive.

8th January 2014

Toby Lewis
Chief Executive
Sandwell & West Birmingham Hospitals
Birmingham City Hospital
Dudley Road
Birmingham
West Midlands
B18 7QH

Dear Toby,

RE: Midland Metropolitan Hospital

We are writing to confirm the CCG Governing Body's support for the Trust's configuration proposals, specifically the business case for the Midland Metropolitan Hospital and associated investments on other sites. These proposals are consistent with our strategy of shifting resource to prevention and primary and community services, reducing dependence on secondary care. This is supported by public consultation in 2006 - refreshed by re-engagement in 2011.

We recognise the activity trajectories, which reflect substantial demand side change. The trajectories and resultant financial values are reflected in our future financial forecasts, taking account of central funding notifications for CCG allocations in future years, and subject to the achievement of our QIPP challenge. This specifically includes our foreseeable Integrated Better Care Fund submission due this year. We recognise the Trust's growth forecast and confirm that our planning assumptions are consistent with this. The Trust's model seeks to repatriate some acute work for local people from other DGHs, as well as to diversify their out of hospital work, taking advantage of their integrated care capability and intermediate care capacity. There is no reason this would be solely for our CCG over the longer term.

From a sustainability point of view, we believe the scheme to be essential to that transformation with its rationalisation of acute care and increased provision in the community to improve quality and sustain safety. Of course, we cannot guarantee a level of income or activity to any provider.

The Trust has demonstrated scheme affordability with the inclusion of £100m public dividend capital. We note that the Trust's ten year LTFM illustrates a CsRR of 3. The commissioner recognises that maintaining this rating demands substantial expenditure cuts and substantial workforce redesign and reductions. It will also require the provider to improve its EBITDA surplus in order to continue to operate as a low risk foundation trust.

Through the Right Care, Right Here partnership we will work alongside the Trust to support them in the execution of the business case plan. In particular we will keep the bed reduction trajectory under review and join the Trust in a formal public review of supply sufficiency in 2017. For that sufficiency to be maintained in the decade after opening we agree that a major change in the health status of our population is required.

Yours Sincerely,

A handwritten signature consisting of a circle with a horizontal line through it, followed by a long horizontal stroke.

Dr Nick Harding
Chair

A handwritten signature in cursive script, appearing to read 'A Williams'.

Andy Williams
Accountable Officer

cc.

Giles Tinsley (NHS TRUST DEVELOPMENT AUTHORITY) giles.tinsley@nhs.net



NHS
Birmingham CrossCity
Clinical Commissioning Group

Bartholomew House
142 Hagley Road
Edgbaston
Birmingham
B16 9PA
Tel: 0121 255 0554

10 January 2014

Toby Lewis
Chief Executive
Sandwell & West Birmingham Hospitals NHS Trust
City Hospital
Dudley Road
Birmingham B18 7QH

Dear Toby

I am writing to offer our continued support for the development of a single acute site in the Midland Metropolitan Hospital. The Trust recognises that the exact nature of that acute service will be kept under review over coming years as patterns of specialist care change. For example, there is currently a region-wide examination of stroke services. Undoubtedly the next five years will see further change in emergency medical care configuration across other parts of Birmingham which will have to take account of the recent Keogh report into urgent care. This may result in some specialist services becoming more aggregated. However, it is likely that a centre for urgent care will still be needed for the local population. We note that that site was purchased by public funds and is now to be developed.

The Trust's proposals see care transfer into the community, which we welcome. We look forward to working with the organisation to examine what further outpatient care can be delivered in primary care and community settings, and we note that the building proposal does not assume centralisation of clinics into a single location. There is a significant transfer of the bed base from acute to intermediate care. This is consistent with our expectations of the direction of travel, although clearly the provider landscape will be commissioned through a formal procurement route.

The Trust continues to engage actively in the development of integrated care for both adults and children. And we note the reliance of the business case on our success in delivering the performance indicators implied within the Better Care Fund.

Yours sincerely

Gavin Ralston
Chair

Thursday 9th January 2014

Toby Lewis
Chief Executive
The Corporate Suite – Ward D29
City Hospital
Dudley Road
Birmingham
B18 7QH

Birmingham South Central CCG
Ground Floor
Bartholomew House
142 Hagley Road
Edgbaston
Birmingham
B16 9PA
0121 255 0863
Fax. 0121 456 3464

Dear Toby

Re: Midland Metropolitan Hospital

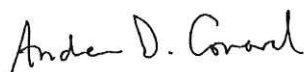
I am writing to confirm the continued support of Birmingham South Central CCG Governing Body to the development of the Midland Metropolitan Hospital in Smethwick as part of the wider strategic plans of Sandwell & West Birmingham NHS Trust.

The CCG is strongly supportive of the intention to provide a greater range of services within community settings, and of the move to create acute services which offer specialist expertise on seven day a week basis. Ensuring services of the highest level of quality and safety for our patients is a key priority for the CCG, and the concentration of expertise on the new site, in premises more fit for purpose, will contribute to that ambition. We recognise the Trust's commitment to maintain local access to outpatient care which is another priority for the CCG.

Whilst we are not a major commissioner of services from Sandwell & West Birmingham NHS Trust, we do have a number of practices that have significant patient flows to you. We are not able, however, to offer any guarantees in respect of future patient flows or income levels for the Trust and our support is based on the assumption that the affordability of the new development has been clearly demonstrated within your detailed business plans.

On behalf of the CCG, I look forward to working with you in future to ensure that our residents have access to the highest quality of services in the years ahead.

Yours sincerely



Dr Andrew Coward
Chair
NHS Birmingham South Central

Birmingham South Central
Clinical Commissioning Group
Tel: 0121 255 0863
Email: infobsc@nhs.net
Chair: **Dr Andrew Coward**
Vice-Chair: **Denise Plumptre**
Clinical Vice Chair: **Dr Shahid Gill**



**Birmingham South Central
Clinical Commissioning Group**

24th June 2015

Toby Lewis
Chief Executive
The Corporate Suite
City Hospital
Dudley Road
Birmingham
B18 7QH

Birmingham South Central CCG
Second Floor
Bartholomew House
142 Hagley Road
Edgbaston
Birmingham
B16 9PA
0121 255 0863
Fax. 0121 456 3464

Dear Toby,

Re: Midland Metropolitan Hospital

I am writing to confirm the continued support of Birmingham South Central CCG to the development of the Midland Metropolitan Hospital in Smethwick as part of the wider strategic plans of Sandwell & West Birmingham NHS Trust.

The CCG is strongly supportive of the intention to provide a greater range of services within community settings, and of the move to create acute services which offer specialist expertise on seven day a week basis. Ensuring services of the highest level of quality and safety for our patients is a key priority for the CCG, and the concentration of expertise on the new site, in premises more fit for purpose, will contribute to that ambition. We recognise the Trust's commitment to maintain local access to outpatient care which is another priority for the CCG.

Whilst we are not a major commissioner of services from Sandwell & West Birmingham NHS Trust, we do have a number of practices that have significant patient flows to you. The approval business case (ABC) contains financial assumptions that are in line with the OBC, and with our own expectations. The long term growth assumptions in the ABC are modest and consistent with our plans, recognising population growth and demographic change locally. Our plans for community and acute care are reflected in the Trust's plans to reduce their acute activity and increase the level of care provided in community settings.

We are not able, however, to offer any guarantees in respect of future patient flows or income levels for the Trust, and our support is based on the assumption that the affordability of the new development has been clearly demonstrated within the detailed business plans. No commissioner can guarantee work to a provider and we still have to deliver our overall Better Care Fund and QIPP targets, which are reflected in the current year acute income forecast.

Birmingham South Central
Clinical Commissioning Group
Tel: 0121 255 0863
Email: infobsc@nhs.net
Chair: Dr Andrew Coward
Vice-Chair: Denise Plumptre
Clinical Vice Chair: Dr Raj Ramachandrum

On behalf of the CCG, I look forward to working with you in future to ensure that our residents have access to the highest quality of services in the years ahead.

Yours sincerely

A handwritten signature in black ink that reads "Andrew D. Coward". The signature is written in a cursive style with a large 'A' and a distinct 'D'.

Dr Andrew Coward
Chair
NHS Birmingham South Central

Birmingham South Central
Clinical Commissioning Group
Tel: 0121 255 0863
Email: infobsc@nhs.net
Chair: Dr Andrew Coward
Clinical Vice Chair: Dr Shahid Gill
Lay Advisor Vice Chair: Denise Plumpton

Toby Lewis
Chief Executive
Sandwell and West Birmingham NHS Trust
Birmingham City Hospital
Dudley Road
Birmingham
B18 7QH

Paul Baumann
Chief Financial Officer
NHS England
Skipton House
80 London Road
London
SE1 6LH

Paul.Baumann@nhs.net

16 July 2015

Dear Toby

Re: NHS England Support to the MMH Generic Appointed Business Case

Further to issue by Sandwell and West Birmingham Hospitals NHS Trust (SWBHT) of the Generic Appointment Business Case (GABC) *Midland Metropolitan Hospital* in May 2015 I am writing to confirm that from a strategic perspective this programme of development has commissioner support, addressing as it does some major and fundamental problems with the ageing clinical estate and the resulting poor patient experience, and enabling the development of a new single site acute hospital in Smethwick. We also note that the proposal is a key strategic priority of the commissioner-led Right Care, Right Here programme.

Since we received the GABC a review has been carried out of the activity and income assumptions relating to the NHS England commissioned services in the scheme and of the host Clinical Commissioning Group (Sandwell and West Birmingham CCG). We have also considered your request for transitional revenue support to the scheme in order to appropriately assure ourselves that the assumptions set out in the GABC align with the strategic commissioning plans of commissioners going forward, and are affordable to commissioners.

The intention of this letter is to confirm the extent to which NHS England and the relevant Clinical Commissioning Groups are able to support the activity and associated income assumptions presented in the GABC and the level of transitional revenue support NHS England is prepared to commit to.

Activity and Income assumptions

We note that NHS England in 2014/15 accounted for 12.7% of the Trust clinical income. This figure however includes £6.32m pa related to services for 0-5 year olds

for which the commissioning responsibility will transfer to local authorities in September 2015. Therefore, it should be noted that this letter of support does not cover the future commissioning intentions for this activity.

We note that the GABC contains commissioning income from NHS England as detailed below. The value of the activity forecast to be commissioned from SWBHT in 2019/20 is forecast to be £55.6m as set out in the table below:

	14/15 £m	15/16 £ £m	16/17 £m	17/18 £m	18/19 £m	19/20 £m
NHSE income assumed	50.1	52.1	52.3	53.7	54.8	55.6
Service developments in above			0.8	3.0	4.0	3.7

The contract value of NHS England commissioned activity at SWBHT in 2014/15 has been reconciled to the value above however we would re-iterate that this does include the value of 0-5 services due to transfer to local authorities in September 2015. The contracted income for 2015/16 from NHS England is set at £48.1m which excludes 6 months of the contract for 0-5 services post the 1st October transfer to the Local Authorities.

We note that the values assumed above include service developments that whilst not set at material levels do not at this time link to any firm proposals from commissioners. We also note that to derive these values the Trust has had to use planning assumptions for tariff changes and the impact of patient choice. Both of these variables do not appear unreasonable however should not be seen as a firm commitment of future income from commissioners. In addition you will be aware that as with all providers of Specialised Services, NHS England cannot at this time rule out any finance or activity impact on the Trust of national service model changes in the interest of patients. Finally, as with all contractual arrangements we continue to assume the Trust will continue to work collaboratively with NHS England to deliver its QIPP programme across the planning period.

To support the GABC we have also undertaken a review of alignment of the activity and finance assumptions with the Trust's main host commissioner i.e. Sandwell and West Birmingham CCG. We have taken assurance from the fact that the Trust and CCG commissioners have no contractual disputes outstanding relating to 2014/15 and there is a Payment by Results (PbR) based contract signed for 2015/16.

We note the Trust and host CCG, through the Right Care Right Here (RCRH) programme, have a track record of aligning income and expenditure assumptions into future years. At each stage of the planning process for the business case however we note the CCG has restated that the aligning of activity volumes does not guarantee income for the provider in future years i.e. the CCG has never stated it would underwrite the business case.

Our review has matched the GABC planning assumption in relation to income from the lead commissioner to the CCG long term financial model (LTFM). However, our review noted the following key caveats to the CCG figure:

- CCG view is clear this is a planning assumption only under PbR.

- There is contained within this figure a material value of non PbR RCRH investment opportunities. While they may provide income growth opportunities for the Trust, these will be presented to the market and therefore are not guaranteed income streams for the Trust.
- The CCG LTFM has an appropriate QIPP target across the planning period and this will need to be varied if planning assumptions, most notably around allocation growth and inflation/tariff change. Therefore the CCG has not ruled out seeking to apply higher levels of QIPP to the Trust's income streams.

We note that the GABC makes clear that the Trust business model already provides flexibility for services listed under section 5.3.5. to be delivered from the proposed community facilities so that *"A range of provider organisations including the Trust, primary care and community services providers will operate from the community facilities"*. In providing this letter of support it is our understanding that the Trust undertakes to respond proactively to any future commissioner procurement exercises related to these services with particular regard to potential third party use of NHS assets identified under section 5.3.5.

We are also placing reliance on the fact that the Trust and the other Approving Bodies have assured themselves that the Business Case modelling by the Trust is sufficiently robust for the Trust to remain sustainable at the lower levels of activity that NHS England and the CCGs may intend to commission, and that the build programme is flexible enough to ensure that alternative services can be provided from its footprint should planned service developments prove unaffordable to the Birmingham and Black Country health economy.

Transitional Support to be funded from NHS England central provider revenue support

The Trust has requested that transitional funding be provided to support the MMH GABC costs totalling £22.3million over the period 2016-2020, as set out below:

	16/17 £m	17/18 £m	18/19 £m	19/20 £m	Total £m
Transitional Support	3.0	7.0	7.9	4.4	22.3

In 2013/14 NHS England agreed as part of the mandate commitment with the Department of Health to earmark revenue resources to provide transitional revenue support to a small cohort of NHS Trusts involved in major capital investments. This included the MMH programme. This is not backed by additional funding, and is a call on NHS England financial resources. We have committed to honour this commitment to the extent that the Trust can justify its request for this transitional support against the principles set out in the NHS England *Business Rules for Provider Support (2013)*. We have reviewed your bid for transitional revenue support to the MMH scheme in this context and are satisfied that we should honour this commitment.

All transitional support earmarked will only be provided on the basis of evidenced spend in accordance with the business case, and the Trust will need to bear the risk of overspending.

We trust that this letter will enable the Trust Board to take an informed approval decision on the MMH GABC in relation to the NHS England and CCG commissioning activity and income assumptions, and the commitment we are prepared to make at this stage toward transitional revenue support.

Please contact me should you have any further queries.

Thank you for progressing the scheme to this stage. Subject to confirmation of Trust Development Authority, Department of Health and HM Treasury confirming approval decisions, I look forward to our continued positive collaboration in relation to the MMH Programme, and the successful delivery of the scheme, which we all acknowledge is a positive enabler to long term healthcare improvements for the people of Birmingham and the Black Country.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'P. Baumann', with a horizontal line drawn underneath.

Paul Baumann
Chief Financial Officer

**APPENDIX 23a – DH APPROVAL OF THE CBC FOR NEW MIDLAND
METROPOLITAN HOSPITAL**

Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Final Business Case



BY EMAIL

Mr Toby Lewis
Chief Executive
Sandwell and West Birmingham Hospital NHS Trust
First Floor, Trust Headquarters
Health and Wellbeing Centre
Sandwell Hospital
B71 4HJ

9 December 2015

Dear Toby

Approval of the Confirming Business Case for the new Midland Metropolitan Hospital

I am pleased to confirm that the Department of Health (DH) has formally approved the Confirming Business Case (CBC). The Trust may now proceed to financial close and signing of the PF2 contract.

You should note that approval of the scheme is subject to the scheme remaining within the following key parameters:

- i. No subsequent amendments shall be made to the Project Agreement and Schedules without the approval of the Department's Commercial Division.
- ii. Financial Close must be achieved within three months of the date of this letter. If financial close has not been reached within that time, re-approval will be required.

It is important that both the Trust and its preferred bidder are aware that in the event that either of the approval conditions above are breached, or if agreed positions are reopened (whether in the contract or otherwise) then the Department may require re-approval of the business case which would be likely to cause delay to the financial close. In such circumstances, we would expect the party responsible to bear the costs of such delay.

At Appointment Business Case (ABC) stage the assumed Unitary Payment (UP) was £22.272 million (in the first year of operation). Following the funding competitions, the agreed unitary payment is £19.633 million (excluding any buffer for interest rate movements). The UP is expected to remain below the figure of £22.272 million identified at ABC stage and the Trust should inform the Department if it considers that this is at risk of being exceeded.

Please note that further approval is required from the Department if any additional variations during construction exceed £2 million or 2% of capital costs, whichever is the lesser. Where there is more than one variation, their aggregate costs count towards the limit.

Under the terms of its agreement with HM Treasury regarding the investment of public sector equity in the MMH Project Company, DH has the right to appoint an observer to attend, but not

participate in or vote at, Board meetings of the Project Company. DH has agreed that the Trust will be entitled to nominate the observer, subject to the following terms:

- The Trust will consult with DH and HM Treasury's Infrastructure investment unit (IUK) before nominating an observer.
- The Trust will change the nominated representative whenever DH so requests.
- Each observer will be required to sign a confidentiality undertaking in a form required by IUK.
- The observer will comply with any requirements of the memorandum and articles of the Project Company which may be relevant to the observer.
- The observer will not be entitled to receive any fee or other remuneration in connection with his or her role.

The NHS Trust Development Authority (TDA) has the following approval conditions:

- iii. The NHS Trust should continue to work towards satisfying conditions that were imposed for completion by financial close.
- iv. The Trust to work with the TDA to make sure that the Key Performance Indicators that have been developed as a response to ABC approval condition 46 (develop a framework to measure actual performance) are collated and shared quarterly as agreed by the Stakeholder Board. The framework in operation should also monitor:
 - Assumptions underpinning activity changes under the umbrella of Right Care Right Here
 - Assurance regarding the delivery of the assumed margin on repatriation activity within the model
 - Monitoring delivery of CIP against assumptions in the model, including tracking of whole time equivalent net reductions
 - Tracking delivery of the assumed reconfiguration savings relating to hard and soft facilities management services
 - Annual refresh of the downside scenario planning modelling, to include where appropriate, further development of Project Initiation Documents and appropriate engagement with stakeholders (e.g. staff side, commissioners, staff)
 - Monitoring the development of profitability targets by service line, using SLR, Carter model hospital work, and external benchmarking, to ensure that target EBIDTA overall is understood by service line and ultimately achieved.
- v. The Trust should undertake a review of their derogated clinical spaces within three months of the operational opening of the new hospital and this review should be shared with all partners.
- vi. The Trust should continue their work to finalise designs in line with the project timetable. This work should be in line with the recommendations in the NHSE PAU letter dated 5 November; in addition to some technical matters the letter asks the Trust to continue work to ensure that clear documented evidence of scenario testing outcomes and follow up actions is maintained for good audit and legacy purposes.
- vii. The Trust should monitor the swap rate after CBC approval and notify the TDA if it moves outside of the 0.5% buffer during the period leading up to financial close. The Department would also expect to be notified if this were to occur.

- viii. That the Trust should ensure it obtains a satisfactory independent opinion on the accounting treatment of the asset when it comes on Balance Sheet, as well as External Audit agreement.
- ix. The Trust should ensure it resolves the recommendations associated with the Internal Audit report on the Cost Improvement Programme, "Delivery and Compliance with Process", rated Amber/Red. This will be assured through the monitoring framework post financial close.
- x. The Trust should respond to the recommendations in the Gateway Review report as described in the paper to their October Reconfiguration Committee.

To complete our audit trail, please would you ensure that:

- Any amendments arising from the approval process are incorporated into the business case and the final CBC is fully checked for internal consistency.
- An electronic copy of the final combined ABC and CBC is forwarded to DH with the final project agreement, project financial model, affordability and value for money figures as at the date of contract signature.
- These combined cases are published, with a summary of the contract terms, within six weeks of financial close, incorporating all changes.

In addition, I draw your attention to the Department's guidance on post-project evaluations, requiring an initial PPE to be made 6-12 months after the new facility has been commissioned and a further review two years later to assess the long-term outcome. Copies of these evaluations must be sent to the Department.

I would like to thank your team at the trust for the excellent work they have put in to prepare and deliver your project.

I am copying this letter to Jim Mackey, Bob Alexander, Paul Baumann and Richard Samuda.

Yours sincerely



DAVID WILLIAMS
DIRECTOR GENERAL, FINANCE, COMMERCIAL AND NHS