Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 29 March 2012; 1530h - 1730h

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

Item	Title	Reference Number	Lead
1	**Apologies**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 23 February 2012 as true and accurate records of discussions*	**SWBTB (2/12) 025**	**Chair**
4	**Update on actions arising from previous meetings**	**SWBTB (2/12) 025 (a)**	**Chair**
5	**Chair's opening comments**	**Verbal**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	FOR APPROVAL		
7	**Trust Board reporting cycle for 2012/13**	**SWBTB (3/12) 037** **SWBTB (3/12) 037 (a)**	**SG-P**
8	**Annual financial plan 2012/13**	**SWBTB (3/12) 048** **SWBTB (3/12) 048 (a)**	**RW**

9	**Application of the Trust Seal to the lease for the letting of shop premises to WRVS at City and Sandwell Hospitals**	**SWBTB (3/12) 033**	**GS**
10	**Estates rationalisation plans**	**SWBTB (3/12) 032** **SWBTB (3/12) 032 (a)**	**GS**
11	**Business Case for the development of an Endoscopy unit at Sandwell Hospital**	**SWBTB (3/12) 046** **SWBTB (3/12) 046 (a)**	**RB**
MATTERS FOR INFORMATION/NOTING			
12	**Safety, Quality and Governance**		
12.1	Integrated risk, complaints and claims report – Quarter 3	SWBTB (3/12) 030 SWBTB (3/12) 030 (a)	KD
12.3	Board Assurance Framework update	SWBTB (3/12) 028 SWBTB (3/12) 028 (a)	SG-P
12.4	Equality & Diversity update	SWBTB (3/12) 027 SWBTB (3/12) 027 (a)	RO
12.5	Health & Wellbeing update	SWBTB (3/12) 038 SWBTB (3/12) 038 (a) SWBTB (3/12) 038 (b)	RO
13	**Performance Management**		
13.1	Monthly finance report	SWBTB (3/12) 031 SWBTB (3/12) 031 (a)	RW
13.2	Draft minutes from the Finance and Performance Management Committee meeting held on 22 March 2012	To follow	RT
13.3	Monthly performance monitoring report	SWBTB (3/12) 040 SWBTB (3/12) 040 (a)	RW
13.4	NHS Performance Framework/FT Compliance monitoring report	SWBTB (3/12) 041 SWBTB (3/12) 041 (a)	RW
13.5	Update on the delivery of the Transformation Plan	To follow	RB
14	**Strategy and Development**		
14.1	Business case for the reconfiguration of Vascular Services	SWBTB (3/12) 047 SWBTB (3/12) 047 (a)	JD
14.2	'Right Care, Right Here' programme: progress report including update on decommissioning	SWBTB (3/12) 036 SWBTB (3/12) 036 (a)	MS
14.3	Foundation Trust application programme		
14.4	The Birmingham & Solihull Partnership Compact	SWBTB (3/12) 045 SWBTB (3/12) 045 (a)	MS
▶	Programme Director's report	SWBTB (3/12) 049 SWBTB (3/12) 049 (a)	MS
14.5	Midland Metropolitan Hospital project: Programme Director's report	Verbal	GS

15	**Update from the Trust Board Committees**		
15.1	Update from the meeting of the Quality & safety Committee held on 22 March 2012 and minutes from the meeting held on 19 January 2012	SWBQS (1/12) 015	DA
16	**Any other business**	**Verbal**	**All**
17	**Details of next meeting** *The next public Trust Board will be held on 26 April 2012 at 1530h in the Boardroom, Sandwell Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Boardroom, Sandwell Hospital **Date** 23 February 2012

Present

Mr Roger Trotman (Chair)
Mrs Gianjeet Hunjan
Dr Sarindar Sahota OBE
Mr Phil Gayle (Part)
Mr John Adler
Mr Robert White
Miss Rachel Barlow
Miss Rachel Overfield
Mr Mike Sharon
Mr Donal O'Donoghue

In Attendance

Miss Kam Dhami
Mrs Jessamy Kinghorn
Mr Graham Seager

Guests

Mrs Janice Bayliss [Item 7 only]
Dr Bill Thomson [Item 11.1 only]

Secretariat

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mrs Olwen Dutton, Professor Derek Alderson and Mrs Carol Powney (Sandwell LINks)	
2 Declaration of Interests	**Verbal**
There were no declarations of interest raised.	
3 Minutes of the previous meeting	**SWBTB (1/12) 290**
The minutes of the previous meeting were presented for approval and were accepted as a true and accurate reflection of discussions held on 26 January 2012.	
AGREEMENT: The Trust Board approved the minutes of the last meeting	
4 Update on actions arising from previous meetings	**SWBTB (1/12) 290 (a)**

The updated actions list was reviewed and it was noted that the actions due for completion would be addressed by discussions planned at the meeting of the Quality and Safety Committee on 22 March 2012.	
5 Chair's opening comments	**Verbal**
Mr Trotman advised that this would be Mr O'Donoghue's final meeting before departing the Trust to take up post as Chief Executive of the Royal Orthopaedic Hospital NHS Foundation Trust. He thanked Mr O'Donoghue for his dedicated service to the Trust as Medical Director and wished him well for the future. Mr O'Donoghue in response, thanked the Board for its support during his time in post.	
6 Questions from members of the public	**Verbal**
There were no questions.	
Presentation	
7 Organ Donation update	**Presentation**
Mrs Janice Bayliss joined the meeting to present an overview of the challenges generated by the current lack of organ donors from ethnic minority groups. Dr Sahota acknowledged that there were difficulties with engaging some communities, however he pointed out that options were available to address these challenges, including approaching community groups and religious centres and by attending major local events. Mrs Bayliss advised that a number of these options had been tried and although the concept of organ donation had been well received, the response to the requirements had been limited to date. Mrs Hunjan advised that the use of individuals who were able to discuss the requirements in the language of some of the ethnic minorities might assist. Mrs Bayliss agreed, however she advised that given the number of languages used across the region there remained a difficulty with gaining the required support in this respect. Dr Sahota suggested that radio stations could be used to promote the need for a greater number of organ donors. Mrs Kinghorn reported that Trust membership activities were currently undertaken at festivals across the region and suggested that consideration should be given to seeking the sponsorship of the publications distributed at these events for promoting the requirements. Additionally, Mrs Bayliss was encouraged to consider the use of local networks and newsletters. Mrs Bayliss was thanked for her informative and enlightening update.	
Items for Approval	

8 Execution of a contract as a Simple Contract – Pharmacy Automated Storage and Distribution system at City Hospital	**SWBTB (2/12) 003**
Mr Seager presented a proposal to execute a contract as a Simple Contract in respect of an automated storage and distribution system for the Pharmacy Department. The Board approved the proposal to execute the contract in the manner suggested.	
AGREEMENT: The Trust Board approved the proposal to execute a contract as a Simple Contract for a Pharmacy Automated Storage and Distribution system at City Hospital	
9 Execution of a contract as a Simple Contract – Reconfiguration of Paediatric Unit at Sandwell Hospital	**SWBTB (2/12) 004**
Mr Seager presented a proposal to execute a contract as a Simple Contract in respect of reconfiguration works to the Paediatric Unit at Sandwell Hospital. The Board approved the proposal to execute the contract in the manner suggested.	
AGREEMENT: The Trust Board approved the proposal to execute a contract as a Simple Contract for reconfiguration of the Paediatric Unit at Sandwell Hospital	
10 Execution of a contract as a Simple Contract – Reconfiguration of Fracture Clinic at Sandwell Hospital	**SWBTB (2/12) 005**
Mr Seager presented a proposal to execute a contract as a Simple Contract in respect of reconfiguration works to the Fracture Clinic at Sandwell Hospital. The Board approved the proposal to execute the contract in the manner suggested.	
AGREEMENT: The Trust Board approved the proposal to execute a contract as a Simple Contract for reconfiguration of the Fracture Clinic at Sandwell Hospital	
11 Safety, Quality and Governance	
11.1 Radiation Protection update	**SWBTB (2/12) 011** **SWBTB (2/12) 011 (a)**
Dr Bill Thomson joined the meeting to present the annual update on Radiation Protection. The Board was asked to note the distinction between exposure error messages and exposure errors, where there had been no reported instances of the latter	

and therefore no impact on public, patients or staff. The Board was advised that a robust Quality Assurance programme was in place for radiation protection activities. Staff radiation doses were reported to have been robustly monitored throughout the year and in areas using higher levels of radiation, measures had been taken to ensure that staff were registered as classified radiation workers. A central database of all staff exposure levels was reported to be in place, which was highlighted to cover 399 staff. Research work in the area was noted to have been undertaken during the year, including a continuing collaboration with the Cancer Treatment Hospital in Cardiff. Mr O'Donoghue advised that legal advice had been taken recently concerning the possibility of using non-medical referrers to request x-rays. The Board was advised that the opinion had maintained that Physicians Assistants could not be used for this responsibility. Dr Thomson added that a procedure had been developed which was fit for purpose, which although did not expressly permit x-ray requests being made by non-medical referrers, did require these staff to work closely with doctors to organise the process. Mrs Hunjan noted that the report highlighted that a number of Radiopharmacy staff had been subject to increased exposure to radiation, with the number of recordable doses returned being 45 during the year. Dr Thomson acknowledged that this was the case and advised that these were associated with staff in the Nuclear Medicine and Radiopharmacy areas. Mrs Hunjan asked whether periods of sickness and leave impacted on the level of exposure due to workload increases by staff in the department. Dr Thomson agreed that in some instances, some individuals had been impacted, however he asked the Board to note that staff classified as radiation workers were exposed to levels of 30% or less of the levels legally permitted, therefore there was no cause for concern in this respect. Mrs Hunjan asked whether parents were monitored in cases where they supported a child undergoing an x-ray. Dr Thomson advised that the level of exposure would not be sufficiently high as to necessitate such monitoring. He advised however that parents were provided with lead aprons as a precautionary measure. Dr Thomson was thanked for his informative report.	
11.2 Quarterly Infection Control report (October – December 2011)	**SWBTB (2/12) 013** **SWBTB (2/12) 013 (a)**
Miss Overfield advised that infection rates for MRSA bacteramia and *C. difficile* continued to remain within trajectory. Thirty day mortality percentages for *C. difficile* cases were highlighted to continue	

to be declining, attributed to the dual test undertaken allowing speedier intervention. Of concern however, the Board was advised that the Strategic Health Authority had requested reporting of infections through the use of a single test, which Miss Overfield advised would reduce the number of overall tests recorded. Internally, however it was reported that the use of the dual test would continue. The Board was informed that in recent weeks, a number of diarrhoea and vomiting cases had been reported, although Norovirus had been confirmed on only one ward. It was reported that one ward remained closed due to this outbreak, however this would be opened again shortly. Miss Overfield remarked that the outbreak had been well controlled and appropriately managed. The Board was informed that the Henderson Ward at Rowley Regis Hospital remained closed to admissions as MRSA screening had detected a number of colonised patients. It was reported that it was unlikely that operational issues would ensue from this situation. Dr Sahota remarked that Tuberculosis appeared to be declining in the Local Health Economy, however he suggested that Surgical Site Infections and Sepsis cases could be monitored. Miss Overfield advised that these infections were monitored and reported where possible, however Surgical Site Infections were difficult to record given that many did not arise until after the patient had been discharged from hospital. Mr O'Donoghue confirmed the difficulty with monitoring these infections. Mr Adler advised that Surgical Site Infections had been previously reported, however the value of the information had been agreed to be low . He highlighted however, that MSSA and *E. coli* infections were now reported, as mandated nationally. Mr O'Donoghue reported that the National Joint Registry tracked infection following implants and it had shown that the Trust's level of infections was within the expected range. Miss Overfield reported that catheter associated Urinary Tract Infections would need to be reported in due course. Mr Adler noted that the percentage of contaminated blood cultures appeared to be high. Mr O'Donoghue advised that this situation appeared to be linked to the turnover of Junior Doctors. Miss Overfield added that the situation was frustrating and additional focus on handling this issue may be required.	
11.3 Cleanliness update	**SWBTB (2/12) 009** **SWBTB (2/12) 009 (a)**
Miss Overfield presented the latest cleanliness update, including PEAT scores for receipt and noting. She advised that an external PEAT inspector had suggested that the Trust should be rated as 'excellent' across all sites for cleanliness.	
11.4 National Outpatient Department survey 2011	**SWBTB (2/12) 014** **SWBTB (2/12) 014 (a)** **SWBTB (2/12) 014 (b)**

Mrs Kinghorn asked the Board to note that the latest national Outpatient Department survey results suggested that there had been a significant improvement in the number of patients rating quality of care as 'excellent'. In terms of the report produced by Quality Health, the Board was informed that the Trust was reported to be within the 20% of trusts performing least well nationally for appointment times being changed by the hospital, although this appeared to have improved slightly from the previous results. Mr Trotman remarked that in some instances the results were contrary to those gained through the Trust's inpatient surveys, where significant improvements had been seen against a number of indicators. Mr O'Donoghue noted that there appeared to be an issue with staff speaking in front of patients as if they weren't there. He advised that much work was underway through the work on clinical communications to improve this position and there was an expectation that the use of the communications tools and survey would be able to identify areas of poor practice. Miss Barlow advised that improvements in some areas could be delivered through the Transformation Plan and led by the Transformation Support Office. Mr Adler remarked that the results were encouraging, particularly given that 95% of patients rated the quality of care delivered by the Trust as being 'good' to 'excellent'.	
12 Performance Management	
12.1 Monthly finance report	**SWBTB (2/12) 008** **SWBTB (2/12) 008 (a)**
Mr White reported that the financial performance during the month had been positive and that within the past three months, the budgeted pay bill had been above the actual spend. It was reported that the income position had been less volatile recently. The Board was informed that a year end allocation from the Department of Heath would be made available to support waiting time initiatives and pressures in Accident and Emergency. It was reported that a bid for the funds had been submitted to the Trust's commissioners.	
AGREEMENT: The Trust Board approved the proposed changes to the Capital Plan	
12.2 Update from the meeting of the Finance and Performance Management Committee held on 16 February 2012	**Hard copy papers**
Mr Trotman asked the Trust Board to receive and note the draft minutes from the	

meeting of the Finance and Performance Management Committee held on 16 February 2012. The Board was informed that the Sandwell Community Adult Health division had reported to the Committee for its second time during the financial year, having joined the Trust in April 2011. The Board was asked to note that the division was reporting a surplus of £304k year to date, which Mr Trotman described as a credible performance given the assimilation process undertaken. Mr Trotman reiterated the pleasing position with the Trust having generated a healthy surplus of £69k ahead of forecast, with payroll costs moving in a positive direction and the portents for the year end being good. The Board was advised that the Committee had been appraised that the Cost Improvement Programme might fall slightly short of the planned target for the first time in a number of years. The Committee was also reported to have received some early details of the Transformation Plan for the coming year and that the detailed numbers would be considered on a monthly basis by the Committee. The Board was informed that the Committee had received a financial planning update, together with a copy of the financial plan structure prescribed by the Strategic Health Authority, in addition to news that the surplus for 2012/13 needed to be 1% of income: a challenging target.	
12.3 Monthly performance monitoring report	**SWBTB (2/12) 018** **SWBTB (2/12) 018 (a)**
Mr White highlighted that performance was concerning against the Delayed Transfers of Care and acute stroke care targets, which he advised impacted on the Trust's position against the NHS Performance Framework. Against some of the local indicators, the Board was asked to note that there was further room for improvement, particularly around sickness absence rates and PDR compliance. A significant improvement against the high risk TIA target was pointed out however. Miss Barlow advised that it was hoped that a sustained improvement could be delivered in this area and that work with GPs was underway to ensure that referrals were made as timely as possible. Performance against the low risk TIA target was noted to be 62%. The Board noted that there had been in month slippage against the target related to percentage stay on an acute stroke unit, although an improved position was anticipated in the coming month. Mr Trotman noted the disappointing performance against the ambulance turnaround target. Miss Barlow advised that improvements on previous months' position had been seen, however the situation would continue to be discussed with the Ambulance trusts. It was reported that a robust escalation process had been implemented, however large batches of patients continued to arrive by ambulance causing a degree of difficulty with meeting the targets. Mr Adler	

advised that February had been a difficult monthly operationally and that the performance against the Accident and Emergency department target had deteriorated as a consequence, although year to date the position remained in excess of 95%. It was highlighted that the recent Infection Control outbreaks had exacerbated the position, in addition to the decision to limit the use of flexible bed capacity on quality grounds. Mr Gayle left the meeting at this point. Dr Sahota noted that the Trust's sickness absence position remained in excess of the target and asked how far the sickness absence position was embedded at ward level. Miss Overfield advised that the current position was significantly below that of the previous year and an overall positive trend was evident.	
12.4 NHS Performance Framework/FT Compliance monitoring report	**SWBTB (2/12) 019** **SWBTB (2/12) 019 (a)**
Mr White presented the NHS Performance Framework/FT Compliance Framework update for receiving and noting. It was highlighted that the Trust remained classed as a 'performing organisation' against the NHS Performance Framework, despite the shortfall in performance against the Delayed Transfers of Care and stay on a stroke unit targets.	
13 Strategy and Development	
13.1 'Right Care, Right Here' programme: progress report including an update on decommissioning	**SWBTB (2/12) 015** **SWBTB (2/12) 015 (a)**
Mr Sharon advised the Board that the recent contract negotiations had focussed on the need for care pathway redesign and had therefore incorporated some concepts from the Transformation Plan. Discussions regarding the final contractual position were reported to be continuing. Mr Trotman asked for clarity on the stage reached in the negotiations to date. He was advised that an initial offer had been received from the Clinical Commissioning Groups and that the Trust was working through the terms of the offer. The Board was informed that the activity and finance positions were expected to be finalised shortly. Mr O'Donoghue remarked that the negotiations had built in the requirements of GPs and clinicians, which was seen as a positive step. The link with the decommissioning work was also highlighted to be an encouraging measure. It was noted that the trajectories of the 'Right Care, Right Here' programme needed to be reviewed in the light of the revised timescale for the new hospital project.	
13.2 Reconfiguration	
Clinical Reconfiguration update	**SWBTB (2/12) 016** **SWBTB (2/12) 016 (a)**

Mr Sharon reported that current reconfiguration activity included that of maternity services, where 30 babies per month had been born in the new Halcyon standalone birthing centre, a position closer to the anticipated trajectory. In terms of reconfiguration of breast services, the Board was advised that a series of engagement events were planned to ensure a smooth transition to a single site service. Public consultation on the stroke services reconfiguration plans was reported to be underway, following recent discussions with the local Joint Overview and Scrutiny Committee. It was reported that a further update to this Committee was expected in March 2012. Discussions regarding reconfiguration of Vascular services was reported to be underway with University Hospital Birmingham NHS Foundation Trust, with the business case for the plans expected to be presented to the Trust Board at its March 2012 meeting. Miss Overfield asked what systems were in place to monitor the effectiveness of reconfiguration work. She was advised that this was discussed as part of the divisional review process and at the meetings of the Strategic Investment Review Group (SIRG) at which post project evaluations were considered. Mr O'Donoghue advised that the emergency gynaecology reconfiguration had arisen from changes in maternity services and was a reactive measure rather than having been specifically planned. Returning to the reconfiguration of stroke services Mr O'Donoghue asked the Board to note the positive endorsement of the plans by the National Clinical Advisory Team (NCAT). It was noted that further detail needed to be provided concerning with issue flagged by the Team in connection with Interventional Radiology. Mr Sharon reported that a discussion had been held with the Divisional Director and Divisional General Manager for Imaging, together with the Clinical Director for Interventional Radiology to resolve the matter.	
Minutes of the Reconfiguration Board	**SWBTB (2/12) 024**
Mrs Hunjan asked the Board to receive and note the minutes from the Reconfiguration Board held on 2 February 2012. The Board was advised that the plans for the revision of Pathology services had been discussed at the meeting and consideration was being given as to whether the Trust should bid for work in its own right. In terms of undergraduate teaching, it was reported that the Trust had performed well in all areas apart from that concerning surgery, where there were issues here associated with reconfiguration. It was highlighted however that the matter was	

being investigated and that an action plan would be prepared to address the position where possible.	
13.3 Foundation Trust application: progress update	
Programme Director's report	**SWBTB (2/12) 017** **SWBTB (2/12) 017 (a)**
Mr Sharon presented the Foundation Trust Programme Director's report for receiving and noting.	
Minutes of the FT Programme Board	**SWBFT (1/12) 010**
The Trust Board received and noted the minutes of the FT Programme Board held on 26 January 2012.	
13.4 Midland Metropolitan Hospital project: progress report	**Verbal**
Mr Seager reported that there had been no significant developments on the new hospital project during the month. He advised that transformation work was ongoing however, pending the outcome of the Treasury review of Private Finance Initiative (PFI). It was reported that the Trust had prepared a formal submission as part of the Treasury's consultation.	
14 Operational Management	
14.1 Sustainability update	**SWBTB (2/12) 002** **SWBTB (2/12) 002 (a)**
Mr Seager reported that power management software had been implemented and was working well. A number of sustainability events were reported to have been arranged and roll out of waste management, including recycling was underway. The Board was informed that the Trust was performing well against the targets within the Good Citizen Charter. Mr Sharon asked what degree of objectivity was applied to this assessment. Mr Seager confirmed that the evaluation of performance was subjective, however the view remained that the Trust was performing well.	
15 Update from the Trust Board Committees	
15.1 Update from the meeting of the Audit Committee held on 9 February 2012	**Verbal**
Mrs Hunjan reported that the agenda of the Audit Committee on 9 February 2012 had included internal audit, external audit and governance matters. The scope of the audits undertaken during the period was noted to include key financial and governance matters. The future external audit work was also highlighted to	

include the assessment of the Trust's Use of Resources and a review of the Quality Account. In terms of internal audits undertaken, the Board was advised that eight reports had been issued, of which three had provided full assurance. Significant assurance was reported to have been provided by the reviews of Pharmacy and the Transfer of Community Services (TCS) work. Moderate Assurance was reported to have been provided by the review of Medicines Management. Of the recommendations arising from internal audits, the Board was informed that 93% of the 484 had been implemented and those outstanding were being monitored by the Committee. It was reported that the Medicines Management internal review had been considered in detail and a follow up report was planned. The Board was advised that the Internal Audit plan for 2012-15 was had been considered, which was reported to be linked to the organisation's key risks. The Counter fraud workplan was reported to have been reviewed and it had been noted that the Chief Nurse had agreed to include consideration of Counter fraud matters within the ward review process. Mrs Hunjan reported that in addition, the Committee had considered its annual cycle of business and the Quality Account action plan. The Board was advised that the Committee had been joined by the Director of Governance who had provided an update on the consultant job planning work, which had been well received. A data Quality Assurance report was also noted to have been presented to the Committee by the Head of Planning and Performance, which had been later considered by the Finance and Performance Management Committee from an operational perspective. Mr Adler remarked that the proportion of Internal Audit recommendations implemented was pleasing and noted that the level of assurance gained from the reports had improved significantly.	
15.2 Update from the meeting of the Charitable Funds Committee held on 9 February 2012	**Verbal**
Dr Sahota reported that a presentation of the performance of the Charitable Funds investment portfolio had been received from the Trust's Investment Adviser from Barclays Wealth. The Trustees were reported to have been appraised of the challenging economic climate that was influencing the performance of the portfolio at present. It was reported that the Committee had been assured that the recruitment to the post of Head of Fundraising was in hand. Mrs Kinghorn confirmed that the candidates for this post were restricted to those identified as being at risk of redundancy at present, but that external advertising would follow if no 'at risk' staff were suitable.	

Mr Trotman highlighted that attendance at the meeting by Trustees had been poor and encouraged a better level of attendance at future meetings.	
16 Any other business	**Verbal**
There was none.	
17 Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 29 March 2012 and would be held in the Anne Gibson Boardroom at City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 29 March 2012, Anne Gibson Boardroom @ CityHospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

23 February 2012, Boardroom @ Sandwell Hospital

Members present: Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr P Gayle (PG), Mr J Adler (JA), Mr R White (RW), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO), Mr D O'Donoghue (DO'D)

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

Apologies: Mrs O Dutton, Prof D Alderson, , Mrs C Powney (CP) [Sandwell LINks]

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 22 March 2012

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.195	Update on complaints handling	Hard copy papers	28-Apr-11	Consider the suggestion made to organise a 'walk through' a complainant's experience and the complaints process	KD	~~31/07/2011~~ ~~22/09/2011~~ ~~15/12/2011~~ 22/03/2012	Process flow of complaints process being developed at as part of the revised Complaints Handling strategy which will be presented to the Trust Management Board for approval in ~~December~~ February ~~March~~ April ~~2011~~ 2012	A
SWBTBACT.218	Monthly performance monitoring report	SWBTB (11/11) 228 SWBTB (11/11) 228 (a)	24-Nov-11	Discuss the additional material needing to be included within the performance exceptions report with Mr White	JK	~~26/01/2012~~ 23/02/2012	Wider discussion to be held including comments from Executive Directors not in attendance at F & PMC to include more detailed quality metrics	Y
SWBTBACT.216	Integrated risk report - Quarters 1 & 2	SWBTB (11/11) 237 SWBTB (11/11) 237 (a)	24-Nov-11	Build in the suggested changes to the integrated risk report into future versions	KD	~~26/01/2012~~ ~~23/02/2012~~ 29/03/2012	Integrated risk report for Q3 presented in March 2012 and suggestions picked up as part of this report	B

KEY:

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

Next Meeting: 29 March 2012, Anne Gibson Boardroom @ CityHospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

23 February 2012, Boardroom @ Sandwell Hospital

Members present: Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr P Gayle (PG), Mr J Adler (JA), Mr R White (RW), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO), Mr D O'Donoghue (DO'D)

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

Apologies: Mrs O Dutton, Prof D Alderson, , Mrs C Powney (CP) [Sandwell LINks]

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 22 March 2012

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.261	Minutes of the previous meeting	SWBTB (1/12) 290	23/02/2012	The Trust Board approved the minutes of the last meeting

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Board Reporting Cycle 2012/13
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	29 March 2012

SUMMARY OF KEY POINTS:

The Trust Board reporting cycle for 2012/13 is presented for approval.

The reporting cycle is similar to that for the previous year, being based on the model included in the Appointment Commission's 'The Intelligent Board' publication, together with some items of specific relevance to the Trust.

New items added into the reporting cycle include:

- Monthly Quality Report, which subsumes the quarterly Infection Control, Cleanliness and Safeguarding updates
- Monthly Provider Management Regime return
- Monthly update on progress with the delivery of the Transformation Plan
- Twice yearly update on delivery of the Trust's research & development strategy
- Twice yearly update on Medical Education activities
- Twice yearly update on Business Development activities

Matters requiring the Board's urgent attention will continue to be presented at the earliest opportunity outside of the standard cycle of business.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to approve its proposed annual cycle of business.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically but supports good corporate governance arrangements in the Trust
Annual priorities	
NHS LA standards	
CQC essential standards of quality and safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Issued to the Executive Team to allow sufficient time for comment and amendment prior to presentation to the Trust Board.

TRUST BOARD REPORTING CYCLE 2012/13

	QUARTER 1		
	APRIL	**MAY**	**JUNE**
QUALITY, SAFETY AND GOVERNANCE	▪ Patient Experience – themed report (CN) ▪ Assurance Framework update (Q4) (DG) ▪ Register of seals (DG) ▪ Register of directors' interests (DG) ◆ ▪ Quality report (CN/MD/DG)	▪ Patient Experience – themed report (CN) ▪ Infection control annual report (CN) ▪ Agree 2012/13 Assurance Framework (DG) ◆ ▪ Audit Committee annual report (CoAC) ▪ Approve changes to the SOs/SFIs (DFPM) ◆ ▪ Quality and Safety Committee annual report (CoQSC) ▪ Trust Board Committees' Terms of Reference (DG) ◆ ▪ Quality report (CN/MD/DG)	▪ Patient Experience – themed report (CN) ▪ Annual risk report (DG) ▪ Annual complaints report (DG) ▪ Integrated risk, complaints and claims report (Q4) (DG) ▪ National patient surveys (HCE) ▪ Freedom of Information annual report (DG) ▪ Quality report (CN/MD/DG) ▪ Update on Medical Education (MD) ▪ Approval of annual report and accounts 2011/12[#] (DFPM) ◆ ▪ Approval of the external audit plan 2012/13[#] (DFPM) ◆
STRATEGY AND DEVELOPMENT	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ Midland Metropolitan Hospital programme: progress report (DENHP) ▪ Update on Workforce strategy (CN) ▪ Transformation Plan progress report (COO)	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ Midland Metropolitan Hospital programme: progress report (DENHP) ▪ Communications and engagement strategy update (HCE)◆ ▪ Reconfiguration update (DSOD) ▪ Transformation Plan progress report (COO) ▪ Research strategy update (MD)	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ Midland Metropolitan Hospital programme: progress report (DENHP) ▪ Owning the Future update (HCE) ▪ Listening into Action update (CEO) ▪ Transformation Plan progress report (COO)
PERFORMANCE MANAGEMENT	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Progress against corporate objectives (Q4) (DSOD) ▪ Performance Management Regime return (DSOD) ◆	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Performance Management Regime return (DSOD) ◆	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Performance Management Regime return (DSOD) ◆
OPERATIONAL MANAGMENNT	▪ Sustainability (DENHP)	▪ Staff survey report and action plan (CN)	

NOTE: Policies and strategies may be presented for approval as required throughout the year

◆ Denotes items for approval

[#] Special meeting held in early June 2012

	QUARTER 2		
	JULY	**AUGUST**	**SEPTEMBER**
QUALITY, SAFETY AND GOVERNANCE	▪ Patient Experience – themed report (CN) ▪ Assurance Framework update (Q1) (DG) ▪ Annual Health and Safety report (DG) ▪ Quality report (CN/MD/DG)	▪ Patient Experience – themed report (CN) ▪ Quality report (CN/MD/DG)	▪ Patient Experience – themed report (CN) ▪ Integrated risk, complaints and claims report (Q1) (DG) ▪ National patient surveys (HCE) ▪ Equality and Diversity update (CN) ▪ Quality report (CN/MD/DG)
STRATEGY AND DEVELOPMENT	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ Midland Metropolitan Hospital programme: progress report (DENHP) ▪ Transformation Plan progress report (COO)	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ Midland Metropolitan Hospital programme: progress report (DENHP) ▪ Annual plan process for 2012/13 (DSOD) ◆ ▪ Health and Wellbeing update (DSOD) ▪ Business Development update (DSOD) ▪ Transformation Plan progress report (COO)	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ Midland Metropolitan Hospital programme: progress report (DENHP) ▪ IM & T strategy update (CEO) ▪ Reconfiguration update (DSOD) ▪ Transformation Plan progress report (COO)
PERFORMANCE MANAGEMENT	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Progress against Annual Plan priorities (Q1) (DSOD) ▪ Performance Management Regime return (DSOD) ◆	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Performance Management Regime return (DSOD) ◆	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Performance Management Regime return (DSOD) ◆
OPERATIONAL MANAGMENNT	▪ Sustainability (DENHP)		

NOTE: Policies and strategies may be presented for approval as required throughout the year

◆ Denotes items for approval

	QUARTER 3		
	OCTOBER	**NOVEMBER**	**DECEMBER**
QUALITY, SAFETY AND GOVERNANCE	▪ Patient Experience – themed report (CN) ▪ Assurance Framework update (Q2) (DG) ▪ Quality report (CN/MD/DG)	▪ Patient Experience – themed report (CN) ▪ Nursing annual report (CN) ▪ Quality report (CN/MD/DG)	▪ Patient Experience – themed report (CN) ▪ Fire safety annual report (DENHP) ▪ Radiation protection annual report (COO) ▪ Integrated risk, complaints and claims report (Q2) (DG) ▪ National patient surveys (HCE) ▪ Quality report (CN/MD/DG)
STRATEGY AND DEVELOPMENT	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ Midland Metropolitan Hospital programme: progress report (DENHP) ▪ Estates strategy annual review (DENHP) ▪ Transformation Plan progress report (COO)	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ Midland Metropolitan Hospital programme: progress report (DENHP) ▪ Transformation Plan progress report (COO)	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ Midland Metropolitan Hospital programme: progress report (DENHP) ▪ Communications and engagement strategy update (HCE) ▪ Owning the Future update (HCE) ▪ Listening into Action update (CEO) ▪ Reconfiguration update (DSOD) ▪ Transformation Plan progress report (COO) ▪ Research strategy update (MD)
PERFORMANCE MANAGEMENT	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Progress against Annual Plan priorities (Q2) (DSOD) ▪ Sign off annual audit letter (DFPM) ◆ ▪ Performance Management Regime return (DSOD) ◆	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Performance Management Regime return (DSOD) ◆	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Performance Management Regime return (DSOD) ◆
OPERATIONAL MANAGMENNT	▪ Sustainability (DENHP)		

NOTE: Policies and strategies may be presented for approval as required throughout the year

◆ Denotes items for approval

	QUARTER 4		
	JANUARY	**FEBRUARY**	**MARCH**
QUALITY, SAFETY AND GOVERNANCE	▪ Patient Experience – themed report (CN) ▪ Assurance Framework update (Q3) (DG) ▪ Quality report (CN/MD/DG) ▪ Update on Medical Education (MD)	▪ Patient Experience – themed report (CN) ▪ Quality report (CN/MD/DG)	▪ Patient Experience – themed report (CN) ▪ Integrated risk, complaints and claims report (Q3) (DG) ▪ Annual cycle of business for Trust Board (DG) ◆ ▪ National patient surveys (HCE) ▪ Equality and Diversity update (CN) ▪ Quality report (CN/MD/DG) ▪ Declaration of compliance with CQC essential standards (DG)
STRATEGY AND DEVELOPMENT	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ New acute hospital programme: progress report (DENHP) ▪ Transformation Plan progress report (COO)	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ New acute hospital programme: progress report (DENHP) ▪ Health and Wellbeing update (DSOD) ▪ Reconfiguration update (DSOD) ▪ Business Development update (DSOD) ▪ Transformation Plan progress report (COO)	▪ 'Right Care, Right Here' programme: progress report (DSOD) ▪ FT application update (DSOD) ▪ New acute hospital programme: progress report (DENHP) ▪ Transformation Plan progress report (COO)
PERFORMANCE MANAGEMENT	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Progress against Annual Plan priorities (Q3) (DSOD) ▪ Performance Management Regime return (DSOD) ◆	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Performance Management Regime return (DSOD) ◆	▪ Financial performance (DFPM) ▪ Performance monitoring report (DFPM) ▪ NHS performance framework update (DFPM) ▪ Annual corporate plan (DSOD) ◆ ▪ Annual financial plan and budget (DFPM) ◆ ▪ Performance Management Regime return (DSOD) ◆
OPERATIONAL MANAGMENNT	▪ Sustainability (DENHP)		

NOTE: Policies and strategies may be presented for approval as required throughout the year

◆ Denotes items for approval

KEY

DFPM	Director of Finance and Performance Management
DSOD	Director of Strategy and Organisational Development
COO	Chief Operating Officer
CN	Chief Nurse
MD	Medical Director
DG	Director of Governance
DENHP	Director of Estates/New Hospital Project
HCE	Head of Communications and Engagement
CoAC	Chair of Audit Committee
CoQSC	Chair of Quality and Safety Committee

NOTE: Policies and strategies may be presented for approval as required throughout the year

◆ Denotes items for approval

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	2012/13 & Medium Term Draft Financial Plan
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White, Director of Finance and Performance Mgt
DATE OF MEETING:	29 March 2012

SUMMARY OF KEY POINTS:

This paper presents the final 2012/13 & medium term financial plan for consideration and approval by the Trust Board.

The financial plan was reviewed and scrutinised by the Finance & Performance Management Committee on 22nd March 2012.

The forecast of income and expenditure is consistent with wider health economy plans culminating in an agreed budget surplus target of just over £4.2m based on a turnover of £422.8m.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to:

RECEIVE the final draft budget

APPROVE the 12/13 Budget as part of the 3 year financial plan as recommended by the Finance & Performance Management Committee

AGREE to receive in-year monitoring of financial performance

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Delivery of Transformation plan savings and financial surplus target.
Annual priorities	Supports achievement of strategic and operational objectives
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial	**X**	Provides the basis for delivering volumes and quality patient care within predefined resources
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

The Finance & Performance Management Committee has considered the draft plan during January to March 2012.

Sandwell & West Birmingham Hospitals NHS Trust

Paper to the Trust Board

Thursday 29th March 2012

2012/13 Budget & Medium Term Financial plan

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Thursday 29th March 2012

2012/13 Budget & Medium Term Financial plan

1.0 Introduction

At the time of writing the Trust is on course to deliver a surplus of at least £1.8m in 2011/12 and dependent upon the trends seen in the last few months, this may be exceeded owing to an improved income position and cost controls. The organisation can be proud of itself for continuing to deliver high quality healthcare to its patients within the resources available to it. In certain areas, budgetary pressures emerged early in the year prompting immediate and concerted action to correct adverse trends. The improved income position has corrected the position and strengthened the financial performance in a number of clinical divisions.

Despite this encouraging position, the Finance committee and Trust Board are aware of the challenges ahead. The Trust is well placed to respond to these challenges given the RCRH (right care, right here) partnership and its plans to devolve activity to the community and concentrate inpatient and specialist acute services. It is important in the period of transition that costs are effectively managed and quality is maintained and improved and these objectives form the core of Trust objectives as supported by the Transformation Plan.

References to TP (transformation plan) and TSP (transformation saving plan) should be read as 'Overall Cost Improvement Programme' and individual CIPs respectively. The Transformation Plan is described in detail later on and is made up of discrete transformation projects. The headline projects will in many cases be cross-cutting with contributions towards a project generated from different business units (divisions and directorates within SWBH). The TSPs can be individually assessed for quality and safety risks, but the fundamental difference is that whilst divisions are being performance-managed against set bottom-line savings targets, the TP moves aware from a silo-based approach to the identification and delivery of efficiency savings recognizing the whole-system approach to levering out costs. More will be said on this later, but for now it is important to point out the change in our internal nomenclature.

At a high level, the Trust is projecting income of just over £422.8m and a net surplus of £4.2m. This includes a pure national efficiency programme of £21.7m (per FIMS) with this element sitting within the overall TP total of £25.7m. The TP is in part a function of final agreed activity trajectories especially where these are inextricably linked to RCRH (right care, right here) and final agreement on this will be reached with CCGs/Clusters over the coming weeks. The TP may therefore be subject to change, either in total or within individual components. Detailed saving submissions have been prepared by business units and these are being subjected to scrutiny and challenge. At the time of writing approximately 91.1% of the programme has been identified. Multi-year targets have been issued linked to transformational change projects as measured by actual cost behavior, reference costs and benchmarking opportunities.

The capital programme totals £21.5m and includes the SHA approved land business case acquisitions deferred from 11/12. During 11/12 CRL was offered back to the SHA owing to timing differences in the original plan in terms of completing the CPO for land at the Grove Lane Site. The Trust will be considering the timing of plans to progress with these expenditures based on the previously agreed business case. Any other new schemes above the delegated £3m limit would be prepared for SHA approval, but as stated, the Trust will consider progress with the land component of the programme based on existing approvals.

This paper includes the final draft budget plan for 2012/13 – 2014/15 which provides detailed plans for 2012/13 and financial planning estimates for year 2 and 3. The plan has been compiled in accordance with the statutory duties of an NHS Trust. However, there is a benchmark emerging that all aspirant Foundation Trusts should be planning for a surplus of 1% of turnover.

As well as being used as a benchmark to measure FT readiness, the planned level of surplus forms an integral part of the measurement of a Trust's FRR (financial risk rating) according to *Monitor,* the independent regulator of NHS Foundation Trusts. The components of the FRR are as follows:

Financial Criteria	Weighting	Metric	Rating Categories				
			5	**4**	**3**	**2**	**1**
Achievement of Plan	10	EBITDA (%) of plan	100	85	70	50	<50
Underlying Performance	25	EBITDA margin (%)	11	9	5	1	<1
Financial efficiency - 1	20	Return on Capital (%)	6	5	3	-2	<-2
Financial efficiency - 2	20	I&E Surplus on turnover (%)	3	2	1	-2	<-2
Liquidity	25	Liquidity ratio (days)	60	25	15	10	<10

The '1' highlighted above refers to 1% of total Trust resources. A surplus of at least 1% attracts a risk score of '3'. The department of health is focussing heavily on this single measure for determining the acceptability of an aspirant Trust's financial standing as well as its plans for 12/13. The last version of the plan seen in February 2012 showed a surplus of £3.1m. This plan incorporates a surplus of £4.2m which is approximately double the level of surplus generated in 11/12, but not inconsistent with surpluses generated in earlier years. Through a combination of the LDP (local delivery plan) negotiations with commissioners and a review of reserves, it has been possible to amend the planned surplus. This should move the financial assessment to 'Green' for the purposes of the FIMS plan submission to the SHA on 22nd March 2012.

The full detail of the Transformation Plan including divisional and project based TSPs (transformation savings plans) was reviewed by the F&PMC following recommendations from the PMB (performance management board). As part of the approval process, the Quality and Safety aspects of the plan are also being considered.

This composite and joined-up approach provides the necessary cross checks on the governance and implementation risks associated with Transformation Plan and for external consideration, what would be regarded as the Cost Improvement Plan.

2.0 Planning & Financial Strategy Context

The Financial Strategy is embedded within the Trust's overall Integrated Business Plan which is informed by the Right Care, Right Here programme. RCRH encompasses a single site acute hospital with devolved planned care delivered through a network of community hospitals

and primary care provision. For the sake of brevity, it is not intended to describe the contents of the OBC nor the RCRH programme. There are detailed documents to support these initiatives. The outcome of the Financial Strategy supporting the Trust's plans is however, reflected in its LTFM and IBP. The financial results reflect the objectives to:

- Ensure operational efficiency through the delivery of service redesign resulting in reductions in acute based expenditures, whilst maintaining and improving quality
- Meet all compliance requirements for the Foundation Trust regime through the shadowing monitoring of both operational standards and financial covenants
- To integrate long term operational and strategic plans by ensuring financial flexibilities exist (e.g. the availability of capital) to support reconfiguration
- Apply a TFF (transitional financial framework) in the period leading up to the commissioning of the new hospital
- To maximize cash holdings through the effective management of balance sheet assets and liabilities and in turn improve overall Financial Risk Ratings
- To streamline financial transactions and exploit available technologies in managing the movement of resources and the supply chain
- Review the capacity of Financial management (both systems and human resources) to ensure the Trust can meet the rigorous requirements of self-governing status
- To align Service Line management and SLR in support of discrete business units as part of an overall financial governance regime
- To create the conditions whereby the organization can viably respond to risks and remain within governance risk ratings throughout the period covering its FT application. This includes meeting prudential borrowing targets.
- For the time as an NHS Trust, the Trust is forecasting to meet all of its statutory duties, e.g. breakeven, CRL, EFL, CCA (capital cost absorption)

2.1 High Level Control Total

For as long as the Trust remains within the performance management remit of the West Midlands SHA (Strategic Health Authority) it must adopt high level control totals involving surplus results and capital spending limits. The SHA has previously issued multi-year surplus control totals. However, as stated in the introduction, there is an expectation that a 1% surplus is planned. This approach fosters financial stability and other associated benefits such as:

- future investment (predominately a conversion into capital spending where additional Capital Resource Limit is granted)
- strengthening of the Statement of Financial Position (balance sheet) as organisations prepare for self-governing status
- creating sufficient surpluses to counteract the effects of an adverse risk

2.2 The Operating Framework

The operating framework was published on 15th December 2011 and many of its features have been circulated within the Trust. The NHS Confederation has published a summary with the key points set out below.

The Government's priorities for this year's framework are:

- The quality of care for older people;
- The need to maintain strong financial performance and service quality, including meeting the eighteen weeks target;
- The need to create the foundations for sustainable delivery against the QIPP challenges
- The need to complete the transition to the new delivery system for the NHS

The entry at paragraph 17 is helpful in terms of supporting the Trust/PCT past arrangements for managing risk.

17. There could be some benefits to this if the risk/gain share arrangements are sufficiently sophisticated and the proposed variations have a clear evidence base for driving integration and patient benefit. There would also need to be sufficient transitional arrangements which suitably recognised the resources tied into existing models of delivery; and sufficient regard for competition and procurement law.

As can be seen below, a focus remains on waiting times and this is extending to other categories.

18 week target

36. In moves pre-announced by Government the Operating Framework offers further guidance on the operation of 18 week targets, including that:

    - If the target is at risk PCT clusters should publicise the right and the local options available;
    - Trusts must ensure patients have the information they need to exercise the options;
    - In 2012/13 there will be pilots to identify the best ways trusts can meet that responsibility in the best interests of patients, focusing on orthopaedics
    - Operational standards will remain (90% for admitted and 95% for non-admitted completed waits), and trusts will need to ensure 92% of patients on an incomplete pathway should have been waiting no more than 18 weeks;
    - RTT operational standards should be achieved in each specialty by each organisation, monitored monthly;
    - Less than 1% of patients to wait longer than six weeks for diagnostic tests.

The 4 hour target remains and there is an expectation that Trust's need to perform above this level in order to ensure delivery by yearend.

Urgent Care

37. The Framework re-focuses attention on the 95% maximum four hour wait measure as the means of deriving a national measure of performance, within the basket of indicators that were introduced last year. It also signals roll-out of the 111 number by April 2013, led by CCGs who will procure it either through AQP; pilots with single or multiple providers; or through an "opt-in" model around a consortium of NHS Direct, ambulance services and other local providers.

Funding for CQUIN (commissioning for quality and innovation) is being uplifted by 1% in 12/13. Until the impact of the tariff changes are known, the extent to which this money has been made available from reductions elsewhere in the tariff is not known.

CQUIN Framework

38. In 2012/13 CQUIN will be developed so that, for all standard contracts, the amount that providers can earn will be increased to 2.5% on top of actual outturn value. There is a gentle reminder to commissioners that CQUIN is supposed to be an increment over and above the standard contract.

The OF presents the financial constraints within which the NHS will be expected to operate in 12/13. Key financial and business elements include the following:

- Local variation permitted to the 'one set of rules' for operating the Payment by Results system where commissioners and providers find that this 'prevents them from doing what is best for patients'.
- National efficiency in the tariff is -4% with price inflation assessed at +2.2%. The resultant -1.8% adjustment is amended by 0.3% for changes in prices associated with BPT (best practice tariffs). Consequently, tariff prices have been adjusted by -1.5%.
- Changes in CNST premiums have been applied directly to tariff prices.
- Average PCT growth is 2.5% in cash uplift terms
- The 30% marginal rate remains for additional emergency activity above the 08/09 baseline. Commissioners retain the other 70% but must demonstrate how this is being used to manage any growth in emergency admissions/post discharge care. In the 11/12 agreement, the 'emergency threshold' monies have been retained by the Trust as set against initiatives to improve emergency care, e.g. the Acute Physician model.
- The non-payment of avoidable readmissions in 2012/13 will continue (a clinically led review process is being introduced)

The operating framework business rules can be found at **Annex A.**

3.0 Financial Plan 12/13 and medium term

This year's round of financial planning has been the most challenging yet as the Trust and its partners move into a period of significantly reduced growth. Therefore, the Transformation Plan financial benefit is vital for ensuring Trust stability and the delivery of efficient, high quality services. The impact of moving acute services to a more appropriate community/primary care setting requires continuous monitoring and managing against the assumptions in the RCRH programme and the overall affordability of the Trust.

Following a period of intensive planning, a surplus income and expenditure position has been identified which includes agreed income agreements, Transformation Plan Savings (TSPs) that exceed national efficiency levels as well as a second full year of the impact of community services becoming part of the Trust.

The 5 year Transformation Plan was launched in September 2011 and is designed to improve the quality and safety of the Trust's services whilst meeting demanding national efficiency targets.

The scale of the Transformation Plan is ambitious in that it aims to save £125m over 5 years. Achieving savings on this scale, whilst not denuding care, requires a more sophisticated approach than we have used previously. The Plan is made up of large scale projects, each with targets to achieve in each of the 5 years. The projects are:

- Demand and capacity planning
- Outpatients efficiency
- Urgent care re-design
- Theatre productivity
- Effective patient flow and bed utilisation
- Community Service efficiency and integration
- Workforce efficiency
- Medical workforce efficiency
- Diagnostics
- Procurement
- Corporate Services and Facilities productivity
- Estates rationalisation
- Strategic IT enablement

As mentioned in the introduction, the financial savings which come out of the Transformation Plan are known as Transformation Savings Plans (TSPs). These have completely replaced the previous CIPs and QUEP programme, so as to ensure that all savings are properly linked to the Plan and thus to avoid piecemeal cuts and working on 'silo' projects.

The plan must underpin the delivery of national efficiency requirements, the FT LTFM and new hospital business case. Delivery of the financial targets remains the responsibility of operational divisions although delivery of the plan will be supported by a Transformation Support Office (TSO) providing enhanced project management capacity and functionality across the organisation. The Trust established the TSO to provide additional capacity and support to establish financial delivery plans.

The delivery of the Transformation Plan is consistent with the Trust priorities. The Transformation Plan also helps us to deliver our part of the Right Care Right Here Programme and plans for the new hospital.

3.1 Income assessment:

The GP Commissioning Consortia for SWBH facing practices led this year's negotiations as supported by PCT cluster managers. At a gap closure meeting on 13th March 2012, general agreement was reached on the financial planning 'quantum' for each body. This includes a total for all WM associated CCGs/PCTs. The gap had been created not so much as a result of competing views of the trend line basis of acute sector activity, but rather as a result of a series of coding, counting and non-PbR (payment by results) contract lines that required adjustment. Further detailed work is required in converting an activity based QiPP initiatives aimed at reducing acute sector activity and devolving/managing this within Primary Care. The source of these changes will come from three areas:

- Risk stratification measures adopted in primary care
- RCRH pathway redesign
- SWBH Transformation Plan

These strands of work contribute to the QiPP agenda. The financial impact of the settlement has been taken account of as linked to the multi-year TFF (transitional financial framework) which supports change during the transition period.

The LDP agreement sought to address:

- The effect of decommissioned activity in 11/12. This includes procedures of limited clinical value, reductions in new:review outpatient ratios and reductions in consultant to consultant referrals
- The impact of activity performance in excess of the RCRH trajectories and the pace at which all parties must work to get back on track
- The basis for formulating activity estimates for 12/13 (rolling averages versus trend data)
- Best Practice tariff in TIA and Stroke
- Best Practice tariff in Paediatric Diabetes
- Repatriation of some paediatric surgery and respiratory services
- Community Midwifery caseloads
- Digital mammography expansion
- MDT meetings and costs thereof
- Commissioning for Quality (CQuIN)

The remaining two weeks in March will be spent working on the Heads of Terms for incorporation into the final contract.

3.2 The TFF (transitional financial framework)

The contract settlement includes a continuation of the transitional financial framework resources to recognise the lagging nature of fixed and semi-fixed cost release as activity reduces. In this respect these costs become non-recurring in the short to medium term. The TFF was developed to address the financial impact of the RCRH Partnership activity plan (in the years leading up to the opening of new healthcare facilities). The activity trajectories create situations where income is redirected from the Acute Trust in the short-term leading to a full tariff reduction in value terms. Conversely, the cost base of the organization contains 'lags' owing to the time required to reduce semi-fixed and fixed costs as it works towards planned infrastructure projects. Given the anticipated behavior of future I&E, the RCRH partnership concluded that a resourcing mechanism was needed to enable delivery of the wider strategy.

A foundation document of 14 principles was agreed to guide the development of the TFF. The Acute Trust commenced work on the financial impact of the RCRH plan as did the PCTs on transitional costs expected for primary care changes. The submission of first cut financial estimates by the Trust prompted a program of scrutiny into the nature, timing and affordability of transitional costs. Latterly, this document has been written to deal with the management of the transition phase (2009/10 to 2014/15) and its prime purpose is to:

- Show anticipated costs and assumptions included in the local Health Economy and Trust's OBC
- Confirm financing routes for meeting these costs
- Comment upon the process for incorporating agreements within service contracts

As stated the assessment of transitional costs is not confined to the Acute Trust alone. The substance of transitional costs across the Health Economy shows that:

SWBH must address:

- the difference between the cost reductions achievable by the Trust as it reduces in size and its loss of income (some costs are fixed in the short term whilst income is lost at 100% of tariff rates);
- the acquisition costs of the new hospital; and
- the costs of landholding prior to the opening of the new hospital.

And;

The SWBH facing commissioners must address:

- the double-running costs associated with the commissioning of new community and primary care premises in advance of activity transfers;
- decanting costs associated with refurbishment schemes; and
- revenue to capital transfers to fund the new community capital developments.

In addition, the health economy is likely to incur additional costs as part of the process of workforce restructuring.

Principles

Four principles underpin the implementation of the TFF:

- all plans, costs and transactions will be shared on an 'open-book' basis;
- the agreement should neither inappropriately disadvantage any of the partners nor create perverse incentives that might compromise the implementation or spirit of RCHR;
- risks should be shared in a manner which enables individual organisations to assess the likelihood and scale of future commitments; and
- any cost pressures incidental to the transition arrangements shall fall outside the scope of the agreement.

The relevance of the TFF runs to the heart of the first year of SCR (strategic change reserve) and the second year TFF as linked to the usage of 2% system resources moving forward during the transition phase. For this reason, and given the presence of a medium term plan set out in the Trust's OBC, IBP and LTFM the presence of transformational funding creates a situation where the agreed and supported fixed cost release is regarding as non-recurrent during this same medium term period. In this respect, the underlying position is balanced in the lead up to the opening of the new hospital. Whilst no PFI support is assumed in the plan for 12/13, tapering relief of 7.5% of 'capex' continues to be profiled in future projections. These funds commence at the time the TFF ceases and are based on 2.5% in the first year.

3.3 Other income

CQUIN funding has increased to 2.5% in total. The headline schemes continue to be negotiated representing a mix of nationally mandated and locally agreed schemes. As part of the LDP negotiations, it was agreed that the Trust should be paid full CQUIN during the year for the purposes of managing working capital with final values agreed closer to yearend.

In terms of risk sharing, general agreement has been reached to operate a multi-variate contract in 12/13 with features of non-variable resource streams for non-elective care, sophisticated cost and volume segments linked to referral behaviour and acute based take-on rates and more routine methodologies for A&E and maternity based services. Whilst

introducing more complexity into the contracting arrangements, the proposed risk sharing arrangements offer a significant opportunity to progress with system redesign throughout entire care pathways. The detail will be shared with the F&PMC and Trust Board is due course.

The activity that underpins the 2012/13 income is based on existing trends with QiPP initiatives contributing to RCRH trajectories. Consequently, the work on de-commissioning specific cohorts of activity continues and will be incorporated in the final price activity matrix.

An estimate has been made regarding other non patient related income sources (educational levies and research) as formal notification is yet to be received.

3.4 Expenditure Plans (including key schedules) and Transformation Plan

Expenditure Plans are based on startpoint budgets, activity related changes, the implementation of TSPs, regulatory pressures, wage and other contractual increases and agreed developments with commissioning bodies. An overall picture of Income and Expenditure is presented at **Appendix 1.** This shows total income as £422,829,000 and expenditure of £418,599,000 resulting in a surplus of £4,230,000 (or £3,677,000 after IFRS adjustments). The income position is now based upon agreed values for those CCGs/PCT cluster contracts overseen by Sandwell PCT (i.e. general and acute services for West Midlands CCGs/PCT clusters). Final confirmation of other income budgets is not yet complete, e.g. specialised services and meetings continue in this regard.

This new year plan contains a similar level of flexibility when compared with 2011/12. This reflects a challenging TP target within the tariff (4.0%) coupled with additional local savings plans. Reserve allocations are now frozen in value terms although the detailed distribution will undergo further internal review based on annual plan submissions, TSP performance and affordability positions. A number of reserves have been established through a combination of reinvested cost savings, inflation within tariff and non-tariff prices and discrete investment decisions by the CCGs/PCTs. **Appendix 9** for example contains a summary schedule of pay settlement cost changes and other nationally directed/estimated cost pressures. These reflect inflation settlements for staff earning below a certain threshold and increments as part of agenda for change.

As a general point, any non-recurrent slippage owing to a delay in implementing various schemes reverts to the control of the accountable officer (CEO).

In addition to more ‘contractual’ cost rises, risk reserves have been established, some of which were agreed by the Trust Board in 11/12.

Any reserves linked to pay awards and costs occurring from 1 April 2012 onwards will be allocated to budgets from the outset. Other reserves are subject to further scrutiny and will be held pending these reviews. The bulk of the divisional costs pressures are committed to meeting activity related pressures currently in the system. They are not therefore discretionary.

3.5 Financial Appendices

Each of the financial appendices is described below.

Appendix 1 – Income and Expenditure

This schedule shows the financial plan in the context of prior year outturn performance. Care is required when making comparisons as some years such as 2009/10 contain one-off income not replicated in other years. Unlike in previous years the schedule shows pay and nonpay quantums after the allocation of reserves. This provides a basis for comparison notwithstanding the comment above and shows a cessation of the annual growth in income and expenditure. A memorandum column has been added to disclose the element of TCS income and costs.

Appendix 2 – Service Level Agreements

This schedule holds SLA values for CCG/PCTs and other income sources. The Sandwell and HoB figures are subject to minor adjustment following the final format of Heads of Terms (i.e. they may be adjusted further for items held in PCT reserves). However, the schedule of income does represent the latest estimate of income which in turn supports the expenditure base.

Appendix 3 – Divisional Startpoint Budgets

This schedule summarises the divisional rollover budgets as set against TP targets. The process of sign-off of these control totals is underway.

Appendix 4 – Divisional Workforce Budgets

This schedule charts the whole time equivalent budgets contained in pay budgets prior to the allocation of in year reserves associated with developments.

Appendix 5 – Statement of Financial Position (Balance Sheet)

The schedule includes new borrowings and the impact of the capital programme on fixed asset carrying values along with the main categories of assets and liabilities. It has been stated on the basis of International Financial Reporting Standards.

Appendix 6 & 7 – Draft Capital Programme

The Draft capital plan for 2012/13 shows a significant investment in Land as part of the overall acquisition, with future years shown in Appendix 7. The former is based on previous plans as part of the paper presented to the acute hospital project board explaining the timing of resources. In summary, the Trust is placing itself in a position such that it has sufficient resources to undertake further land transactions as and when it effects future stages of the GVD (general vesting declaration).

The balance of the programme represents the outcome of the capital planning process and many of the schemes are subject to further business case approvals.

Appendix 8 – Cash Flow

The cashflow reflects all movements of cash (both revenue and capital) and assumes a degree of borrowing contingent upon progress with land acquisition.

Appendix 9 – Budget Reserves

These reserves are established to meet unavoidable pressures associated with pay awards and nonpay inflation. Other reserve allocations are also shown. As part of its financial

strategy, the Trust is preparing to create underlying surpluses as part of RCRH. In the transition period these can be used non-recurrently and this is where a link to the Transformation Plan is made as described below.

Appendix 10 – Transformation Plan

The level of complex change required within the TP means that whilst the full year effect is being targeted in terms of identified TSPs, an enabling period has been allowed for that will see transitional periods supported. This ensures both the cash effect of the plan and the recurrent benefit. The temporary use of these funds is applied to divisions with underlying recurrent balance owing to the value of TSP plans. The objective is to reach 100% compliance at the point of submission to the Trust Board.

Appendix 11 – Sensitivity

This section describes a range of financial planning risks and how they would be managed in the event they materialised.

Appendix 12 – LTFM outputs

Four schedules appear that incorporate short and medium term financial plans. These represent the output from the LTFM (long term financial model). In each case the Trust is shows that it is meeting the 11/12 Compliance Framework. The first appendix incorporates the three 3 year I&E summary, with the balance sheet, cashflow and compliance measures captured with appendices LTFM – 2/3/4 respectively.

4.0 Acute Hospital Project - related costs

Both income and expenditure plans are excluded at this stage for the costs associated with the RCRH acute project fees. Separate financial arrangements are in place via the SHA and PCT for the funding of the programme and resources are available to meet the 2012/13 forecast expenditure. This will result in additional income and expenditure over and above the current draft plan levels.

5.0 Financial Planning Risks

As part of preparing its next stage IBP, the Board of Directors has reviewed in detail the quantified risks facing the organization. The table at Appendix 11 shows the unmitigated risks to enable the reader to consider the magnitude of any one risk. As part of the risk management measures, the Trust is agreeing mitigations strategies in an effort to eliminate these. Offsetting strategies are described within the table.

6.0 Next Steps

In terms of setting budgets, the next steps include but are not limited to:

- Conversion of contract activity targets to divisional contracts
- Summarisation of the CQUIN schemes to the committee once agreed

- Divisional startpoint budget and TSP sign-off
- Approval of the final draft financial plan by the Trust Board
- A refresh of the LTFM to support future work on the Integrated Business Plan which extends beyond the medium term

The SHA requires the conversion of this plan into a format commonly referred to as 'FIMS' (financial information management system). The final FIMs and Finance Director narrative was submitted at noon on 22nd March 2012. It has been reviewed by the F&PMC with copies made available to the Trust Board.

7.0 Summary and Recommendations

The Trust is in the process of working through detailed contractual terms as part of the LDP settlement. The plan as presented includes a significant element of joint QiPP initiatives to assist in moving towards RCRH activity trajectories as backed by TFF monies to meet related transitional costs.

Given the degree of volatility within NHS funding generally, it is important that the TP is fully delivered as the ability to respond centrally to operational or regulatory risks is reduced, albeit a reserve has been established for the management of change. A number of risks will need to be addressed as described earlier in the document and due consideration is being given to issues within the corporate risk register, RCRH risk register and assurance framework.

The Trust Board is asked to:

RECEIVE AND CONSIDER the final draft budget

AGREE that its contents and assumptions are used for the 12/13 FIMS plan

RECOMMEND the 12/13 Budget and medium term Plan to the Trust Board for approval

AGREE to receive in-year monitoring of financial performance

Robert White
Director of Finance & Performance Management

22 March 2012

Annex A: Summary of Payment by Results arrangements for 2012-13

Tariff structure and adjustments

Issue	Detail
Tariff structure	Although there are no fundamental changes to the structure of the tariff, we have again set prices for a small number of Healthcare Resource Groups (HRGs) which are the same across all settings, or across day case and outpatient procedures. This is designed to incentivise the provision of care in less acute settings where clinically appropriate. There will be an increase in the number of Healthcare Resource Groups (HRGs) that will have a mandatory outpatient procedure tariff.
Underpinning cost data	The 2012-13 tariff is largely based on 2009-10 reference cost data. We have excluded some organisations' data from the tariff calculation following the Audit Commission's findings from the audit of 2009-10 reference costs.
Healthcare Resource Groups	There is a small increase in the number of HRGs that will have a mandatory tariff, primarily as a consequence of HRG design changes. However there is no change to the coverage of the HRGs. Information on changes to HRG design that are reflected in the 2012-13 tariff can be found on the NHS Information Centre website.[1]
Maternity	We will make available a maternity pathway system for payment, in shadow form, with the intention of mandating its use in 2013-14. Further information will be published on the Department's website in the new year to allow organisations to test the financial impact.
Funding for specialised services	The specialist service top-ups for 2012-13 are as follows: • Children – 50%, restricted eligibility • Spinal surgery - 32%, restricted eligibility • Neurosciences - 28%, restricted eligibility • Orthopaedic - 24%, no restriction on eligibility The reduction in the children's top-up from the current level of 60% reflects a continuation of the managed transition towards a top-up level that is more consistent with the outcomes of the analysis undertaken by the

[1] http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads

Issue	Detail
	University of York's Centre for Health Economics. We have removed cochlear implants from eligibility for the specialist children's top-up.
Long stay payments	We are continuing with the approach to the reimbursement of long stays which we introduced in 2011-12, namely: • Having a five-day trim point 'floor,' so that relatively short stays don't attract a long stay payment • Standardising the long stay payment at HRG chapter level.
Short stay emergency tariff	Threshold percentages are unchanged.
Exclusions	We have reviewed and updated the list of exclusions.
ICD-10 fourth edition	The fourth edition of the ICD-10 diagnosis classification will be implemented from April 2012. The revised set of ICD-10 codes will be in built into the Local Payment 2012-13 Grouper, with new codes included and deleted codes removed. For the Local Payment 2012-13 Grouper, the HRG structure will be maintained where practicable such that the base design used to collect 2009-10 reference costs (which underpin the 2012-13 tariff) is retained.

Best practice tariffs

Issue	Detail
Best practice tariffs	We are rolling forward the existing best practice tariffs (BPTs) listed below: • Adult renal dialysis (with the transition to a mandatory tariff being completed in 2012-13) • Cataracts • Cholecystectomy (gall bladder removal) • Transient ischaemic attack (mini-stroke) • Primary total hip and knee replacements We are revising existing BPTs in a number of areas: • **Fragility hip fracture and stroke –** We have increased the payment differential between best practice and non-best practice approaches by 50 per cent. The best practice criteria for fragility hip

Issue	Detail
	fracture will also be expanded to include cognitive impairment testing for dementia. • **Paediatric diabetes –** We will introduce a mandatory pathway tariff. We will also expand the best practice approach to the following service areas: • **Interventional radiology –** We are extending the BPT approach to peripheral artery disease, TIPS for portal hypertension, thoracic EVAR, diabetic foot disease and percutaneous excision of benign breast lesions. The aim is to increase the visibility of and provide fair reimbursement for less invasive techniques. • **Same day emergency care –** We are introducing best practice tariffs for a number of emergency clinical scenarios. The aim is to promote management of these scenarios on a same day basis in an ambulatory emergency care manner. The clinical scenarios are: o cellulitis o pulmonary embolism o asthma o acute headache o chest pain o lower respiratory tract infections without chronic obstructive pulmonary disease o appendicular fractures not requiring immediate fixation o renal/ureteric stones o falls including syncope and collapse o epileptic seizure o deliberate self harm o deep vein thrombosis • **Day case setting –** We are extending the number of procedures covered by the BPT approach to include some tonsillectomy and septoplasty HRGs. The aim is to incentivise procedures being undertaken on a day case basis where appropriate. • **Outpatient setting –** We are setting BPTs for three procedures to incentivise these being performed in an outpatient setting: o Diagnostic cystoscopy o Diagnostic hysteroscopy

Issue	Detail
	○ Hysteroscopic sterilisation • **Home haemodialysis and assisted automated peritoneal dialysis –** Building on the adult renal dialysis tariff introduced in 2011-12, the aim of these new BPTs is to promote greater choice for patients of home therapies for dialysis.
Major trauma	We will introduce a best practice tariff designed to reward providers who meet quality criteria on a per-patient basis, through an additional payment. The aim is to support the transition from current patterns of provision to those envisaged under the Major Trauma Centre plan.

Expanding the scope of PbR

Issue	Detail
Post discharge	We will introduce post discharge tariffs for: • Cardiac rehabilitation • Pulmonary rehabilitation • Hip replacement rehabilitation • Knee replacement rehabilitation The tariffs will be mandatory where acute and community services are integrated in one trust.
Adult renal dialysis	The transition to a mandatory tariff for adult renal dialysis will be completed.
Direct access diagnostic tests	We will introduce mandatory tariffs for: • Direct access diagnostic imaging • Direct access respiratory tests for simple airflow studies and simple bronchodilator studies • Direct access flexible sigmoidoscopy
Adult mental health services	We will mandate the use of 'care cluster' currency for contracting, with local prices, for the adult mental health services.
Chemotherapy and radiotherapy	We will mandate the use of national currencies for contracting for chemotherapy delivery and external beam radiotherapy. We will also publish non-mandatory prices for these services.

Issue	Detail
Cystic fibrosis	We will phase in the introduction of a year of care tariff for cystic fibrosis by transitioning from local to national prices in 2012-13, with a view to introducing a national mandated tariff in 2013-14. We will make the 2012-13 tariff available later. This transitional year will give providers and commissioners an opportunity to do further work on this and on issues associated with shared care outside of specialist centres and GP prescribing of specialist drugs.
Ambulance services	We will mandate the use of the national currency for contracting, with local prices, for ambulance services.
Community services	As part of the Any Qualified Provider programme of work, we will also introduce currencies for the following community services: • Musculo-skeletal services for back and neck pain • Adult hearing services • Continence services • Diagnostic tests closer to home • Wheelchair services for children • Podiatry services • Venous leg ulcer and wound dressing • Primary care psychological therapies for adults. We will again publish non-mandatory currencies for smoking cessation.

Business rules

Issue	Detail
Marginal rate	The 30 per cent marginal rate for increases in the value of emergency admissions above a 2008-09 baseline will continue to apply.
Emergency readmissions	The policy of non-payment for emergency readmissions, with some exceptions, will continue to apply. Further work is underway to inform final guidance to be published in mid February.
Flexibilities	Existing tariff flexibilities will remain in place, with additional flexibility introduced in response to concerns about 'cherry picking.'

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2012/2013

Income & Expenditure Position Actual, Forecast and Plan

		Accounts Mar - 08 £000's	Accounts Mar - 09 £000's	Accounts Mar - 10 £000's	Accounts Mar - 11 £000's	Forecast Mar - 12 £000's	Outline Mar - 13 £000's
INCOME							
Main Commissioner Contracts		290,081	296,695	327,369	337,782	368,061	374,699
Other SLA Income				6,043	6,840	7,431	6,674
Market Forces Factor		18,499	20,458	9,140	0	0	0
Total Category A Income		**308,580**	**317,153**	**342,552**	**344,622**	**375,492**	**381,373**
Non NHS Clinical Income							
Private Patient Income		134	132	164	170	150	103
Other Non Protected Income		1,031	1,712	2,375	3,574	2,994	2,060
	Total	**1,165**	**1,844**	**2,539**	**3,744**	**3,144**	**2,163**
Other Income							
Education and Training		16,874	17,062	18,473	18,116	18,006	17,383
Research & Development		1,082	1,303	1,889	1,826	1,875	1,139
Other Income		20,774	21,799	19,321	19,562	20,185	20,770
	Total	**38,730**	**40,164**	**39,683**	**39,504**	**40,066**	**39,292**
TOTAL INCOME		**348,475**	**359,161**	**384,774**	**387,870**	**418,702**	**422,829**
EXPENDITURE							
Base Position							
Pay		(219,686)	(238,675)	(252,557)	(259,889)	(289,048)	(287,996)
Non Pay		(95,484)	(93,929)	(101,341)	(104,274)	(106,546)	(109,667)
TOTAL OPERATING COSTS		**(315,170)**	**(332,604)**	**(353,898)**	**(364,163)**	**(395,594)**	**(397,663)**
EBITDA		**33,305**	**26,557**	**30,876**	**23,707**	**23,108**	**25,165**
Profit / loss on asset disposals		(101)	(109)	(102)	(234)	0	0
Fixed Asset impairments		(3,346)	0	(36,463)	(9,532)	0	0
Depreciation & Amortisation		(15,725)	(15,587)	(13,913)	(13,266)	(12,889)	(13,525)
Total interest receivable		1,664	1,048	80	87	104	100
Total interest payable on Loans and Leases		(442)	(104)	(2,179)	(1,902)	(2,156)	(2,114)
PDC Dividend		(8,831)	(9,258)	(6,945)	(5,745)	(5,803)	(5,396)
NET SURPLUS/(DEFICIT)		**6,524**	**2,547**	**(28,646)**	**(6,885)**	**2,364**	**4,230**
IFRS/Impairment Related Adjustments				35,906	9,078	(557)	(553)
SURPLUS/(DEFICIT) FOR DOH TARGET		**6,524**	**2,547**	**7,260**	**2,193**	**1,807**	**3,677**

APPENDIX 2

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2010/2011

Patient Related Service Level Agreements

Commissioner	Total SLA Value £000
Black Country Cluster	205,983
Birmingham & Solihull Cluster	136,097
Other PCTs/Clusters	7,549
West Midlands Specialised Services (including repatriated services)	21,001
Non Commissioned Activity	2,654
Other Contracts	1,415
Total	**374,699**

APPENDIX 3

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2012/2013

Divisional Baseline Pay and Non Pay Base Budgets and Transformation Programme Target

Division	Pay £000	Non Pay Budget £000	Total Expenditure £000	TP Value £000
Chief Executive	1,362	1,040	2,402	120
Estates	3,264	8,471	11,735	1,417
Facilities	17,349	6,961	24,310	1,500
Finance	4,160	767	4,927	320
Governance	2,846	603	3,449	214
Workforce	4,541	586	5,127	321
IM&T/Patient Process	3,863	1,240	5,103	299
Imaging	14,446	4,138	18,584	1,345
Medicine & Emergency Care	65,343	23,408	88,751	5,868
Nursing & Therapies	7,570	703	8,273	553
Pathology	13,923	6,076	19,999	1,259
Operations/Strategy	13,634	1,491	15,125	942
Surgery B	18,145	6,406	24,551	1,672
Surgery A, Anaesthetics & Critical Care	54,316	13,209	67,526	4,999
Womens & Childrens	40,855	7,447	48,302	3,110
SHCS: Adult Services	18,173	5,922	24,096	1,581
Other	2,971	15,616	18,588	238
TOTAL	**286,762**	**104,087**	**390,849**	**25,758**

Notes

Budgets reflect underlying costs within operational divisions in 2011/12 but confirmation of this requirement will be subject to the budget allocation process.

Other includes National Poisons Information, Research and Development, Post Graduate Centre, clinical negligence costs, deprecaition charges and other Corporate Services.

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2012/2013

Divisional Workforce Budgets (Whote Time Equivalents)

Division	Mar-12	April	May	June	July	August	September	October	November	December	January	February	March
Chief Executive	29.23	29.23	29.23	29.23	29.23	29.23	29.23	28.23	28.23	28.23	28.23	28.23	28.23
Estates	102.92	99.22	99.22	99.22	99.22	99.22	99.22	99.22	99.22	99.22	99.22	99.22	99.22
Facilities	749.22	728.89	728.89	728.89	728.89	728.89	728.89	728.89	728.89	728.89	728.89	728.89	728.89
Finance	107.06	107.06	107.06	107.06	98.81	98.81	98.81	98.81	98.81	98.81	98.81	98.81	98.81
Governance	77.30	73.62	73.62	73.62	73.62	73.62	73.62	73.62	73.62	73.62	73.62	73.62	73.62
IM&T	106.00	101.98	101.98	100.98	100.98	100.98	100.98	100.98	100.98	100.98	100.98	100.98	100.98
Imaging	302.53	304.84	304.84	303.84	298.22	298.22	298.22	297.72	296.72	296.72	296.72	296.72	296.72
Medicine & Emergency Care	1,573.28	1,572.07	1,518.87	1,483.32	1,472.32	1,444.72	1,443.72	1,442.72	1,442.72	1,442.72	1,442.72	1,442.72	1,442.72
Nursing & Therapies	237.50	224.17	224.17	224.17	224.17	224.17	225.17	226.17	226.17	226.17	226.17	226.17	226.17
Operations/Strategy	433.82	416.50	416.50	416.50	416.50	416.50	416.50	416.50	416.50	416.50	416.50	416.50	416.50
Pathology	349.36	340.33	340.33	340.33	340.33	340.33	340.33	340.33	340.33	340.33	340.33	340.33	340.33
SCHS - Adults	571.69	603.65	603.65	603.65	603.65	603.65	603.65	603.65	603.65	603.65	603.65	603.65	603.65
Surgery A, Anaesthetics & Critical Care	1,101.81	1,133.64	1,132.64	1,119.64	1,083.10	1,080.10	1,050.10	1,044.10	1,044.10	1,044.10	1,044.10	1,044.10	1,044.10
Surgery B	350.92	356.59	356.59	356.59	348.79	348.79	344.49	344.49	344.49	344.49	344.49	344.49	344.49
Womens & Childrens	971.72	990.07	990.07	990.07	990.07	990.07	990.07	990.07	990.07	990.07	990.07	990.07	990.07
Workforce	116.87	112.24	112.24	112.24	112.24	112.24	112.24	112.24	112.24	112.24	112.24	112.24	112.24
Other	59.07	57.40	57.40	57.40	57.40	57.40	57.40	57.40	57.40	57.40	57.40	57.40	57.40
TOTAL	**7,240.30**	**7,251.49**	**7,197.29**	**7,146.74**	**7,077.53**	**7,046.93**	**7,012.63**	**7,005.13**	**7,004.13**	**7,004.13**	**7,004.13**	**7,004.13**	**7,004.13**

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2012/2013

Statement of Financial Position

		Opening Balance as at 1st April 2012 £000	Balance as at 31st March 2013 £000
Non Current Assets	Property, Plant and Equipment	201,235	209,423
	Property, Plant and Equipment (PFI)	18,430	17,910
	Trade and Other Receivables	650	650
Current Assets	Inventories	3,584	3,584
	Trade and Other Receivables	14,863	14,634
	Investments	0	0
	Cash	28,367	19,764
Current Liabilities	Trade and Other Payables	(37,717)	(36,061)
	Loans	(2,000)	(2,000)
	PFI and Finance Leases	(996)	(1,221)
	Provisions for Liabilities and Charges	(4,958)	(4,958)
Non Current Liabilities	Trade and Other Payables	0	0
	Loans	(5,000)	(3,000)
	PFI and Finance Leases	(30,190)	(28,969)
	Provisions for Liabilities and Charges	(2,337)	(1,737)
		183,931	188,019
Financed by: Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Retained Earnings	(25,535)	(21,346)
	Revaluation Reserve	38,672	38,571
	Donated Asset Reserve	0	0
	Other Reserves	10,563	10,563
		183,931	188,019

APPENDIX 6

Sandwell & West Birmingham Hospitals

Financial Plan 2012/2013

Draft Capital Programme

		2012/13 Programme £000
Capital Resources	Internally Generated Cash (depreciation)	13,525
	Additional CRL	7,973
Total Resources		**21,498**
Brought Forward Commitments	Capitalised Salaries	475
	Other Slippage and Retentions B/F	500
	Total Brought Forward	**975**
Land Acquisition	Scheduled Land Purchases	5,000
Statutory Standards	Statutory Standards and Estates Risk Related Expenditure	3,000
	Sandwell Ward Block - relocation of non-clinical functions from wards	150
	Replace washer/disinfectors in Endoscopy Unit at SGH	1,000
	Review location of paediatric surgery for low complexity work. Working towards privacy and dignity for paediatric patients recovering from surgical procedures.	100
Estates Rationalisation/TSP Enablers	Estates Rationalisation TSP - Office moves and closure of peripheral buildings	2,920
	Dermatology - sanitary facilities, enhancement and relocation	10
	Provision for T&O reconfiguration - clean air theatre systems	250
Imaging Equipment	Imaging - GC diagnostics and facility reconfiguration	1,482
	Mammography unit infrastructure/breast service improvements	235
Other Medical Equipment	Outline provision for medical equipment committee - replacement/renewal inc. TCS	1,176
Other Equipment	PTS and GTS Vehicles (year 3 replacement programme)	150
	Cleaning Equipment	50
IM&T	Provision for all schemes linked to HIS plan improvements	1,170
Strategic Investment	Phase 1 pathology reconfiguration	1,450
	Residual contingency	1,880
Service Reconfiguration	Provision for Stroke Reconfiguration	500
Total Expenditure		**21,498**
Net Under/(Over) Spend Against Capital Resources		**0**

APPENDIX 7

Sandwell & West Birmingham Hospitals

Financial Plan 2012/2013

Future Outline Capital Programme

		2013/14 Outline £000	2014/15 Outline £000	2015/16 Outline £000	2016/17 Outline £000
Land: Acquisition & Disposals	Land Acquisition & Demolition	2,536	2,015	382	58
Buildings - New Developments	Service Reconfiguration	1,272	178	1,225	1,300
	Estates Rationalisation Schemes	0	0	434	0
	Ophthalmology	350	350	0	0
	Urgent Care	0	0	600	0
	Intermediate Care	0	1700	0	0
	Capitalised Salaries	475	475	475	475
Buildings - Statutory Standards	Statutory Standards	3,000	3,000	3,000	4,225
Buildings - Other Schemes	Other	300	300	500	500
Health Informatics	IT & Telecoms	400	400	400	400
	Health Related IT	600	600	600	600
Medical Equipment	General Medical Equipment	2,500	1,850	2,500	2,500
	Imaging Equipment	2,000	2,000	2,000	2,000
Other Equipment		150	200	384	442
Total All Schemes		**13,583**	**13,068**	**12,500**	**12,500**

Sandwell & West Birmingham Hospitals

Financial Plan 2012/2013

Cash Flow

	Period											
	April	May	June	July	August	September	October	November	December	January	February	March
Opening Balance	**28,367**	**28,252**	**28,126**	**28,066**	**28,006**	**27,947**	**23,944**	**23,883**	**23,823**	**23,763**	**23,703**	**23,643**
EBITDA	2,169	2,169	2,169	2,169	2,169	2,169	2,169	2,169	2,169	2,169	2,169	2,169
Other increases/(decreases) to reconcile to profit/(loss) from operations	(40)	(40)	(40)	(40)	(40)	(40)	(40)	(40)	(40)	(40)	(40)	(40)
Operating cash flows before movements in working capital	**2,130**	**2,130**	**2,130**	**2,130**	**2,130**	**2,130**	**2,130**	**2,130**	**2,130**	**2,130**	**2,130**	**2,130**
Movement in Working Capital												
(Increase)/decrease in Inventories	(10)	0	0	0	0	0	0	0	0	0	0	0
(Increase)/decrease in Trade and Other Receivables, Current	180	60	0	0	0	0	0	0	0	0	0	0
(Increase)/decrease in Trade and Other Payables and Accruals, Current	(325)	(226)	(100)	(100)	(100)	(205)	(100)	(100)	(100)	(100)	(100)	(100)
Increase/(decrease) in working capital	**(155)**	**(166)**	**(100)**	**(100)**	**(100)**	**(205)**	**(100)**	**(100)**	**(100)**	**(100)**	**(100)**	**(100)**
Increase/(decrease) in Non Current Provisions	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)
Net cash inflow/(outflow) from operating activities	**1,925**	**1,914**	**1,980**	**1,980**	**1,980**	**1,875**	**1,980**	**1,980**	**1,980**	**1,980**	**1,980**	**1,980**
Cash flow from investing activities												
Capital Spend	(1,792)	(1,792)	(1,792)	(1,792)	(1,792)	(1,792)	(1,792)	(1,792)	(1,792)	(1,792)	(1,792)	(1,792)
PFI residual interest	0	0	0	0	0	0	0	0	0	0	0	0
Cash receipt from asset sales	0	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow/(outflow) from investing activities	**(1,792)**	**(1,792)**	**(1,792)**	**(1,792)**	**(1,792)**	**(1,792)**	**(1,792)**	**(1,792)**	**(1,792)**	**(1,792)**	**(1,792)**	**(1,792)**
Cash Flow before Financing	**133**	**122**	**188**	**188**	**188**	**83**	**188**	**188**	**188**	**188**	**188**	**188**
Cash flow from financing activities												
Public Dividend Capital received	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0	0	0	0	0	0	0	0
Dividends paid	0	0	0	0	0	(2,698)	0	0	0	0	0	(2,698)
Interest (paid) on loans and leases	(4)	(4)	(4)	(3)	(3)	(143)	(3)	(3)	(3)	(2)	(2)	(122)
Interest element of PFI Unitary Charge	(169)	(169)	(169)	(169)	(169)	(169)	(169)	(169)	(169)	(169)	(169)	(169)
Interest received on cash and cash equivalents	7	7	7	7	7	7	6	6	6	6	6	5
Drawdown of loans and leases	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of loans and leases	(83)	(83)	(83)	(83)	(83)	(1,083)	(83)	(83)	(83)	(83)	(83)	(1,083)
Movement in Other grants/Capital received	0	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow/(outflow) from financing	**(248)**	**(248)**	**(248)**	**(248)**	**(248)**	**(4,086)**	**(248)**	**(248)**	**(248)**	**(248)**	**(248)**	**(4,066)**
Net cash outflow/inflow	**(115)**	**(126)**	**(60)**	**(60)**	**(60)**	**(4,003)**	**(60)**	**(60)**	**(60)**	**(60)**	**(60)**	**(3,878)**
Closing Balance	**28,252**	**28,126**	**28,066**	**28,006**	**27,947**	**23,944**	**23,883**	**23,823**	**23,763**	**23,703**	**23,643**	**19,765**

APPENDIX 9

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2012/2013

Reserves

INFLATION	Total £000
Pay Award	
AfC	
Other Incremental Drift	
Medical Employer Based Excellence Awards	
Non Pay Inflation	
IT Licences	
CNST	
TOTAL	**8,113**

OTHER RESERVES	Total £000
RCRH Transition Fund	
Service Developments: Volume Changes	
Service Developments: Digital Mammography	
Service Developments: Other Acute	
Service Developments: Health Visitors	
Service Developments: Intermediate Care	
Service Developments: Community Midwifery	
Service Developments: Other Community	
Excluded Drugs	
Divisional Cost Pressures	
Other	
TOTAL	**18,599**

TOTAL RESERVES	**26,711**

APPENDIX 10

Sandwell & West Birmingham Hospitals

Financial Plan 2012/2013

Divisional Summary Transformation Programme

	TARGET £000	FULL YEAR EFFECT £000	PART YEAR EFFECT				INTERNAL TRANSITIONAL FUNDING £000	TOTAL TP £000
			PAY £000	NON PAY £000	INCOME £000	TOTAL £000		
OPERATIONAL DIVISIONS								
Imaging	1,345	1,663	900	291	155	1,345		1,345
Medicine & Emergency Care	5,868	6,043	3,894	565	340	4,799	1,069	5,868
Nursing & Therapies	553	541	509	30	14	553		553
Pathology	1,259	1,221	601	618	40	1,259		1,259
Surgery A, Anaesthetics & Critical Care	4,999	4,965	3,432	522	0	3,954	1,045	4,999
Surgery B	1,672	2,314	1,276	195	202	1,672		1,672
Womens & Child Health	3,110	3,383	2,291	320	232	2,843	267	3,110
SCHS: Adult Services	1,562	1,601	1,328	252	0	1,581		1,581
CORPORATE AREAS								
Chief Executive	120	123	46	74	0	120		120
Operations/Strategy	942	942	586	336	0	923	20	942
Facilities	1,500	1,500	1,130	30	340	1,500		1,500
Estates	1,594	1,581	793	473	70	1,336	81	1,417
Finance	320	431	320	0	0	320		320
Governance	209	234	131	42	40	214		214
Postgraduate Centre	63	56	56	4	0	60		60
Workforce	321	327	232	35	53	321		321
IM&T	294	307	208	90	0	299		299
Other							177	177
TOTAL	**25,733**	**27,232**	**17,734**	**3,878**	**1,485**	**23,099**	**2,660**	**25,758**

Sandwell & West Birmingham Hospitals

Financial Plan 2012/2013

Risk and Sensitivity Analysis

Area of Risk/Sensitivity		Financial Effect	Mitigating Actions Details
		£000	
Downside Risk of Planned TSP Targets not being achieved.	1	(1,907)	Contingency Reserves available, bringing forward of aspects of 13/14 plan
Downside risk of Losing TFF Support.	2	(997)	Largely mitigated through LDP settlement, identified as a risk during Board assessment
Downside risk of Losing CQUIN Funding for Non Achievement of Quality Initiatives..	3a	(904)	Negotiations on sliding scale reimbursement in line with other Trusts coupled with earmarked enabling resources
Downside Risk of Losing Admitted Patient Care Activity to other Providers due to fall in Standards of Care.	3b	(973)	Sophisticated contracting mechanisms, but overriding mitigation is to meet positive net promoter score
Downside Risk due to loss of the discount on CNST Premium	4a	(322)	Plans in place for assessments, Maternity Level 1 March 2012, Level 2 in year
Downside Risk due to incurring CQC Fines	4c	(36)	Ensure early warning risk management system is effective, coupled with implementation of funded initiatives
Downside Risk due to closure of Pharmacy	4d	(484)	
Downside Risk associated with an increase in community demand without an increase in income.	5a	(278)	Largely mitigated through LDP settlement, additional data on 'demand led' services under negotation
Downside Risk of losing health visitors and district nursing services.	5b	(410)	Back to practice placements filled, funding in place and primary care contract under negotiation
Downside Risk of Trust Deviating from National Sickness Target of 3.39%.	6a	(1,168)	Targeted in-year sickness reviews, continuation of occy-health support, counselling, back to work initatives
Downside Risk of Deviations in Staff Turnover.	6b	(580)	Staffing capacity plan in place, current trends suggest stable workforce, entry level posts being supported
Downside Risk of Losing Specialist Registrars Training Posts.	7	(729)	Taken account of in all reconfigurations including timing issues associated with house rotations
Downside Risk of Trust losing its Emergency Work in Trauma and Orthopaedics and Vascular (net).	8	(1,100)	Mitigated within LDP settlement and therefore budgeted for
The Downside Risk if the OBC is approved but during the Procurement Phase a problem occurs.	9	(334)	Ensure sufficient contingencies in place, not an issue for 12/13
Downside Risk of Cost Reductions not being achieved during the Transitional Stage.	11	(164)	Contingency reserves in place, but implement measures seen in 12/13 involving specific turnaround controls
Downside Sensitivity of the RCRH Clinical Modelled Activity being lower than predicted.	12a	(1,127)	Cost base would need to be adjusted accordingly as the Trust would not be delivering the activity. Contingencies.
Downside Risk of the Redundancy Contingency Deviating from planned levels.	13	(585)	Current estimates suggests funds are available to meet projected separation costs.

APPENDIX 12

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2012/2013

Medium Term Financial Plan: Extract from Long Term Financial Model

Units
£m unless otherwise stated
All amounts shown here are nominal

Income Statement	Plan Mar-13	Forecast Mar-14	Forecast Mar-15
NHS Acute Activity Revenue			
Elective revenue (long and short stay)	52.8	52.4	50.5
Non-Elective revenue	94.9	94.0	93.9
Outpatient	67.0	62.4	59.7
A&E	17.9	17.9	17.8
Other NHS	134.7	123.5	128.4
NHS Acute Activity Revenue, Total	367.4	350.2	350.4
PBR (Clawback)/ Relief	0.0	0.0	0.0
NHS Clinical Revenue, Total	367.4	350.2	350.4
Non NHS Clinical Revenue			
Private patient revenue	0.1	0.1	0.1
Other non-NHS clinical revenue (incl. CRU)	2.3	4.4	5.4
Non NHS Clinical Revenue, Total	2.4	4.5	5.5
Other Operating income			
Research and Development income	0.9	0.7	0.7
Education and Training income	17.6	18.7	19.0
PFI Specific income	0.0	0.0	0.0
Other Operating Income	34.6	35.8	31.4
Other Operating income, Total	53.1	55.3	51.1
Operating Revenue and Income, Total	**422.9**	**410.0**	**407.0**
Operating Expenses			
Employee benefits expense	(288.0)	(283.1)	(272.9)
Drug expense	(28.4)	(30.5)	(32.8)
Clinical supplies	(39.3)	(40.1)	(40.7)
Non Clinical Supplies	(40.7)	(29.6)	(34.3)
PFI operating expenses	(1.4)	(1.1)	(1.2)
Other Operating expenses	0.0	0.0	0.0
Operating Expenses, Total	**(397.7)**	**(384.5)**	**(381.9)**
EBITDA	**25.2**	**25.5**	**25.1**
Surplus (Deficit) from Operations margin	*6%*	*6%*	*6%*
Non-Operating income			
Gain/(loss) on asset disposals	0.0	0.0	0.0
Income from NHS Charitable Funds			
Other Non-Operating income			
Non-Operating income, Total	**0.0**	**0.0**	**0.0**
Non-Operating expenses			
Interest expense on overdrafts and working capital facilities	(0.1)	(0.1)	(0.1)
Interest expense on loans and leases	(2.0)	(2.3)	(2.2)
Depreciation and Amortisation	(13.5)	(13.3)	(13.0)
PDC Dividend	(5.4)	(5.6)	(5.9)
Impairment Losses (Reversals) net	0.0	0.0	0.0
Other Non-Operating expenses			
Non-Operating expenses, Total	**(21.1)**	**(21.3)**	**(21.2)**
Surplus/(Deficit)	**4.2**	**4.4**	**4.0**
Net margin	*1%*	*1%*	*1%*

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2012/2013

Medium Term Financial Plan: Extract from Long Term Financial Model

Units
£m unless otherwise stated
All amounts shown here are nominal

	Plan Mar-13	Forecast Mar-14	Forecast Mar-15
Balance sheet			
ASSETS, NON CURRENT			
Property, Plant and Equipment and intangible assets, Net	209.4	210.7	211.8
Property, plant & equipment (PFI)	17.9	17.4	16.9
PFI Other Assets	0.0	0.0	0.0
Investments, Non-Current	0.0	0.0	0.0
Trade and Other Receivables, Net, Non-Current (including prepayments)	0.7	0.7	0.7
Other Assets, Non-Current	0.0	0.0	0.0
Assets, Non-Current, Total	**228.0**	**228.8**	**229.3**
ASSETS, CURRENT			
Inventories	3.6	3.6	3.6
NHS Trade Receivables, Current	9.8	9.7	9.7
Non NHS Trade Receivables, Current	(0.9)	(0.8)	1.0
Other Receivables, Current	3.4	3.4	3.4
Other Financial Assets, Current (e.g. accrued income)	0.1	0.1	0.1
Prepayments, Current, PFI related	0.0	0.0	0.0
Prepayments, Current, non-PFI related	2.3	2.3	2.3
Cash and Cash Equivalents	19.8	17.8	22.3
Other Assets, Current	0.0	0.0	0.0
Assets, Current, Total	**38.0**	**36.0**	**42.3**
ASSETS, TOTAL	**266.0**	**264.8**	**271.7**
LIABILITIES, CURRENT			
Bank Overdraft and Working Capital Facility	0.0	0.0	0.0
Interest-Bearing Borrowings , Current (including accrued interest)	(2.0)	(2.0)	(1.0)
Deferred Income, Current	(7.2)	(6.6)	(6.6)
Provisions, Current	(5.0)	(5.0)	(5.0)
Trade Payables, Current	(6.9)	(6.4)	(12.3)
Other Payables, Current	(3.8)	(3.8)	(3.8)
Capital Payables, Current	(1.6)	(1.6)	(1.6)
Accruals, Current	(16.6)	(16.0)	(16.0)
Payments on Account	0.0	0.0	0.0
Finance Leases, Current	(0.2)	(0.0)	(0.0)
PDC dividend creditor, Current	0.0	0.0	0.0
Other Liabilities, Current	(1.0)	(1.0)	(1.0)
Liabilities, Current, Total	**(44.2)**	**(42.3)**	**(47.2)**
NET CURRENT ASSETS (LIABILITIES)	**(6.2)**	**(6.3)**	**(4.9)**
LIABILITIES, NON CURRENT			
Interest-Bearing Borrowings, Non-Current	(3.0)	(1.0)	0.0
Deferred Income, Non-Current	0.0	0.0	0.0
Provisions, Non-Current	(1.7)	(1.1)	(1.1)
Trade and Other Payables, Non-Current	0.0	0.0	0.0
Finance Leases, Non-current	(0.1)	(0.0)	(0.0)
Other Liabilities, Non-Current	(28.9)	(27.9)	(26.9)
Liabilities, Non-Current, Total	**(33.7)**	**(30.1)**	**(28.0)**
TOTAL ASSETS EMPLOYED	**188.0**	**192.4**	**196.4**
TAXPAYERS' EQUITY			
Public dividend capital	160.2	160.2	160.2
Retained Earnings (Accumulated Losses)	(21.3)	(17.0)	(13.0)
Charitable Funds	0.0	0.0	0.0
Donated asset reserve	2.0	2.0	2.0
Revaluation reserve	36.6	36.6	36.6
Miscellaneous Other Reserves	10.6	10.6	10.6
TOTAL TAXPAYERS EQUITY	**188.0**	**192.4**	**196.4**

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2012/2013

Medium Term Financial Plan: Extract from Long Term Financial Model

Units
£m unless otherwise stated
All amounts shown here are nominal

	Plan Mar-13	Forecast Mar-14	Forecast Mar-15
Cash flow			
EBITDA	**25.2**	**25.5**	**25.1**
Other increases/(decreases) to reconcile to profit/(loss) from operations	(0.5)	(0.5)	(0.5)
Operating cash flows before movements in working capital	**24.8**	**25.0**	**24.6**
Movement in working capital:			
(Increase)/decrease in Inventories	0.0	0.0	0.0
(Increase)/decrease in NHS Trade Receivables	(0.0)	0.1	(0.0)
(Increase)/decrease in Non NHS Trade Receivables	0.2	(0.1)	(1.8)
(Increase)/decrease in other Receivables	0.0	0.0	0.0
(Increase)/decrease in Other financial assets (e.g. accrued income)	0.0	0.0	0.0
(Increase)/decrease in Prepayments	0.0	0.0	0.0
(Increase)/decrease in Other assets	0.0	0.0	0.0
Increase/(decrease) in Deferred Income & Payments on account	(0.6)	(0.6)	0.0
Increase/(decrease) in Provisions	0.0	0.0	0.0
Increase/(decrease) in Trade Payables	(0.5)	(0.5)	5.9
Increase/(decrease) in Other Payables	0.0	0.0	0.0
Increase/(decrease) in PDC Dividend Creditor			
Increase/(decrease) in accruals	(0.6)	(0.6)	0.0
Increase/(decrease) in Other liabilities			
Increase/(decrease) in working capital	**(1.4)**	**(1.7)**	**4.0**
Increase/(decrease) in Non Current Provisions	(0.6)	(0.6)	0.0
Net cash inflow/(outflow) from operating activities	**22.7**	**22.7**	**28.7**
Cash flow from investing activities			
Property, plant and equipment expenditure	(21.5)	(13.6)	(13.1)
Proceeds on disposal of property, plant and equipment	0.0	0.0	0.0
Other cash flows from investing activities, e.g. expenditure or proceeds from Investments & Dividends			
Net cash inflow/(outflow) from investing activities	**(21.5)**	**(13.6)**	**(13.1)**
CF before Financing	**1.2**	**9.1**	**15.6**
Cash flow from financing activities			
Public Dividend Capital received	0.0	0.0	0.0
Public Dividend Capital repaid	0.0	0.0	0.0
Dividends paid	(5.4)	(5.6)	(5.9)
Interest (paid) on Loans and Leases	(2.3)	(2.3)	(2.2)
Interest (paid) on bank overdrafts and working capital facilities			
Interest received on Cash and Cash equivalents	0.1	0.1	0.1
Drawdown of Loans and Leases	0.0	0.0	0.0
Repayment of Loans and Leases	(3.0)	(3.2)	(3.0)
Other cash flows from financing activities			
Net cash inflow/(outflow) from financing	**(10.6)**	**(11.0)**	**(11.1)**
Taxes paid	0.0	0.0	0.0
Net cash outflow/inflow	**(9.4)**	**(1.9)**	**4.5**

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2012/2013

Medium Term Financial Plan: Extract from Long Term Financial Model

		Plan Mar-13	Forecast Mar-14	Forecast Mar-15
Units				
£m unless otherwise stated				
All amounts shown here are nominal				
Key Ratios				
Data				
Revenue		422.9	410.0	407.0
Revenue available for debt service		26.1	25.5	25.2
Annual dividend payable		5.4	5.6	5.9
Annual Debt Service		5.3	5.5	5.3
Annual Interest payable		2.3	2.3	2.2
Debt		35.2	32.0	28.9
PBC Ratios				
Dividend Cover		4.4x	4.2x	3.9x
Interest Cover		11.3x	11.1x	11.2x
Debt Service Cover		4.9x	4.6x	4.8x
Debt Service to Revenue		1.3%	1.3%	1.3%
Tier 1 Test	Limits			
Minimum Dividend Cover	1.0x	TRUE	TRUE	TRUE
Minimum Interest Cover	3.0x	TRUE	TRUE	TRUE
Minimum Debt Service Cover	2.0x	TRUE	TRUE	TRUE
Maximum Debt Service to Revenue	2.5%	TRUE	TRUE	TRUE
Tier 1 PBC ratio test passed		TRUE	TRUE	TRUE
Tier 2 Test	Limits			
Minimum Dividend Cover	1.0x	TRUE	TRUE	TRUE
Minimum Interest Cover	2.0x	TRUE	TRUE	TRUE
Minimum Debt Service Cover	1.5x	TRUE	TRUE	TRUE
Maximum Debt Service to Revenue	10.0%	TRUE	TRUE	TRUE
Tier 2 PBC ratio test passed		TRUE	TRUE	TRUE
Risk rating				
Metric				
EBITDA margin		6.2%	6.2%	6.2%
EBITDA, % achieved		100.0%	100.0%	100.0%
ROA		5.1%	5.1%	5.1%
I&E surplus margin		1.0%	1.1%	1.0%
Liquid ratio		22.1	15.9	15.9
Risk Rating				
Financial Risk Rating				
Metric				
EBITDA margin	6.2%	3	6.2%	3	6.2%	3
EBITDA, % achieved	659.4%	5	100.0%	5	100.0%	5
ROA	5.1%	4	5.1%	4	5.1%	4
I&E surplus margin	1.0%	3	1.1%	3	1.0%	3
Liquid ratio	22.1	3	15.9	3	15.9	3
Weighted Average		3.4		3.4		3.4
Financial Criteria						
Underlying Performance		3		3		3
Achievement of Plan		5		5		5
Financial Efficiency		4		4		4
Liquidity		3		3		3
Overriding rules						
One financial criterion scored at '1'	NO		NO		NO	
One financial criterion scored at '2'	NO		NO		NO	
Two or more financial criteria scored at '2'	NO		NO		NO	
Two or more financial criteria at '1'	NO		NO		NO	
PBC breached	1.0		1.0		1.0	
Less than 1 year as an Foundation Trust	YES	4	YES	4	YES	4
Overriding rules rating		4		4		4
Overall Rating		3		3		3
Risk Rating to calculate maximum debt to assets ratio		3		3		3
Maximum Debt/ Assets Ratio		15%		15%		15%

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Application of the Trust Seal to Leases at Sandwell and City Hospitals**
SPONSOR (EXECUTIVE DIRECTOR):	**Graham Seager, Director of Estates/New Hospital**
AUTHOR:	**Rob Banks, Head of Estates**
DATE OF MEETING:	**29 March 2012**

EXECUTIVE SUMMARY:

The Board is asked to agree the application of the Trust Seal to the following documents:

1. Lease for the letting of shop premises to WRVS at City Hospital
2. Lease for the letting of shop premises to WRVS at Sandwell Hospital

The principle terms of the leases are identical but with changes between each relating only to site specific matters.

The key terms are:

- Term – from completion until 31 March 2016
- Rent - £10,500 per annum, per site, exclusive (£21,000 total). The rent is reviewed annually by reference to RPI.
- The Tenant has the right to operate a mobile trolley service through the hospitals (as it currently does)
- There are restrictions on what the Tenant is able to sell (clauses 4.11.6 and 4.11.7)
- The leases are to be excluded from the protections of the Landlord and Tenant Act 1954
- There is a mutual break clause which will be on the third anniversary of the commencement of the lease exercisable on 6 months prior written notice

REPORT RECOMMENDATION:

The Board is recommended to approve the application of the Trust Seal to the following documents:

1. Lease for the letting of shop premises to WRVS and City Hospital

2. Lease for the letting of shop premises to WRVS at Sandwell Hospital

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
None specifically
PREVIOUS CONSIDERATION:
None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Estates Rationalisation Programme**
SPONSOR (EXECUTIVE DIRECTOR):	**Graham Seager, Director of Estates/New Hospital Project**
AUTHOR:	**Graham Seager, Director of Estates/New Hospital Project**
DATE OF MEETING:	**29 March 2012**

EXECUTIVE SUMMARY:

This paper describes the Estates Rationalisation programme planned for 2012/13 and the option appraisal which underpins it. It asks for board approval for the first phase of the programme namely declaring as non operational with no intended future use those buildings which are already closed.

REPORT RECOMMENDATION:

NOTE that Option 2 is the preferred option for estates rationalisation and is currently being implemented.

AGREE that the following buildings should be declared non operation with no intended future use from 31/3/12.

Site	Name	Area m2	Total Saving Per Block £
City	Sisters' Home	0	£28,773
Sandwell	Hallam Close Residential Block 4	765	£43,123
Sandwell	Hallam Close Residential Block 3	765	£45,721
Sandwell	Hallam Close Residential Block 2	765	£43,123
Sandwell	Hallam Close Residential Block 1	765	£43,123

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial	**x**	Environmental	**x**	Communications & Media	
Business and market share		Legal & Policy		Patient Experience	
Clinical		Equality and Diversity		Workforce	**x**
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Strategic Objective	**Annual Objective**	**Compliance of Estates Rationalisation Programme**
Good use of resources	Deliver CIP through the Transformation Plan TSP	As one of the cross cutting themes the programme has a target to deliver £709k of savings in 2012/13.
21st century facilities	Continue to improve current facilities	The Programme will deliver improvements to current facilities and will improve the efficiency of the current estate.
	Begin to procure a new hospital	The Programme will facilitate transition to the new ways of working proposed for the Midland Metropolitan Hospital (MMH)

PREVIOUS CONSIDERATION:

Considered by Strategic Investment Review Group

Report to Trust Board
Estates Rationalisation Programme

1. Introduction

The purpose of this paper is to gain Board support and approval of the scope, rationale and implementation of the Estates Rationalisation programme planned for 2012/13 and to gain their approval for the first step in the programme of declaring the first phase of peripheral buildings non operational with no intended future use. This is the first in a series of papers which will be issued each quarter to update the Board on the progress of the Estates Rationalisation programme and ask for approval to declare buildings closed in that quarter as non operational/ no future use.

2.Estates Rationalisation Programme 2012/13

During 2012/13 the Estates Rationalisation Programme aims to improve the efficiency of Trust estate by:

- Closing inefficient peripheral buildings to reduce the costs of capital charges, rates, energy and facilities management.

- Transferring staff offices into purpose designed facilities within other trust buildings to implement '*Agile Working'*across the Trust.

- Implementing a booking system for desks and meeting rooms to support the implementation of *'Agile Working'.*

- Transferring the following clinical services into more central locations to close inefficient peripheral buildings, improve utilisation of the estate, reduce costs as outlined above and deliver some clinical benefits:

  - *Sickle Cell and Thalassaemia service* to be transferred to a dedicated area on the main spine at City. This will improve access to pharmacy and other key services. It will also protect the distinctiveness of the service by retaining its own departmental area.

  - *Cardiac Rehabilitation* to be transferred to a new location to release costs as outlined above. The high risk patients will be relocated to a new area at City Hospital. The lower risk patients could be transferred to a community location or could transfer with the high risk ones. These proposals need to be developed fully taking space availability and future service into account. There is potential to improve patient care with the development of a community service as patients may be able to transfer to local gym membership with longer term health benefits.

  - *Community Physiotherapy and Hand services* to be transferred to a new location which will provide an improved environment for patient care since current facilities are very poor. The current assumption is that it will be on the Sandwell Hospital site.

  - *Diabetes Services at Sandwell Hospital* to transfer to new facilities and a new model of care provision which could lead to eventual transfer of appropriate activities to a community location(s)

- Developing an integrated Clinical Research Unit (CRU) to rationalise the estate used for research across the Trust. This will reduce costs for the separate clinical trials facilities; facilitate a multidisciplinary approach to clinical research; increase the profile of research in the organisation and may help to bring new research projects into the Trust.

- Improving the utilisation of the remaining facilitiesby consolidating services within central areas e.g.:

  - Transferring in-patient physiotherapy at City into Theatre 5 (from D22 which will be converted to agile working). This will provide a more appropriate and comfortable space for rehabilitation.

  - Transferring practical and simulation training for various disciplines, from various locations, into Theatre 4.

  - Transferring a range of elderly care clinics to the BTC and moving rehabilitation activities to appropriate settings to enable conversion of the space in the Day Hospital to agile working.

- Converting a range of facilities to agile working to maximise utilisation: e.g.:

  - Refurbishing part of Miller's Restaurant to agile working.

  - Converting the management block and the Department of Geriatric Medicine (DGM) building to agile working.

3. Strategic Context

a) Compliance with Trust Priorities

The strategic context for this business case is consistent with the Trust's Annual Plan as follows:

Strategic Objective	**Annual Objective**	**Compliance of Estates Rationalisation Programme**
Good use of resources	Deliver CIP through the Transformation Plan TSP	As one of the cross cutting themes the programme has a target to deliver £709k of savings in 2012/13.
21st century facilities	Continue to improve current facilities	The Programme will deliver improvements to current facilities and will improve the efficiency of the current estate.
	Begin to procure a new hospital	The Programme will facilitate transition to the new ways of working proposed for the Midland Metropolitan Hospital (MMH)

The case is consistent with the planning assumptions for Right Care, Right Here as follows:

- Services that could be delivered in community settings will be transferred away from acute sites.

- Maximal use will be made of all facilities.

- New ways of working that will be implemented in the MMH will be adopted in the rationalised estate.

b) Reasons for Proposed Change

Estates Costs for Peripheral Buildings

The main reasonfor the change is that the Trust has a fragmented site with many buildings that are no longer fit for purpose. This causes inefficiency and cost to the Trust which can be reduced to support achievement of the TSP. High level benchmarking with other large acute trusts indicates that the overall size of the SWBH estate is larger for its income and activity levels than many other trusts in this category.

In addition to cost savings the Board will also be aware that the Trust has targets to achieve in relation to carbon savings as detailed in the Board approved Carbon Management Plan (CMP). The Estates Rationalisation Plan will realise a significant proportion of these carbon savings.

The table below provides detail of the current annual recurring revenue costs of a number of peripheral buildings which have been considered for closure.

The savings are generated partly from reducing utilities, rates, facilities and maintenance costs. In addition by declaring the building will not be used again the capital charges can be eliminated.

Site	**Name**	**Area m2**	**Total Saving Per Block £**
City	Arden House - Cardiac Rehab	2,238	£162,764
	Doctors Annexe/Mill Court and associated buildings	632	£26,554
	Social Workers	194	£10,037
	Gynae Oncology Offices	739	£49,222
	Hospital Radio & SCAT	544	£50,525
	St. Stephen's House	119	£7,941
	Brookfield House	1,025	£61,691
	Trade Union Offices	71	£5,176
	Capital Projects	199	£10,629
	Transport Portacabin	32	£2,423
	Summerfield House	1,568	£94,614
	Ann Gibson	100	£20,316
	Hilda Lloyd	316	£23,342
	Security	182	£15,084
	Sisters' Home	0	£28,773
	Total	**7,959**	**£569,091**

Site	Name	Area m2	Total Saving Per Block £
Sandwell	Ante Natal	505	£59,498
	Dartmouth Clinic	371	£46,271
	Hallam Building – Physio	1,190	£95,459
	Hallam Building – Diabetes	1,076	£111,778
	Social Club	381	£26,822
	Hallam Building - Former Child Health	992	£82,637
	Hallam Building - Med Secs/Supplies	708	£50,778
	Hallam Close Residential Block 4	765	£43,123
	Hallam Close Residential Block 3	765	£45,721
	Hallam Close Residential Block 2	765	£43,123
	Hallam Close Residential Block 1	765	£43,123
	Total	**8,283**	**£648,333**
	Grand Total	**16,242**	**£1,217,424**

Note: There are a number of possible ways to close all or some of these buildings in 2012/13. These are described in detail in Section 4 below. All require a significant investment in alternative facilities to house the people and services therein. This has a capital charge / maintenance consequence which will reduce the achievable savings. It also requires capital to be available to invest.

Poor Utilisation of Office Accommodation

Office accommodation and meeting rooms are underutilised as demonstrated by utilisation studies undertaken across a range of buildings and departments on both City and Sandwell sites. The table below shows the combined results of surveys undertaken in 2010 and 2011.

Function	Quantity Surveyed	Average Utilisation	Minimum Unused (%)	Minimum Unused (Number)
Desks	1065 (City 614) (Sandwell 451)	40.3%	48.9%	521
	60	34.2%		19 rooms

Inconvenience of Geographical Separation of Facilities

Staff often have to travel significant distances across the site to get to and from their office accommodation and clinical bases. For example the cardiologist's offices are in Arden House.

Clinical Issues for Resolution: SCAT

The Sickle Cell and Thalassaemia (SCAT) service is based in an old building on the periphery of the estate. This building is of poor quality, is heated by steam, suffers from security issues requiring bars at the windows and does not provide a good environment for patient care.

The building is distant from the main spine meaning that patients have to walk a considerable distance to pharmacy and will require transport by ambulance if they need to be admitted.

Clinical Issues for Resolution: Poor Quality of Estate

The Community Physiotherapy and Hand Therapy Services are provided from the Hallam building at Sandwell Hospital. High levels of activity are delivered from poor quality facilities with impact on privacy and dignity. Activity figures for 2009/10 are presented in the table below.

Activity Type	**Contacts**
Musculo-skeletal	17,864
Hand therapy	3,098
Total activity	20,962

Other community physiotherapy and clinical nurse specialist activity is undertaken in this area (scope as yet unknown), sharing facilities and maximally utilising the space available. Activity overflows into the Diabetes Centre during periods of high activity.

Clinical Issues for Resolution: Eventual Service Transfer to Community Location

The Diabetes Service at Sandwell Hospital is being considered for eventual transfer to a community location in line with the principles of Right Care, Right Here.

4. Planned Outcomes and Benefits

Benefits	**Achieved by when**	**How will it be measured**	**Review Date and Forum**	**Lead Director**
Better utilisation of estate City	01/07/12	Reduction in m2 occupied	Space Utilisation Group	Graham Seager
Better utilisation of estate Sandwell	01/01/13	Reduction in m2 occupied	Space Utilisation Group	Graham Seager
Increase in utilisation of desks in agile working areas	01/07/12 & 01/01/13	Occupancy calculated from booking system compared to 2011 surveys	Space Utilisation Group	Graham Seager
Increase in utilisation of meeting rooms	01/07/12	Occupancy calculated from booking system compared to 2011 surveys	Space Utilisation Group	Graham Seager
Fewer clinical staff located in peripheral buildings	01/07/12	Number of clinical staff moved out of peripheral buildings	Space Utilisation Group	Graham Seager
SCAT patients closer to main	01/07/12	Patient attendances	Space	Graham Seager

spine services (safety / patient experience)		moved out of old SCAT building	Utilisation Group	

5. Options

To determine the best solution, the project team have conducted an option appraisal and submitted the appraisal to SIRG. This section summarises that appraisal.

Development of Options

In formulating the options to compare, there are a number of different factors to consider.

1. Which buildings should close
2. How and where to provide sites for agile working
3. What the telephony/voice solution may be to enable agile working
4. What the IT/data solution may be to enable agile working
5. What the best available solution for relocation of each of the clinical services may be
6. What the best solution for the research facility may be

There are clearly an infinite number of options which could be tested against each other so to be practical we have taken a staged approach to developing the options in this case.

Which buildings should close

The buildings listed in the table in section 2b above are the older buildings, generally in poor condition, and generally on the periphery of each site. To increase utilisation of the estate it seems sensible to close as many of these as possible given the limitations of capital and the sites which are available to accommodate the people and services who are displaced. Closing peripheral buildings also allows the site infrastructure services to be reduced, for example long external pipeline services such assteam, heating and hot water can be isolated, saving energy and further reducing our carbon footprint.

How to provide sites for agile working

In June 2011 Holbrow Brookes conducted an option appraisal for the Trust on the most economic way of re-providing office accommodation to facilitate estates rationalisation,

The report is available on request.

They examined a number of options:

- **Option 1** - Utilisation of the existing Catering Production Unit (CPU) at City Hospital.

- **Option 2** - Development on existing Estate of offices using “modular” building solutions.

- **Option 3** - Utilisation of the existing (Post Graduate) Education Centre at Sandwell DGH.

- **Option 4A** - Utilisation of the existing Maternity Unit at Sandwell DGH to provide offices;

- **Option 5** - Development / redevelopment by the Trust of part of the existing Trust’s Estate to provide new build offices.

- **Option 6** - Development / redevelopment by a third party / private developer of part of the

existing Trust's Estate to provide new build offices on a "Sale and Leaseback" arrangement.

- **Option 7 -** Off site rented solution

They developed costs for each option considering the cost of provision and the service costs over 30 years.

A summary is included in the table below.

Option	Cost per work station over 30 years	Service Costs per work station over 30 years	Combined costs per work station over 30 years
Option 1 – CPU (City)	£19K	£12K	£31K
Option 2 – Modular (on Trust Land)	£25K	£12K	£37K
Option 3 – PGMC at Sandwell (light touch)	£17K	£12K	£29K
Option 4a – Convert Sandwell Maternity	£24K	£12K	£36K
Option 5 – Traditional New Build (on Trust Land)	£29K	£12K	£41K
Option 6 – As Option 5 but sale and leaseback	£33K	£12K	£45K
Option 7 – Rent from Private Sector	£42K	£24K	£66K

Whilst the options considered by Holbrow Brookes do not directly relate to the options in this business case, it can be seen from this that the options of provision in new build or rented accommodation exceed the costs in converted accommodation.

A simple example demonstrates that this holds for current plans even in a building with a five year life. A ward costs about £100k to convert (excluding IT and furniture) and holds about 40 desks. The cost of provision of one desk for the five years period involved is therefore £4,500 (£2.500 initial capital plus £2,000 service charge). From the table above the costs of renting a desk from the private sector for five years would be £11,000

In addition provision of new space in new build, rental or currently unused buildings does not fulfill the objective of increasing estate utilisation within the current foot print of the Trust.

We have therefore excluded the option of external rental from this business case.

Where to provide sites for agile working

The location of *Agile Working* areas and relocated clinical services depends on availability of space. On City site we are currently making the following assumptions for agile working areas:

- Management Block
- Millers Restaurant (Part)
- D22

- D24
- D29
- Sheldon day hospital
- Sheldon D46
- DGM building

Currently there is no certainty that these wards will be the ones which are available to convert, but there is a high probability that at least this amount of space will be available after all the TSP plans are agreed. The precise location of the *Agile Working* spaces is not critical and the costs of conversion of one ward is not likely to be significantly different to another hence although this case is based on the locations listed, it is unlikely to be materially changed if the location changes although it will be if the number of locations changes.

On Sandwell site we are currently assuming that *Agile Working* areas will be provided in the old maternity building.

Sandwell site is complicated by the potential need to provide *Agile Working* accommodation for staff displaced due to the Sandwell Ward Block Improvement Project. No account is taken of this requirement in this business case, but it should be noted that if this case does not result in approval there will be increased cost to the Sandwell Ward Block Improvement project to provide traditional office space for the people coming out of the wards.

What the voice/telephony solution may be to enable agile working

To work most efficiently in an *Agile Working* environment, it is essential to provide a solution which allows users to log in at any desk and receive their phone calls and voice messages there. Modern telephone installations are based on Voice Over IP (VOIP) solutions which incorporate these functions as standard.

The Trust anticipates installing VOIP in the MMH and, even if the MMH does not happen, will at some time in the next five to ten years have to replace its current telephone system (probably with a VOIP system) as it becomes obsolete and uneconomic to maintain. This is in the ten year capital plan as part of the equipment identified for MMH.

At this point in time however there is still an option to utilise some basic functions in our current switchboard which allow calls to be diverted to any phone to enable agile working.

This requires increased infrastructure (cabling costs) when compared with VOIP but overall is less expensive as VOIP would have impacts both in purchase of licences and ongoing maintenance.

The functionality would be less than VOIP and we there is a risk we would be “wasting” money on old technology which would in any case need to be replaced in a short period.

To assess the difference in costs we have included options to implement agile working with VOIP and without VOIP.

What the IT/data solution may be to enable agile working

To work most efficiently in an agile working environment, it is essential to provide a solution which allows users to log in at any desk and seamlessly access their own desk top, files and user programmes. There are three potential methods of providing this access.

- All PCs in agile working areas could be configured with the profile of any user who may use them. This is impractical in terms of IT resource to install and maintain and has not been considered further.
- All users could be issued with laptops and desks provided with screens, keyboards and docking stations.
- All users could access systems under a Virtual Desktop (VDI) emulator which means that current PCs could be utilised acting as thin clients. This solution would take some time to implement and test for all programmes used by trust employees.

A comparison of the costs of solutions 2 and 3 show that the VDI solution is the least expensive per unit at £531 per pc (based on 500 pcs) versus £750 for a laptop. In addition it only has to be implemented on the agile working desktop PCs (approximately 600) whereas laptops would need to be supplied for all 900 agile working users. Therefore VDI has been assumed in the *Agile Working* options in this business case although a mixed economy for people who already have laptops has not been ruled out.

To assess whether the investment in IT needed for *Agile Working* is value for money we have included an option for people to be transferred to new refurbished office space but working in a traditional way, one person per desk. Since the supply of space which can be refurbished is limited this means that fewer buildings can be closed under this option but there are no increased IT costs.

What the best available solution for relocation of each of the clinical services may be

The main driver for moving each of the clinical services has been that the building where they currently reside needs to close.

We have therefore not completed individual business cases for each service and our principle has been that they will be relocated to the most appropriate available location. Since available locations are not abundant this severely limits the choice available. We have therefore included a set of assumptions as to location and associated costs which may be amended over time in the same way as the agile working assumptions may change.

Proposals are still being worked up with the clinical teams, but current assumptions are as follows:

- The Sickle Cell and Thalassaemia Centre (SCAT) will benefit from being moved to a new location on the main spine because of the poor condition of the current building and the benefits of being closer to key services. A range of options have been considered and will be taken into account as part of the Divisional approval process. The best approach currently seems to be to move the service into the Discharge Lounge, which will be refurbished to make it fit for purpose. This is a smaller facility than the current building, but there is good potential to build some clinical and patient experience improvements into the design.
- The Cardiac Rehabilitation service, currently situated in Arden house, will need to be relocated. Proposals for this are still being developed, but will involve a move to an exercise facility at City Hospital and eventual transfer of the lower risk patients to the community.
- Planning for the relocation of the Diabetes service at Sandwell has been initiated. Some of the specialist consultant clinics may be relocated to the Sandwell Out-patient Department. Other parts of the service will eventually transfer into the community. It is unlikely that there will be a requirement for permanent dedicated clinical space to be developed for this service.
- The Community Physiotherapy and Hand Service will need to be moved from the current poor facilities in the Hallam Building to a new location. The current assumption is that space will be refurbished on the Sandwell Hospital site for this service. However, this will

need consideration in the context of Divisional plans and the pressure on the estate at Sandwell.

What the best solution for the research facility may be

The University Department of Medicine is based in the Ascot Building, which is identified for closure in the Estates Rationalisation Programme. This department undertakes clinical trials, translational research and other research activities. Clinical activity also takes place for those patients currently taking part in research studies.

Research currently takes place in a number of locations around the Trust and some of these buildings are currently identified for closure or may be in future.

Ophthalmology currently has two small research rooms which are also used for clinical activity. The Directorate has made a case for the development of a larger dedicated research facility in line with what might be expected for a regional ophthalmology unit of high statusnationally.

It is proposed to develop an integrated Clinical Research Unit (CRU) where the disciplines will work together in space that can be booked for their specific research activities. The CRU will provide a suite of clinical rooms, most of which will be generic, but some of them accommodating specialist equipment. The model for this is still under development but the key research leads have endorsed the vision to date which has potential to raise the profile of research in the Trust. A brief is being developed and a separate option appraisal is being undertaken to identify the best location for this facility on the City Hospital site. The outcome of the appraisal may have an effect on the areas free to develop for agile working.

Options Selected for Appraisal

As a result of our consideration of the factors outlined above, we have developed four options to assess. The options we have considered are as follows:

Option	Description
1	**Do nothing** -encompasses declaring as surplus buildings on both sites which are already empty which will yield savings in capital charges.
2	**Agile Working full VOIP.** Closure of all peripheral buildings in table 1. Transfer all office workers in those buildings to agile working locations in refurbished accommodation on City / Sandwell site. Provision of full VOIP services. Provision of “Virtual desktops” allowing staff to work at any PC. Transfer all clinical / education services to new locations. Introduce new meeting room booking systems to increase utilisation / compensate for reduction in meeting and training rooms.
2a	**Agile Working minimum telecoms.** Closure of all peripheral buildings in table 1. Transfer all office workers in those buildings to agile working locations in refurbished accommodation on City / Sandwell site. Provision of minimum “follow me” phone services. Provision of “Virtual desktops” allowing staff to work at any PC. Transfer all clinical education services to new locations. Introduce new meeting room booking systems to increase utilisation / compensate for reduction in meeting and training rooms.
3	**Traditional Working.** Closure of less peripheral buildings (table 1 excluding Arden, Ascot and Hallam) and accommodation of office workers in those buildings in refurbished areas in City / Sandwell maintaining current working practices (one desk per person). Fewer clinical / education facilities are affected but those that are are transferred to new locations. Introduce new meeting room booking systems to increase utilisation / compensate for reduction in meeting and training rooms.

It may be possible to accommodate some senior managers who currently have laptops and mobile phones in *Agile Working* areas without any new technology. This raises the possibility of a variation on

option 3 which allows more people to be transferred to centralised offices than there are desks available. This option has not been fully worked up because of lack of data on suitable personnel.

6. Non Financial Option Appraisal

Benefit Description	Option Scores			
	Option 1	Option 2	Option 2a	Option 3
Better utilisation of estate City	0	5	5	2
Better utilisation of estate Sandwell	0	5	5	1
Increase in utilisation of desks in agile working areas	0	5	5	0
Increase in utilisation of meeting rooms	0	5	5	3
Improvement in carbon target measures	0	5	5	1
Fewer clinical staff located in peripheral buildings	0	5	5	1
SCAT patients closer to main spine services (safety / patient experience)	0	5	5	5
Total Score	**0**	**35**	**35**	**13**

7. Estimated Capital Cost and Funding

All costs, including individually specified items of equipment, are inclusive of VAT where this is applicable.

Expenditure/Funding Item	Option 1 £000s	Option 2 £000s	Option 2a £000s	Option 3 £000s
Expenditure:				
Land				
Buildings		1,654.5	1,654.5	907.7
Furniture & Equipment		300.0	300.0	150.0
IT and Voice		970.0	834.0	398.2
Design Fees				
Other				
Total Expenditure	**0**	**2,924.5**	**2,788.5**	**1455.9**
Funding:				
External Grants				
Other Externally Generated Funds				
Specific Capital Allocation (specify)				
Trust Capital Programme		**2,924.5**	**2,788.5**	**1455.9**
Charitable Funds				
Other (specify)				
Total Funding	**0**	**2,924.5**	**2,788.5**	**1455.9**

8. Estimated Revenue Costs and Income (Full Year Effect)

Income/Expenditure Item	Option 1 £000s	Option 2 £000s	Option 2a £000s	Option 3 £000s
Income:				
Patient Related SLAs				
Non Patient Related (specify)				
Other (specify where significant)				
Total Income	**0**	**0**	**0**	**0**
Costs				
Pay				
Other Running Costs (specify where significant)				
Maintenance Costs (specify where significant)		40.0		
Overheads (specify where significant)*				
Depreciation and cost of financing		434.0	419.1	219.2
Other (specify where significant)				
Total Expenditure		**474.0**	**419.1**	**219.2**
Costs Saved:				
Pay (specify)		127.6	127.6	39.9
Non Pay (rates , utilities and estates/ facilities non pay)	19.1	347.8	347.8	132.8
Capital Charges	184.7	742.0	742.0	382.2
Total Costs Saved	**203.8**	**1217.4**	**1217.4**	**544.9**
Net Income/(Cost) of Proposal	**203.8**	**743.4**	**798.3**	**335.7**

9. Staffing Numbers (Full Year Effect)

The savings for option 2/2a assume a reduction that the closure of the buildings will allow the estates and facilities departments staff on both sites to be reduced. This is likely to involve in total between 5 and 6 staff.It is assumed this can be managed through natural wastage.

The estates rationalisation programme may enable some subsequent staff reductions through integration and the flexibility created by agile working. No assumptions have been made for this in the savings plan.

10. Investment Appraisal (Capital Cases and Mixed Schemes where Capital Investment is over £50,000)

Measure	Option 1 £000s	Option 2 £000s	Option 2a £000s	Option 3 £000s
Payback	0	3.93	3.49	4.34
Payback excluding increased capital harges	0	2.48	2.29	2.62
Payback excluding capital charge savings delivered in Do Nothing option	0	5.42	4.69	11.05
Rate of Return	n/a	25.42%	24.75%	17.6%
Rate of return excluding savings delivered in do nothing option	n/a	18.45%	21.32%	9.05%
Net Present Value (NPV) [Discounted Cash Flow at 6% over 10 years]	n/a	169.42	573.88	-218.95
Equivalent Annual Cost (EAC)	n/a	n/a	n/a	n/a

11. Risk Assessment and Management

Risk	Option Scores (Probability x Impact)				Mitigation
	Option 1	Option 2	Option 2a	Option 3	
That savings agreed will not be made	5x5	3x5	3x5	5x5	O1: Make other savings within Estates and transfer savings targets to other Divisions O2: Robust project management and management of TSP dependencies O2a: Robust project management and management of TSP dependencies O3: Make other savings within Estates and transfer savings targets to other Divisions
That staff may not want to move to agile working – leading to barriers to implementation	N/A	3x2	3x2	1x2	O2,2a and 3: Engagement programme and senior leadership supporting changes
That the scale of changes may impact on operations in the context of the wider TSP	N/A	3x3	3x3	2x3	O2,2a and 3: close working with other TSP activities to manage pressure across whole programme
Complexity and cost of developing suitable new facilities to enable transfer reduces benefits available	N/A	3x4	3x4	5x4	O2: Continue to refine planning through engagement process and with other TSF programmes O2a: Continue to refine planning through engagement process and with other TSF programmes O3: Find ways of sharing desks within staff comfort zone and plan longer term efficiencies
That telecoms does not support working in the new environment and / or follow me technology may not work	N/A	1x5	3x5	5x2	O2: Careful implementing and testing of new system O2a: Careful implementing and testing of new system O3: Staff will need to use allocated desks, cannot use follow me technology

Risk	Option Scores (Probability x Impact)				Mitigation
	Option 1	Option 2	Option 2a	Option 3	
That the complexity of installing virtual desktop may delay the programme.	N/A	3x2	3x2	N/A	Careful project planning and provision of additional resource to IT

12. Preferred Option

Option 2 (Agile Working) full VOIP is the preferred option.

Option 1 requires no capital investment, some savings are delivered but insufficient to meet the target for 2012/13. No increased utilisation of the estate is delivered and the Trust does not move towards the ways of working anticipated in the MMH. Option 1 is therefore excluded.

Option 3 delivers much lower savings than either Options 2 or 2a and has a much longer payback period. The payback period on option 3 excluding the do nothing savings is over 11 years, which is longer than the expected life of some of the assets being refurbished if MMH goes ahead. The NPV of Option 3's cash flow is still negative on a 10 year timeline whilst Options 2 and 2a have a positive value. From an investment appraisal point of view therefore Option 3 is significantly worse than either Option 2 or 2a.

In addition Option 3 does not increase the utilisation of the estate as much as either Option 2 or Option 2a and does not move the Trust towards the ways of working anticipated in the MMH. Option 3 is therefore excluded.

Option 2 and 2a deliver both deliver fye savings in excess of the £709k target for estates rationalisation in year 1. The payback period and rate of return is acceptable. They increase utilisation of the Trust's estate and move the Trust towards ways of working anticipated in MMH.

Option 2 is more expensive than Option 2a as it requires £136k more capital than Option 2a as an initial investment and has maintenance charge consequences.

However £300k of the capital investment in Option 2 relates to VOIP which brings forward an investment the Trust had already planned to make prior to moving to the MMH and will need to make in any case as the current telephone technology becomes obsolete. It seems sensible to make that investment now (reducing the amount required in future years) rather than make a significant investment in old technology which will have to be replaced in a relatively short time. Option 2 is therefore preferred over Option 2a.

13. Cashflow Phasing of Preferred Option

	Current Year (include Part Year Effect) (specify) £000s	Year 2 (specify) £000s	Year 3 (specify) £000s	Year 4 (specify) £000s	Year 5 (specify) £000s	Subsequent years £000s
Capital Expenditure (-)	-586.74	-2337.71				
Income (+)						
Revenue Expenditure (-)		-40.00	-40.00	-40.00	-40.00	-40.00
Cost Savings (+)		295.50	475.41	475.41	475.41	475.41
Net Cash Flow (+/-)	**-586.74**	**-1902.29**	**435.41**	**435.41**	**435.41**	**435.41**

14. Proposed Timetable

Expected Date of Commencement of Work: 20/03/12 (D29)

The hardware to implement VOIP and VDI has been procured. VOIP is planned to be up and running by 30/4/12. A feasibility study to determine the implementation plan for VDI will be complete by 31/3/12.

Expected Date of Completion of Work: 31/12/12

Other Key Dates: City Hospital Buildings closed by 30/6/12
Sandwell Hospital Buildings closed by 31/12/12

15. Additional Notes

The implementation of *Agile Working* on this scale will affect circa 1000 Trust employees. Some will find it a considerable benefit, but many will have difficulty adjusting to changed ways of working. This may give rise to some difficulties during the implementation period.

There are some key dependencies that will impact on the success of this proposal:

- Progress and clarity of other TSP programmes to give certainty regarding which buildings will be available for closure / refurbishment.
- The Sandwell Ward Block Improvement Programme will put additional pressure on the requirement for agile working capacity at Sandwell.
- Medium / long term intentions for services for example commissioning / TSP objectives for Diabetes
- The outcome of an option appraisal for the delivery of an integrated clinical research model
- The outcome of current reconfiguration projects nearing completion e.g. Stroke and Vascular

16. Conclusion

The financial and qualitative analysis show that Option 2 (Agile Working – full VOIP) is the preferred option. This option delivers fye savings of £743.5k which is in excess of the 2012/13 estates rationalisation target of £709k. It requires a total capital spend of £2.92 m.

Our current plan is based on converting one location and making initial investments in IT in 2011/12 for a total of c £587k with the remaining investment required in 2012/13. The target is to close the City buildings by 30/6/12 and the Sandwell buildings by 31/12/12 releasing part year savings in 2012 of £422k. This is however dependent on certainty of the available locations being available in the near future and on the successful implementation of a VDI solution and if the programme slips this amount will be reduced.

The project team are as far as possible making progress by converting those spaces over which there is least doubt e.g. D29

17. Recommendation

Trust Board are asked to:

APPROVE Option 2 as the preferred option and allocate capital resources to undertake the option..

AGREE that the following buildings should be declared non operational with no intended future use from 31/3/12.

Site	**Name**	**Area m2**	**Total Saving Per Block £**
City	Sisters' Home	0	£28,773
Sandwell	Hallam Close Residential Block 4	765	£43,123
Sandwell	Hallam Close Residential Block 3	765	£45,721
Sandwell	Hallam Close Residential Block 2	765	£43,123
Sandwell	Hallam Close Residential Block 1	765	£43,123

NOTE the intention to bring a further paper to the June 2012 Board and quarterly thereafter to report progress and to gain approval for buildings closed in the quarter to be declared non operational.

Graham Seager
New Hospital Project Director and Director of Estates

19th March 2012

C

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Development of Endoscopy unit at Sandwell to meet latest standards for decontamination and JAG accreditation
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Barlow, Chief Operating Officer
AUTHOR:	Bethan Downing/Mike Beveridge/Paul Scott
DATE OF MEETING:	29 March 2012

EXECUTIVE SUMMARY:

This is a joint Business Case developed by both Surgery A & Medicine, prepared in conjunction with the Capital Projects – Endoscopy Services Feasibility Report (Appendix 1), to develop and improve Endoscopy Services and ensure compliance with National Decontamination & JAG (Joint Advisory Group) requirements.

The main drivers of this Business Case are to ensure the Unit on the Sandwell site meets requirements for JAG Accreditation, including compliance with National Decontamination standards, the latest standards on Privacy and Dignity Standards, and to improve service continuity.

The current washers have a short life span and are regularly breaking down. This causes operational service impact and is a risk to business continuity going forward. The current facility does not meet JAG accreditation standards. The Trust is due to be inspected at the end of 2012. Investment is required to meet the standards improve service provision and meet the required standards. Failure to meet accreditation standards could lead to service closure.

The key areas for consideration in this business case are:

- The relocation of decontamination facilities to 2nd Floor (Sandwell Site)
- The development of the area within Endoscopy to improve patient flow and compliance With Privacy and Dignity standards
- Improved Business Continuity within Endoscopy Services.
- The purchase of new decontamination washers and dryer cabinets for Endoscopy
- The purchase of additional scopes

The preferred option 6 requires a capital investment of £1,660,796, and a net recurrent revenue investment of £210,000 in year 1.

REPORT RECOMMENDATION:

Recommendation: The Board is asked to approve investment in the recommended Option 6.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial	**x**	Environmental	x	Communications & Media	x
Business and market share		Legal & Policy	x	Patient Experience	x
Clinical	**x**	Equality and Diversity		Workforce	
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

- Accessible and responsive care
- High quality care
- Risk register rating
- CQC essential standards: cleanliness and infection control, care and welfare of patients who use services

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Standard Business Case Proforma
Final version v3.2

TITLE	**Development of Endoscopy unit at Sandwell to meet latest standards for decontamination and JAG accreditation**
PROPOSED BY	**Surgery A & Medicine**
SPONSOR	**Mike Beveridge/Mark Anderson**
AUTHOR	**Bethan Downing (Deputy Divisional General Manager – Surgery A)**
DATE	**March 2012**

This is a joint Business Case developed by both Surgery A & Medicine, prepared in conjunction with the Capital Projects – Endoscopy Services Feasibility Report (Appendix 1), to develop and improve Endoscopy Services and ensure compliance with National Decontamination & JAG (Joint Advisory Group) requirements.

The main drivers of this Business Case are to ensure the Unit on the Sandwell site meets requirements for JAG Accreditation, including compliance with National Decontamination standards, the latest standards on Privacy and Dignity Standards, and to improve service continuity.

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2. Strategic Context

a) Compliance with Trust Priorities

This Business Case ensures the proposed changes to the existing service meets all or most of the Trust's strategic priorities, and is compatible with the Trusts plans for the retained estate programme.

Trust Objectives

Accessible & Responsive Care

Endoscopy services will be accessible and responsive by continuing to be provided at both Sandwell and City sites. Investment in modern reliable high quality equipment will ensure services run at optimum utilisation, reduce the risk of hospital cancellations, and thereby maintain waiting times within current standards for diagnostic and therapeutic procedures.

Safe High Quality Care
Care will be delivered in a safe, modern environment, which improves privacy and dignity for patients and uses the latest technology in decontamination and traceability of scopes.

Care Close to Home
Endoscopy Services will continue to be delivered at both City and Sandwell Sites providing services to the local communities, in line with RCRH.

Good Use of Resources
Purchase of four new decontamination washer machines and dryer/storage cabinets, as part of dedicated decontamination facility at Sandwell, will provide greater reliability, reduced breakdowns and loss of activity, and increased opportunity to ensure value for money on consumables through standardisation.

21st Century Facilities
Care will be delivered in a safe, modern environment that improves privacy and dignity for patients. Modern washer, dryer and storage technology will be installed in a dedicated decontamination facility that complies with latest standards, that supports increased business continuity.

An Effective Organisation
The new layout of the Endoscopy Unit will improve patient flow and separation of pre and post op patients, within same sex compliant facility, contributing towards overall effectiveness of the service.

b) Reasons for Proposed Change

The changes are being proposed to achieve decontamination requirements, improvements in privacy and dignity, health and safety and JAG Accreditation to enable the unit to continue to provide Endoscopy Services. Failure to comply with the Accreditation Standards could result in services being removed from the Trust impacting on waiting times, loss of income and our ability to provide core services.

To achieve JAG Accreditation the following must be addressed:

i) Three of the four existing endoscopy decontamination washers are in excess of 10 years old and the fourth is 4 years old (the latter has had 16 breakdowns in the last 18 months). None of the four are reliable due to breakdowns and in the case of the older ones, failure in quality of water testing. As a consequence, operational pressures are increased including patient cancellations and non-achievement of diagnostic waiting times. The continued or increasing impact is a risk to the service and unsustainable in terms of business continuity moderate to long term.

ii) Eliminate the risk of using equipment that has not been cleaned by avoiding cross over of clean and dirty flows in the department.

ii) Segregation of male and female patient flows along with separation of pre and post procedure areas.

iii) Eradication of the use of glutealdehyde to meet health and safety requirements (currently used in 3 of the machines)

iv) Safe storage of flammable substances

In addition:-
i) The Choice Framework for Policy and Procedures is in the consultation phase. Trusts will be required to achieve a number of minimum standards which are presently not achieved.

ii) As part of the RCRH retained estate refurbishment programme the solution should provide an interim solution to the final solution and which avoids unnecessary capital expenditure.

iii) There is the potential to expand both the decontamination facilities and the endoscopy capacity to meet future clinical changes in practice.

The purchase of two additional cystoscopes and two gastroscopes will be required to ensure sufficient instrumentation to manage the extended delivery and collection times as a consequence of transfers between the endoscopy unit and decontamination facility.

The endoscopy decontamination facility will relocate to the 2nd floor (previous TSSU area) where the separating of dirty and clean flow of instrumentation can be achieved. This will require investment in staffing (1.2 WTE Band 2) to transport scopes between the decontamination area and the Endoscopy Unit (Sandwell Site), as well as the purchase of scope trolleys to transport the scopes safely in accordance with current standards.

This feasibility case for capital projects is attached (Appendix 1).

3. Planned Outcomes and Benefits

Benefits	Achieved by when	How will it be measured	Review Date and Forum	Lead Manager
Decontamination and traceability requirements achieved.	Jan 2013	Achievement of JAG accreditation.	Jan 2013	Bethan Downing/Warren Chapman
JAG Accreditation achieved along with maintenance of junior doctor training, commissioning confidence, income, Trust reputation and opportunity of new income.	Jan 2013	Achievement of JAG accreditation.	Jan 2013	Bethan Downing/Warren Chapman
Maintain Bowel Screening Status.	Jan 2013	Achievement of JAG accreditation.	Jan 2013	Bethan Downing/Warren Chapman
Fully meet privacy and dignity requirements.	Jan 2013	Achievement of JAG accreditation. Local audit.	Jan 2013	Bethan Downing/Warren Chapman
Improved Business Continuity.	Jan 2013	Reduction in cancelled procedures and additional sessions.	Jan 2013	Bethan Downing/Warren Chapman
Achieves the objectives of the retained estates programme.	Jan 2012	Now forms part of the revised feasibility for the Sandwell Community Hospital.	TBC	Angela Thomas/ Richard Kinnersley

4. Options

The options below are a summary of the short listed options considered. A clinical panel reviewed a long list of options outlined in the capital projects feasibility report (Appendix 1 pages 13-14), recommending options 1.6 and 7 be considered within this case.

Option	Description
1	Do Minimum – within this option the 4 endoscope washers are replaced, but no alterations are carried out on the estate.
6	Permanently transfer the decontamination facilities to the 2nd floor old TSSU area. Use the vacated space of decontamination and the lab with reconfiguration of adjacent areas, to support resolution of patient privacy and dignity issues. As part of the final solution relocate the endoscopy unit to the 1st floor theatres block post MMH. Investment into two additional cystoscopes and two gastroscopes, will be required to ensure sufficient instrumentation to manage the extended delivery and collection times as a consequence of transfers between the endoscopy unit and decontamination facility. In addition, an additional 1.2 WTE HCA will be needed to support the transfer of scopes between departments.
7	Fully refurbish the endoscopy unit and expand into the OPD area currently used by ENT and Oncology. Decant ENT to Medical Records and Medical Records to an alternative location.

5. Non Financial Option Appraisal

Short Listed Option Appraisal For Endoscopy and Decontamination Facilities – 24th November 2011	Option 1	Option 6	Option 7
Decontamination requirements and reduce all associated risks to staff and patients.	0	5	5
Standards required to achieve JAG accreditation.	0	5	5
Maintain Bowel Screening Status and the opportunity to become a pilot site for flexible sigmoidoscopy screening.	0	5	0
Timetable of delivery acceptable to JAG.	NA	5	0
Maintenance of service flexibility to respond to increases in demand and expansion in service.	0	5	5
Fully meet patient privacy and dignity without impacting on efficiency including pre and post procedure.	2	5	5
Fully addresses bronchoscopy requirements up until MMH opens.	0	0	5
Avoids unnecessary capital expenditure.	5	5	3
The Trusts and RCRH objective of providing care closer to home, in facilities fit for the 21st Century and in support of the MMH.	1	4	5
To be in a position to deliver against the choice framework.	0	5	5

Provides an acceptable solution for the oesophageal lab.	5	4	5
Achieve the objectives of the retained estates programme.	0	5	5
Scoring for Stage 1	13	53	48

Stage 2

A further high level appraisal was completed for the three options, as outlined below. The capital and revenue consequences of each can be found under sections 6 & 7, and appendix 1.

Option 1

Project Timeframe: 28 weeks (inclusive of 'settling' period of machines)

Design Solution Limitations: It would not be possible to work around the machines due to the constraints of the environment and therefore an alternative decontamination location is required as a temporary measure. This will increase the project timeframe whilst the machines within the area undergo a settling period which will be up to 3 months.

Design Solution Opportunities: None identified

Business Continuity Requirements: During the period of works, it will be necessary to relocate the entire service as utilities will need to be shut off. Therefore, it will be necessary to hire a temporary decontamination unit at a cost of £13,000/unit/ week based on a 6 month contract (costs will be higher per week if for a shorter period).

To support male and female segregation, 2 units will be required for the duration at a cost of £728,000. The units will provide capacity for 50% of the current of activity therefore a 3 session day will be required to maintain 75% of activity with some transfer of activity to City.

Maintenance of activity will require micro-management of lists and rectal clinics relocated to an alternative location. The latter is still to be identified pending the outcome and timescale of other projects.

Option 6

Project Timeframe: 34 weeks (includes 3mths settling period)

Design Solution Limitations: Minimal disruption whilst undertaking upgrade as work undertaken around the service.

Design Solution Opportunities: Location of machines allows future expansion if required as does the final location of the unit.

Business Continuity Requirements: There will be minimal impact on activity during the 10 week period when work is undertaken within the endoscopy unit as there will be limited disruption and no full close down being required. Close management of sessions will be required although at a lower level and shorter period of time.

Option 7

Project Timeframe: 69 weeks (includes refurbishment of medical records)

Design Solution Limitations: Once completed there will be no opportunity for future expansion of rooms or machines

Design Opportunities: None identified

Business Continuity Requirements:
For a period of 36 weeks when work is carried out within the unit It will be necessary to hire a temporary decontamination unit at a cost of £13,000/unit/ week based on a 6 month contract (costs will be higher per week if for a shorter period).

To support male and female segregation 2 units will be required for the duration at a cost of £936,000. The units will provide capacity for 50% of the current of activity therefore a 3 session day will be required to maintain 75% of activity with some transfer of activity to City.

Maintenance of activity will require micro-management of lists and rectal clinics relocated to an alternative location. The latter is still to be identified pending the outcome and timescale of other projects.

Enabling Works : Refurbishment of the medical records area would be required, identification of a strategy for HCR, space to relocate, additional capital expenditure if location identified or significant increase in revenue requirements (both dependent on strategy and options identified for HCR).

Whilst an appraisal criteria had been developed, the clinical team did not feel it was required as the level of disruption to service and costs were too high to pursue option 7. This Option 7 scored lower than option 6 in stage 1 and has an extended timeframe. The addition of design, impact on service and costs was considered to create a much wider differentiation between options 6 & 7 with option 6 continuing to be the highest scoring.

As a consequence, **option 6 continued to be the preferred option.**

6. Estimated Capital Cost and Funding for Option 6 and 5 options for the washer disinfectors

Capital Requirements

	option 1	option 6.1	option 6.2	option 6.3	option 6.4	option 6.5	option 7
Capital Works	332,192	1,060,796	1,060,796	1,060,796	1,060,796	1,060,796	3,308,550
Replacement Equipment	600,000	521,222	600,000	435,274	435,274	480,000	600,000
Total	**932,192**	**1,582,018**	**1,660,796**	**1,496,070**	**1,496,070**	**1,540,796**	**3,908,550**

Option 6.2 is the preferred capital option. Source of funding: Trust capital programme for the full amount as identified in option 6.2 (includes £50,000 replacement costs identified in capital projects report in phase 2)

7. Estimated Revenue Costs (Full Year Effect)

I&E Summary For the Development of Endoscopy Services Decontamination at SGH

	Years:	1	2	3	4	5	6	7	8	9	10	Total
Option 6.1	Pay	-23	-23	-23	-23	-23	-23	-23	-23	-23	-23	-228
	Non Pay	-321	-318	-315	-311	-307	-303	-300	-296	-292	-289	-3052
	Savings	115	115	114	113	112	108	106	101	101	101	1063
	Net Surplus/Deficit(+/-)	**-228**	**-226**	**-223**	**-221**	**-218**	**-218**	**-217**	**-218**	**-214**	**-211**	**-2217**
Option 6.2	Pay	-23	-23	-23	-23	-23	-23	-23	-23	-23	-23	-228
	Non Pay	-303	-272	-269	-265	-261	-272	-268	-264	-260	-256	-2,687
	Savings	115	115	114	113	112	108	106	101	101	101	1,086
	Net Surplus/Deficit(+/-)	**-210**	**-180**	**-177**	**-174**	**-171**	**-187**	**-184**	**-186**	**-182**	**-178**	**-1,829**
Option 6.3	Pay	-23	-23	-23	-23	-23	-23	-23	-23	-23	-23	-228
	Non Pay	-332	-288	-325	-322	-318	-315	-312	-308	-305	-301	-3,126
	Savings	115	115	114	113	112	108	106	101	101	101	1,086
	Net Surplus/Deficit(+/-)	**-240**	**-196**	**-233**	**-232**	**-229**	**-230**	**-228**	**-230**	**-227**	**-223**	**-2,269**
Option 6.4	Pay	-23	-23	-23	-23	-23	-23	-23	-23	-23	-23	-228
	Non Pay	-298	-254	-291	-287	-284	-280	-277	-274	-270	-267	-2,782
	Savings	115	115	114	113	112	108	106	101	101	101	1,086
	Net Surplus/Deficit(+/-)	**-206**	**-162**	**-199**	**-197**	**-194**	**-195**	**-194**	**-196**	**-192**	**-189**	**-1,924**
Option 6.5	Pay	-23	-23	-23	-23	-23	-23	-23	-23	-23	-23	-228
	Non Pay	-282	-249	-245	-241	-238	-245	-242	-238	-235	-231	-2446
	Savings	115	115	114	113	112	108	106	101	101	101	1086
	Net Surplus/Deficit(+/-)	**-190**	**-156**	**-153**	**-151**	**-149**	**-160**	**-159**	**-160**	**-157**	**-153**	**-1588**

Option 6.2 is the preferred option. Although this has the second lowest revenue consequence (option 6.5 being the lowest), it had unanimous support from the selection panel because of the increased business continuity it offered from four washers (two bowls), rather than two washers (four bowls), and the extra health and safety benefits it offered (eradication of the use of glutealdehyde). The selection panel was made up of clinicians, EBME, decontamination lead and unit staff.

8. Staffing Numbers

The table below demonstrates the increase required in staffing resource for each of the options.

Staff Type/Grade	Option 1 WTEs	Option 6 WTEs	Option 7 WTEs
Band 2	0	1.2	0
Total	**0**	**1.2**	**0**

9. Activity (express on full year basis)

The below table demonstrates the activity breakdown within Endoscopy incorporating the predicted 30% increase in colonoscopy associated with bowel screening. The increase in colonoscopy is predicted following analysis of the increase in demand following awareness campaigns for bowel cancer.

Specialty	2009/2010	2010/2011	2011/2012 (predicted)	2012/2013 (predicted)
Colonoscopies	1178	1197	1172	1524
Gastroscopy	846	760	798	798
Flexi Sigmoidoscopy	357	410	425	425
OGD	846	1220	1108	1108
Cystoscopy	1085	1296	1237	1237
Other	1997	1686	1641	1641
Endoscopy total	**6309**	**6569**	**6381**	**6733**

10. Investment Appraisal (Capital Cases and Mixed Schemes where Capital Investment is over £50,000)

Measure	Option 6.1 £000s	Option 6.2 £000s	Option 6.3 £000s	Option 6.4 £000s	Option 6.5 £000s
Cash flow @ year 10	(2,724.5)	(2,359.5)	(2,799.0)	(2,454.6)	(2,118.5)
DCF @ year 10	(2,543.1)	(2,246.5)	(2,586.9)	(2,296.7)	(2,025.8)

11. Risk Assessment and Management

Risk	Option Scores			Mitigation
	Option 1	Option 6	Option 7	
Washer breakdown causing loss of activity and increased diagnostics wait times	1	1	1	Close management of activity and scheduling will utilise all available washer capacity but will not eliminate lost activity.
Funding not made available for additional 1.2WTE would reduce actual scoping time available	0	5	0	
Non-achievement of JAG Accreditation	5	0	0	
Loss of Bowel Cancer Status	5	0	0	
Non-compliance with Privacy and Dignity Standards	5	0	0	

12. Preferred Option

Option 6 is the preferred capital option as it addresses requirements for JAG (Joint Advisory Group) Accreditation, compliance with National Decontamination standards, the latest standards on Privacy and

Dignity Standards, and improves service continuity. It is also compatible with plans for the retained estate programme.

Managed service options have not been considered as part of this case. If this was to be pursued in the future, this would involve a 3rd party purchasing the equipment at net book value and providing a service with VAT efficient opportunities.

13. Cash flow Phasing of Preferred Option

Preferred Option: 6

Option 6.2	2012/13 £000s	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s	Subsequent years £000s
Capital Expenditure (-)	(1,660.8)					
Income (+)	0.0	0.0	0.0	0.0	0.0	0.0
Revenue Expenditure (-)	(141.6)	(182.2)	(178.3)	(174.3)	(170.4)	(181.3)
Cost Savings (+)	103.0	102.6	102.2	101.8	101.4	101.1
Net Cash Flow (+/-)	**(1,699.4)**	**(79.6)**	**(76.1)**	**(72.6)**	**(69.0)**	**(80.2)**

14. Proposed Timetable

Activity	Date	Action
Feasibility presented to SIRG	13/03/2012	Approval to be considered
Appoint Design Team	14/03/2012	Capital Projects
Equipment procurement (1 week)	19/03/2012	Division/Supplies
Design development (6 weeks)	25/04/2012	Capital Projects/Design Team
Issue Tender	27/04/2012	Capital Projects
Tender period (5 weeks)	01/06/2012	Contractors
Tender analysis (2 weeks)	18/06/2012	Design Team/Capital Projects
SIRG tender approval	10/07/2012	SIRG
Contractor mobilisation (3 weeks)	27/07/2012	Contractor
Phase 1A construction (14 weeks)	05/11/2012	Contractor
Operational Commissioning (4 weeks)	03/12/2012	Division/Specialist Supplier
Phase 1B construction (16 weeks)	27/03/2013	Contractor
Handover and completion	29/03/2013	All

15. Additional Notes

There will be a period of time (3 months) where both the old and new washers are in use. The new washers require a period of time to become operational due to infection control testing. There will be increased cost for the 3 month period of consumables for the washer units.

16. Conclusion

In conclusion, this business case proposes:

- The transfer of the decontamination facility currently located in the Sandwell Endoscopy unit, to a purpose built, dedicated decontamination facility on the second floor of the main ward block (previous TSSU) equipped with modern, standardised equipment for decontamination, drying storage and transfer of scopes.
- Upgrading the existing endoscopy unit to improve patient flows, and privacy & dignity to meet required standards.
- Extra investment in staff, scopes & scope trolleys required to support transfer of equipment between the endoscopy unit and the decontamination facility in line with infection control standards.

17. Recommendation

The Board is asked to **approve**

- Option 6 as the preferred capital works solution and,
- Option 6.2 as the recommended option for the replacement washers, dryers and storage cabinets

SIGN OFF - Development of Endoscopy Services to achieve JAG Accreditation

It is important to ensure that any consequences for other Divisions/ supporting departments are included in this case.

FOR ALL NEW CONSULTANT POSTS

Have OPD Nurse Managers confirmed the availability of clinic sessions?	YES/NO
Have theatre sessions (if required) been reserved?	YES/NO
Have costs been included for the impact on clinical support departments (e.g. pathology, imaging)?	YES/NO
Have costs been included for the impact on non-clinical support departments (e.g. medical records)	YES/NO

FOR ALL CASES
Have you confirmed with other Divisions and/or corporate departments any consequential cost changes arising from the proposal?

Other Divisions or supporting Departments consulted: *Please list as appropriate, for example:*	**Have they confirmed all implications are included?**
Imaging	YES/NO
Pathology	YES/NO
IM&T	YES/NO
Estates e.g. EBME	YES/NO
Facilities e.g. Portering Domestic service	YES/NO
Other – please state	YES/NO

DIVISIONAL SIGN- OFF

_____ Print name _____
Clinical Director

_____ Print name _____
Divisional General Manager

_____ Print name _____
Senior Finance Manager

_____ Print name _____
Divisional Director

Sandwell General Hospital
Endoscopy Services
Feasibility Report

Report to:	**SIRG**
Report of:	**Capital Projects**
Subject:	**Endoscopy Services**
Date:	**13th March 2012**

Version	Date	Comments/Summary of changes
1	20.01.12	First draft
2	01.02.12	Second draft
3	09.02.12	Final draft

EXECUTIVE SUMMARY

The Endoscopy service at Sandwell has a requirement to resolve a number of immediate issues which were initially raised in a SIRG report dated 14th June 2011 and include the following:

- The need for replacement of the existing endoscope washer disinfectors in order to comply with current HTM 01 06 best practice requirements. The existing washers are coming to the end of their operational life span and regular failures of this equipment affect productivity within the department.
- The need to retain JAG accreditation with re-assessment due in June 2012.
- The need to improve the existing department layout and flows in order to address issues around Privacy & Dignity.

A feasibility study was undertaken to identify an optimum solution that not only addressed the issues raised in the SIRG paper of June 14th, but took the opportunity to encompass the long term plan that sits in the context of the wider RCRH Retained Estate.

In November 2011 capital projects identified to SIRG the overall RCRH Community Facilities solution for Sandwell Hospital in which a re-provision and expanded service was to be provided within the existing area at a cost of circa £3.9 million. SIRG determined that this option (option 7 in this paper), be evaluated alongside other options as part of a Business Case to subsequently be presented for approval. This more extensive review of options specific to Endoscopy warranted that further detailed work be undertaken to establish a preferred option.

1.0 PURPOSE

To inform SIRG and the Trust Reconfiguration Board of the approach taken to technically appraise the options based upon the content of the clinical brief. To support the output of this paper the capital projects team have developed an operational policy and a planning policy and design description (PPDD) against which a detailed technical appraisal has been made.

Each option has been appraised against providing a technical solution to achieve the functional content in line with HBN and HTM standards set in the context of delivering a technical solution within the constraints of the existing and available estate which inevitably introduces elements of compromise. The long lists of options appraised are as follows:

- **Option 1** - Do Minimum – Within this option the 4 endoscope washers are replaced, but no alterations are carried out on the estate.

- **Option 2** – Move Bowel Screening (2 sessions) to City Hospital and seek accreditation to that site only

- **Option 3** – Reduce the number of Endoscopy Rooms to 2 and move to a 3 session day.

- **Option 4** - Maintain the number of endoscopy rooms by relocating the oesophageal lab to an alternative location to use as the 3rd endoscopy room and convert an appropriate endoscopy room into a decontamination room to support the installation of replacement disinfecting machines.

- **Option 5** - Permanently transfer the decontamination facilities to the 2nd floor old TSSU area, use the vacated space to support resolution of some patient privacy and dignity issues and as part of the final solution for endoscopy, relocate the unit to the 1st floor theatres block post MMH

- **Option 6** – Permanently transfer the decontamination facilities to the 2nd floor old TSSU area. Use the vacated space of decontamination and the oesophageal lab with reconfiguration of adjacent areas to support resolution of patient privacy and dignity issues. As part of the final solution relocate the endoscopy unit to the 1st floor theatres block

- **Option 7** – Fully refurbish the endoscopy unit and expand into the OPD area currently used by ENT and oncology. Decant ENT to medical records and medical records to an alternative location.

2.0 OVERVIEW OF OPTIONS

The subsequent review of options determined that a short list of options be reviewed in greater detail as follows (option 1 being retained as a base line comparator):

- **Option 1** - Do Minimum – Within this option the 4 endoscope washers are replaced, but no alterations are carried out on the estate.

- **Option 6** – Permanently transfer the decontamination facilities to the 2nd floor old TSSU area. Use the vacated space of decontamination and the Oesophageal lab with reconfiguration of adjacent areas to support resolution of patient privacy and dignity issues. As part of the final solution relocate the endoscopy unit to the 1st floor theatres block post MMH.

- **Option 7** – Fully refurbish the endoscopy unit and expand into the OPD area currently used by ENT and oncology. Decant ENT to medical records and medical records to an alternative location

3.0 SCOPE OF OPTIONS

Option 1

Do Minimum – Within this option the 4 endoscope washers are replaced, but no alterations are carried out on the estate.

Whilst this option replaces key elements of equipment it fails to deliver two of the mandatory objectives identified by JAG as essential for accreditation, these being:

- Resolution of privacy and dignity issues

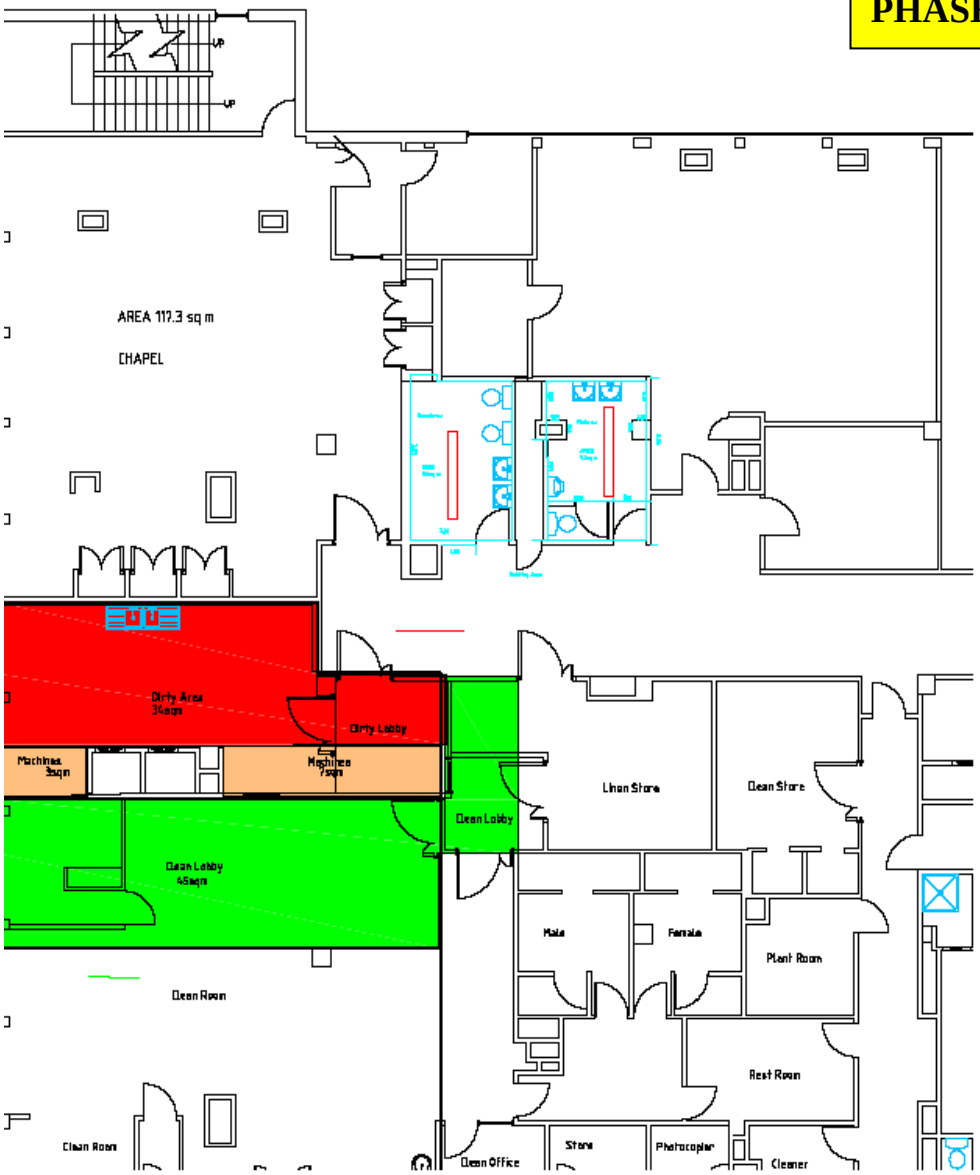
- Providing a decontamination facility with clear separation of clean and dirty processes

Option 6

This option permanently relocates the decontamination function and machines to the second floor theatre block. New machines would be installed along with storage cabinets and IT equipment for monitoring. The vacated space would support resolution of all patient privacy and dignity issues, support patient flow and negate the need for single sex days.

The delivery of the project would be in two principal phases. Phase 1 would be delivered in two sub-phases, 1A and 1B. Phase 1A relocates the decontamination function and machines to the second floor theatre block as follows:

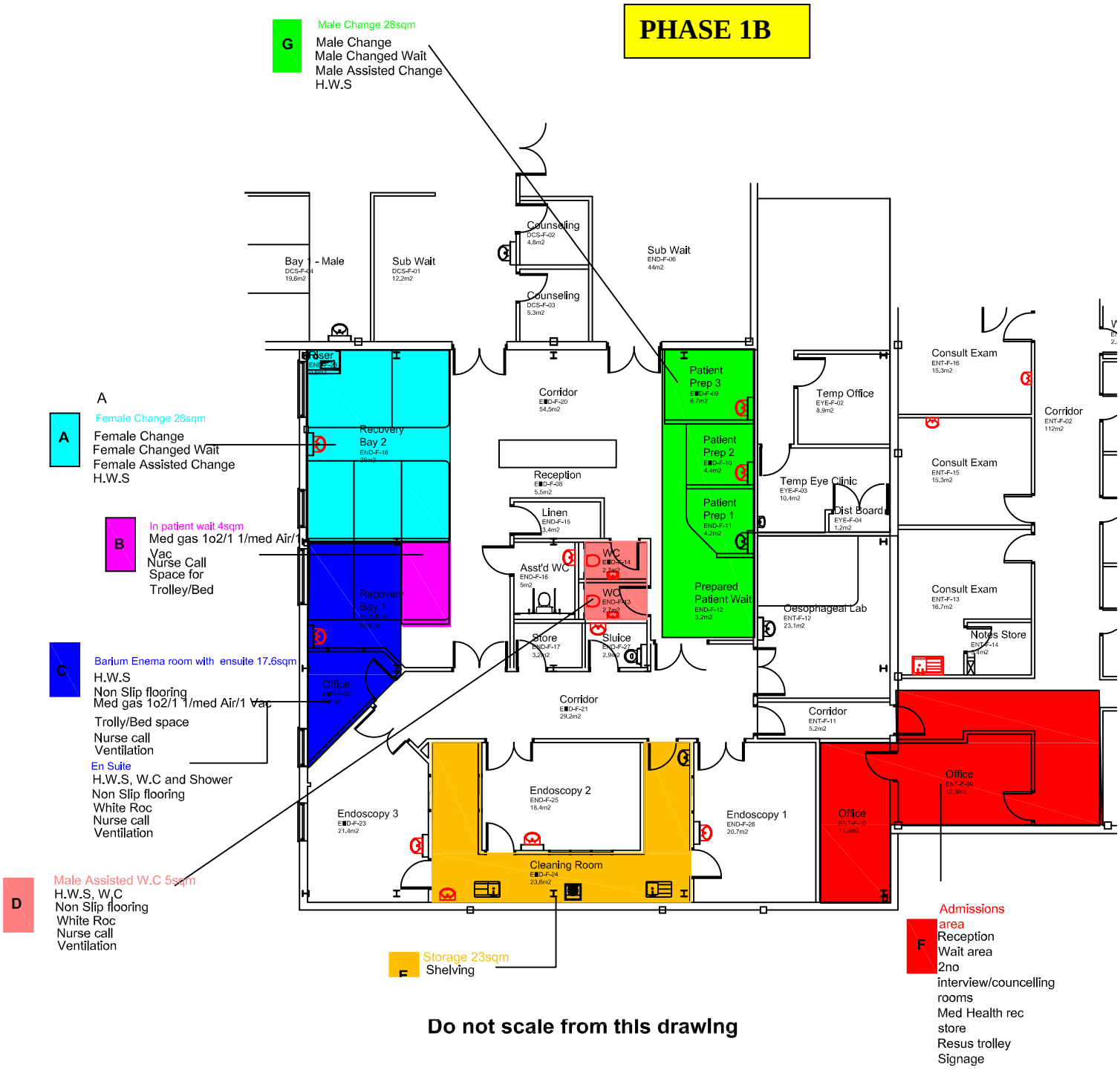
PHASE 1A



Dirty Area Machines Clean Area

The above works can be carried whilst the existing facility remains operational thereby raising no business continuity issues. Upon completion and operational commissioning of phase 1A the service can transfer enabling the next sub phase to commence.

Phase 1B is in the existing endoscopy area to provide refurbished facilities resolving privacy and dignity issues as follows:



The completion of Phases 1A and 1B will deliver JAG accreditation.

Phase 2 comprises the move of Endoscopy Services to the second floor theatre block; however this will not take place until after MMH is operational.

Option 7

This option provides a final solution for endoscopy, developed as part of the Sandwell Feasibility Study, which could be completed in the short-medium term ahead of MMH opening. The future service would remain where it is but expand into the 1st floor outpatient area (currently ENT). This would support the provision of a decontamination solution and address patient flow and privacy and dignity issues whilst also ensuring provision of an environment that will be fit for purpose to take the service into the future as a community site.

4.0 OUTLINE CAPITAL COSTS

4.1 Option Costs

The following table identifies the individual option costs. The equipment costs have been subject to technical review by capital projects. The costs can accommodate the Divisions final equipment selection:

	Option 1	Option 6		Option 7
		Phase 1 (Pre MMH)	Phase 2 (Post MMH)	
Refurbish Washer/Decontamination area	£100,000	-	-	-
Refurbish ENT/Endoscopy Unit for upgraded Facilities	-	-	-	£2,075,000
Provision of Bronchoscopy	-	-	-	-
Refurbish existing Endoscopy Unit for Privacy and Dignity issues etc	-	£275,000	-	-
Permanent Facility for Washer in HSSU	-	£400,000	-	-
Refurbish existing First Floor Theatres for Endoscopy (c675m2)	-	-	£1,350,000	-
Relocate ENT	-	-	-	£290,000
Works Cost	**£100,000**	**£675,000**	**£1,350,000**	**£2,365,000**
Inflation Allowance for works post MMH	-	-	£202,500	-
Design @11%	£11,000	£74,250	£170,775	£260,150
Replacement Equipment	£600,000	£550,000	£50,000	£600,000
Trust Contingency @ 6%/7.5%	£42,660	£77,955	£132,996	Incl above
VAT (@20%, fees excepted)	£148,532	£260,591	£347,099	£593,000
VAT Recovery	- £4,000	- £27,000	- £62,100	- £94,600
Relocate Medical Records	-	-	-	£160,000
Business Continuity	£25,000	-	-	£25,000
Sub Totals	-	£1,610,796	2,191,270	-
OPTION TOTALS	**£923,192**	**£3,802,066**		**£3,908,550**

4.2 Cash Flow

All three options could commence planning and implementation immediately upon SIRG approval. Option 6 includes inflation monies for phase 2 as this cannot commence until MMH is operational. Option 6 does however deliver JAG accreditation in phase 1 for £1,610,796 and within financial year 2012/13.

5.0 OUTLINE PROGRAMME

Activity	Date	Action
Feasibility presented to SIRG	13/03/2012	Approval to be considered
Appoint Design Team	14/03/2012	Capital Projects
Equipment procurement (1 week)	19/03/2012	Division/Supplies
Design development (6 weeks)	25/04/2012	Capital Projects/Design Team
Issue Tender	27/04/2012	Capital Projects
Tender period (5 weeks)	01/06/2012	Contractors
Tender analysis (2 weeks)	18/06/2012	Design Team/Capital Projects
SIRG tender approval	10/07/2012	SIRG
Contractor mobilisation (3 weeks)	27/07/2012	Contractor
Phase 1A construction (14 weeks)	05/11/2012	Contractor
Operational Commissioning (4 weeks)	03/12/2012	Division/Specialist Supplier
Phase 1B construction (16 weeks)	27/03/2013	Contractor
Handover and completion	29/03/2013	All

6.0 RISK ANALYSIS

A mitigation strategy may have to be developed for the following risks:

- Equipment procurement and confirmation (impacts on design process)
- Development of Business Case to support design solution

7.0 CONCLUSION

The output of this report illustrates that the brief can be delivered through Option 6, subject to the risks stated in Section 6 above, within the existing facilities at Sandwell Hospital without the need for additional new build accommodation or displacing other activity from the acute site.

The initial relatively low cost phases deliver the immediate objective of JAG accreditation with the major investment taking place once MMH is operational.

Option 6 has proven to be preferred as part of the feasibility exercise undertaken.

The project is deliverable in construction terms.

8.0 RECOMMENDATIONS

The Capital Projects team provide the following recommendations:

- Capital funding for the delivery of Phases 1A and 1B
    - £1,610,796 – 12/13
- The procurement programme to commence in line with the outline programme in section 5.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Appendix 2: Detailed I&E for options 6.1 to 6.5

Option 6.1	Year: 1	2	3	4	5	6	7	8	9	10	Total
Costs											
Pay											
HCA	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	228,000
Total Pay	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**228,000**
Non Pay											
Loss on disposal of assets	70,700	0	0	0	0	0	0	0	0	0	70,700
Cycle costs	47,320	47,320	47,320	47,320	47,320	47,320	47,320	47,320	47,320	47,320	473,200
Self disinfectant costs	447	447	447	447	447	447	447	447	447	447	4,472
Filter Costs 2	12,960	12,960	12,960	12,960	12,960	12,960	12,960	12,960	12,960	12,960	129,600
Washer Maint	11,600	60,022	60,022	60,022	60,022	60,022	60,022	60,022	60,022	60,022	551,802
Cabinet Filter Costs	585	585	585	585	585	585	585	585	585	585	5,850
Cabinet Maint		11,600	11,600	11,600	11,600	11,600	11,600	11,600	11,600	11,600	104,400
Scope Maint	0	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	144,000
Trolleys &liners	18,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	146,646
Depreciation	105,162	105,162	105,162	105,162	105,162	105,162	105,162	105,162	105,162	105,162	1,051,620
Cost of Financing	53,530	49,850	46,169	42,488	38,808	35,127	31,446	27,766	24,085	20,404	369,673
Total Non Pay	**320,569**	**318,211**	**314,530**	**310,850**	**307,169**	**303,488**	**299,808**	**296,127**	**292,446**	**288,766**	**3,051,963**
Total Costs	**343,369**	**341,011**	**337,330**	**333,650**	**329,969**	**326,288**	**322,608**	**318,927**	**315,246**	**311,566**	**3,279,963**

Savings

Cycle costs	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	383,860
Filter Costs 2	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	
Washer & Cabinet Maint	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	600,860
Depreciation (following disposal of assets)	12,294	12,294	12,294	11,162	10,784	6,752	5,112	0	0	0	70,692
Cost of Financing (following disposal of assets)	2,259	1,829	1,399	988	604	297	90	0	0	0	7,468
Total Savings	**115,325**	**114,895**	**114,465**	**112,922**	**112,160**	**107,821**	**105,974**	**100,772**	**100,772**	**100,772**	**1,062,879**
		-	-	-	-	-	-	-	-	-	-
Net Revenue Surplus/Deficit (+/-)	**-228,044**	**226,116**	**222,865**	**220,728**	**217,809**	**218,467**	**216,634**	**218,155**	**214,474**	**210,793**	**2,217,084**

Option 6.2	Year: 1	2	3	4	5	6	7	8	9	10	Total
Costs											
Pay											
HCA	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	228,000
Total Pay	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**228,000**
Non Pay											
Loss on disposal of assets	70,700	0	0	0	0	0	0	0	0	0	70,700
Cycle costs	39,884	39,884	39,884	39,884	39,884	39,884	39,884	39,884	39,884	39,884	398,840
Washer Maint	4,500	29,500	29,500	29,500	29,500	41,500	41,500	41,500	41,500	41,500	330,000
Cabinet Maint	0	7,600	7,600	7,600	7,600	10,500	10,500	10,500	10,500	10,500	82,900
Scope Maint	0	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	144,000
Trolleys &liners	18,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	146,646
Depreciation	113,040	113,040	113,040	113,040	113,040	113,040	113,040	113,040	113,040	113,040	1,130,398
Cost of Financing	56,150	52,193	48,237	44,280	40,324	36,368	32,411	28,455	24,499	20,542	383,459
Total Non Pay	**302,538**	**272,482**	**268,525**	**264,569**	**260,613**	**271,556**	**267,600**	**263,643**	**259,687**	**255,731**	**2,686,943**

Total Costs	**325,338**	**295,282**	**291,325**	**287,369**	**283,413**	**294,356**	**290,400**	**286,443**	**282,487**	**278,531**	**2,914,943**
Savings											
Cycle costs	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	383,860
Filter Costs 2	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	23,000
Washer & Cabinet Maint	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	600,860
Depreciation (following disposal of assets)	12,294	12,294	12,294	11,162	10,784	6,752	5,112	0	0	0	70,692
Cost of Financing (following disposal of assets)	2,259	1,829	1,399	988	604	297	90	0	0	0	7,468
Total Savings	**115,325**	**114,895**	**114,465**	**112,922**	**112,160**	**107,821**	**105,974**	**100,772**	**100,772**	**100,772**	**1,085,879**
Net Revenue Surplus/Deficit (+/-)	**-210,013**	**180,387**	**176,860**	**174,447**	**171,252**	**186,535**	**184,426**	**185,671**	**181,715**	**177,759**	**1,829,064**
Option 6.3	Year: 1	2	3	4	5	6	7	8	9	10	Total
Costs											
Pay											
HCA	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	228,000
Total Pay	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**228,000**
Non Pay											
Loss on disposal of assets	70,700	0	0	0	0	0	0	0	0	0	70,700
Cycle costs	69,888	69,888	69,888	69,888	69,888	69,888	69,888	69,888	69,888	69,888	698,880
Washer Maint	26,400	39,750	79,800	79,800	79,800	79,800	79,800	79,800	79,800	79,800	704,550
Cabinet Maint	0	4,600	4,600	4,600	4,600	4,600	4,600	4,600	4,600	4,600	41,400
Scope Maint	0	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	144,000
Trolleys &liners	18,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	146,646

Depreciation	96,567	96,567	96,567	96,567	96,567	96,567	96,567	96,567	96,567	96,567	965,672
Cost of Financing	50,673	47,293	43,913	40,533	37,153	33,773	30,393	27,014	23,634	20,254	354,632
Total Non Pay	**332,492**	**288,363**	**325,033**	**321,653**	**318,273**	**314,893**	**311,513**	**308,133**	**304,754**	**301,374**	**3,126,480**
Total Costs	**355,292**	**311,163**	**347,833**	**344,453**	**341,073**	**337,693**	**334,313**	**330,933**	**327,554**	**324,174**	**3,354,480**
Savings											
Cycle costs	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	383,860
Filter Costs 2	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	23,000
Washer & Cabinet Maint	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	600,860
Depreciation (following disposal of assets)	12,294	12,294	12,294	11,162	10,784	6,752	5,112	0	0	0	70,692
Cost of Financing (following disposal of assets)	2,259	1,829	1,399	988	604	297	90	0	0	0	7,468
Total Savings	**115,325**	**114,895**	**114,465**	**112,922**	**112,160**	**107,821**	**105,974**	**100,772**	**100,772**	**100,772**	**1,085,879**
		-	-	-	-	-	-	-	-	-	-
Net Revenue Surplus/Deficit (+/-)	**-239,967**	**196,267**	**233,368**	**231,531**	**228,913**	**229,872**	**228,339**	**230,161**	**226,781**	**223,402**	**2,268,601**
Option 6.4	Year: 1	2	3	4	5	6	7	8	9	10	Total
Costs											
Pay											
HCA	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	228,000
Total Pay	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**228,000**
Non Pay											
Loss on disposal of assets	70,700	0	0	0	0	0	0	0	0	0	70,700
Cycle costs	34,944	34,944	34,944	34,944	34,944	34,944	34,944	34,944	34,944	34,944	349,440

Washer Maint	26,400	39,750	79,800	79,800	79,800	79,800	79,800	79,800	79,800	79,800	704,550
Cabinet Filter Costs	500	500	500	500	500	500	500	500	500	500	5,000
Cabinet Maint	0	4,600	4,600	4,600	4,600	4,600	4,600	4,600	4,600	4,600	41,400
Scope Maint	0	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	144,000
Trolleys &liners	18,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	146,646
Depreciation	96,567	96,567	96,567	96,567	96,567	96,567	96,567	96,567	96,567	96,567	965,672
Cost of Financing	50,673	47,293	43,913	40,533	37,153	33,773	30,393	27,014	23,634	20,254	354,632
Total Non Pay	**298,048**	**253,919**	**290,589**	**287,209**	**283,829**	**280,449**	**277,069**	**273,689**	**270,310**	**266,930**	**2,782,040**
Total Costs	**320,848**	**276,719**	**313,389**	**310,009**	**306,629**	**303,249**	**299,869**	**296,489**	**293,110**	**289,730**	**3,010,040**
Savings											
Cycle costs	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	383,860
Filter Costs 2	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	23,000
Washer & Cabinet Maint	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	600,860
Depreciation (following disposal of assets)	12,294	12,294	12,294	11,162	10,784	6,752	5,112	0	0	0	70,692
Cost of Financing (following disposal of assets)	2,259	1,829	1,399	988	604	297	90	0	0	0	7,468
Total Savings	**115,325**	**114,895**	**114,465**	**112,922**	**112,160**	**107,821**	**105,974**	**100,772**	**100,772**	**100,772**	**1,085,879**
		-	-	-	-	-	-	-	-	-	-
Net Revenue Surplus/Deficit (+/-)	**-205,523**	**161,823**	**198,924**	**197,087**	**194,469**	**195,428**	**193,895**	**195,717**	**192,337**	**188,958**	**1,924,161**
Option 6.5	Year: 1	2	3	4	5	6	7	8	9	10	Total
Costs											
Pay											
HCA	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	22,800	228,000
Total Pay	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**22,800**	**228,000**

Non Pay

Loss on disposal of assets	70,700	0	0	0	0	0	0	0	0	0	70,700
Cycle costs	31,590	31,590	31,590	31,590	31,590	31,590	31,590	31,590	31,590	31,590	315,900
Self disinfectant costs	3,900	3,900	3,900	3,900	3,900	3,900	3,900	3,900	3,900	3,900	39,000
Washer Maint	4,500	25,500	25,500	25,500	25,500	33,500	33,500	33,500	33,500	33,500	274,000
Cabinet Maint	0	7,600	7,600	7,600	7,600	10,500	10,500	10,500	10,500	10,500	82,900
Scope Maint	0	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	144,000
Trolleys &liners	18,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	14,265	146,646
Depreciation	101,040	101,040	101,040	101,040	101,040	101,040	101,040	101,040	101,040	101,040	1,010,398
Cost of Financing	52,160	48,623	45,087	41,550	38,014	34,478	30,941	27,405	23,869	20,332	362,459
Total Non Pay	**282,154**	**248,518**	**244,981**	**241,445**	**237,909**	**245,272**	**241,736**	**238,199**	**234,663**	**231,127**	**2,446,003**
Total Costs	**304,954**	**271,318**	**267,781**	**264,245**	**260,709**	**268,072**	**264,536**	**260,999**	**257,463**	**253,927**	**2,674,003**

Savings

Cycle costs	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	38,386	383,860
Filter Costs 2	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	23,000
Washer & Cabinet Maint	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	60,086	600,860
Depreciation (following disposal of assets)	12,294	12,294	12,294	11,162	10,784	6,752	5,112	0	0	0	70,692
Cost of Financing (following disposal of assets)	2,259	1,829	1,399	988	604	297	90	0	0	0	7,468
Total Savings	**115,325**	**114,895**	**114,465**	**112,922**	**112,160**	**107,821**	**105,974**	**100,772**	**100,772**	**100,772**	**1,085,879**
		-	-	-	-	-	-	-	-	-	-
Net Revenue Surplus/Deficit (+/-)	**-189,629**	**156,423**	**153,316**	**151,323**	**148,548**	**160,251**	**158,562**	**160,227**	**156,691**	**153,155**	**1,588,124**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Management Report – Q3 2011/12
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Allison Binns, Head of Risk Management Hillary Mottishaw, Head of Complaints, Litigation & PALS Dally Masaun, Head of Health and Safety
DATE OF MEETING:	29 March 2012

SUMMARY OF KEY POINTS:

This report combines information on incidents (both clinical and Health & Safety), complaints, PALS and claims.

Key incident statistics:
- There were 3349 reported incidents during Q3 (2564 in Q3 2010/11)
- Reported clinical incidents increased to 2335 during Q3 (1739 in Q3 2010/11)
- Reported health & safety incidents increased to 1014 in Q3 (818 in Q3 2010/11)
- There were 57 incident forms received relating to red incidents during Q3 (2% of the total), compared with 122 in Q3 2010/11 (5% of the total),

Key complaints statistics:
- During the reporting period the complaints team received 215 new complaints contacts. By means of comparison, 256 contacts were received in Q4 2010/11, 252 in Q1 2011/12 and 233 in Q2 2011/12.

Key claims statistics:
- At present the Trust has 369 Clinical claims and 115 personal injury claims at various stages of the legal process.

Key PALS statistics:
  - Total enquiries to PALS team during the quarter 955

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to NOTE the contents of the report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality of care
Annual priorities	
NHS LA standards	Standard 1 'Governance'
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Governance Board on 2 March 2012 and Quality & Safety Committee on 22 March 2012.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Management Report

Quarter 3 - 2011-2012

An Integrated report from Clinical Risk, Health & Safety, PALS, Complaints & Claims

Where EVERYONE Matters

Integrated Risk, Complaints and Claims Report: Quarter 3 2011/12

1. Overview

This report highlights key risk activity including:

- Summary incident data and details of lessons learned
- Summary complaints data and details of lessons learned
- Summary PALS data
- Aggregated analysis of incidents and complaints, and lessons learned.

2. Introduction

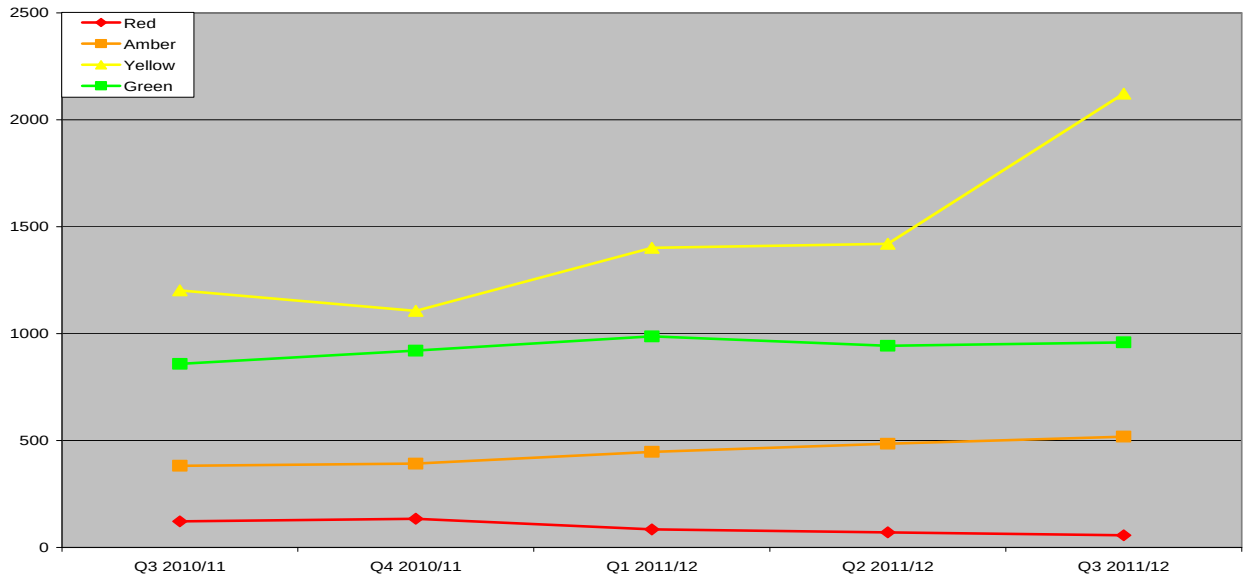
This report combines previous quarterly reports on incident/risk and complaints to implement the Policy for the Investigation, Analysis and Learning of Lessons from Adverse Events and meet NHS Litigation Authority assessment requirements. Where possible, comparisons across these areas of activity will be made to try to identify common trends and actions. Future reports will also include claims and inquest data.

3. Key Issues

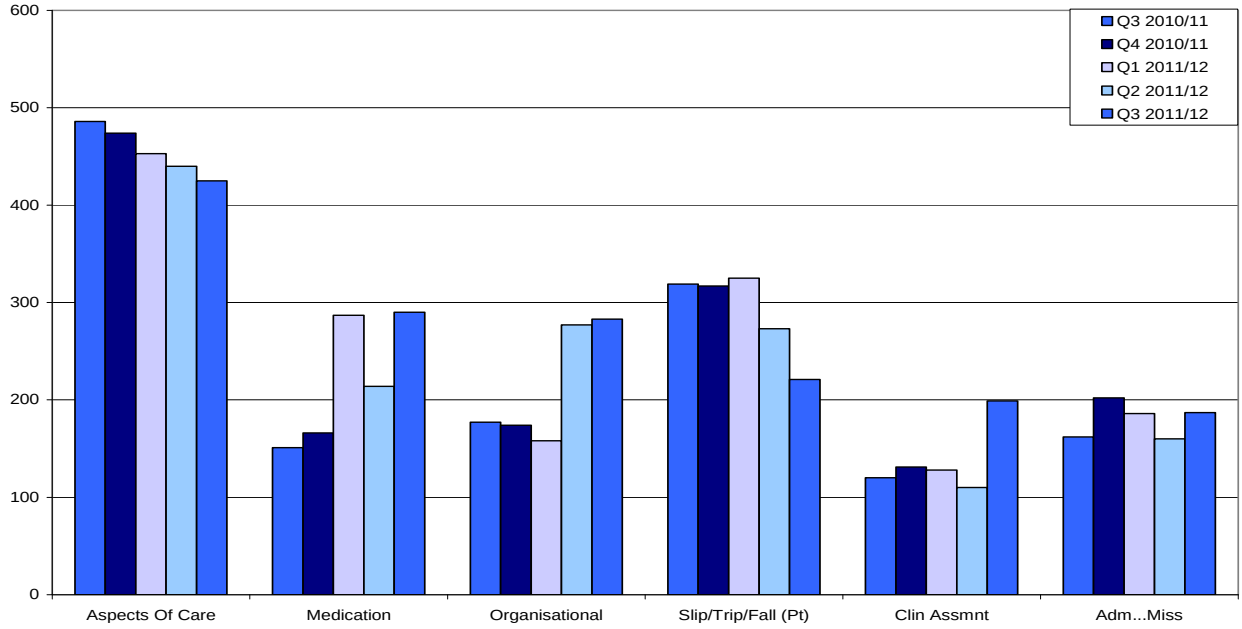
3.1 Review of Quarter 3 2011/12 Incident Data

- There were 3349 reported incidents during Q3 (2564 in Q3 2010/11)
- Reported clinical incidents increased to 2335 during Q3 (1739 in Q3 2010/11)
- Reported health & safety incidents increased to 1014 in Q3 (818 in Q3 2010/11)
- There were 57 incident forms received relating to red incidents during Q3 (2% of the total), compared with 122 in Q3 2010/11 (5% of the total),

Graph 3.1a - **Incident Trends** by risk score Q3 2010/11 – Q3 2011/12



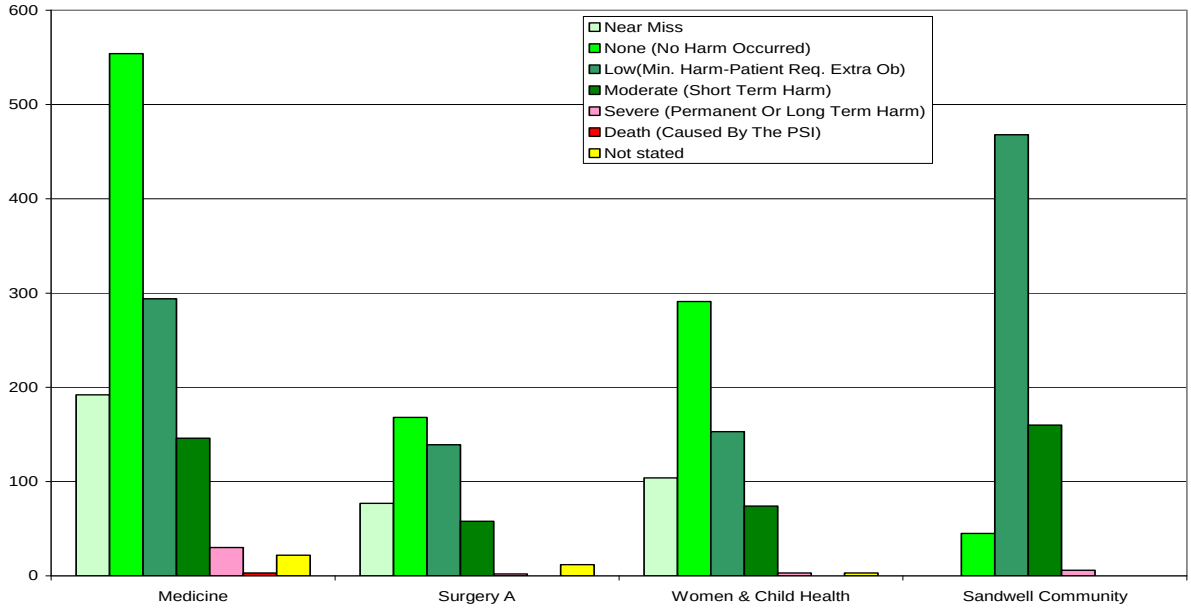
Graph 3.1b – Top 6 reported **clinical incidents** by quarter (Q3 2010/11 – Q3 2011/12)



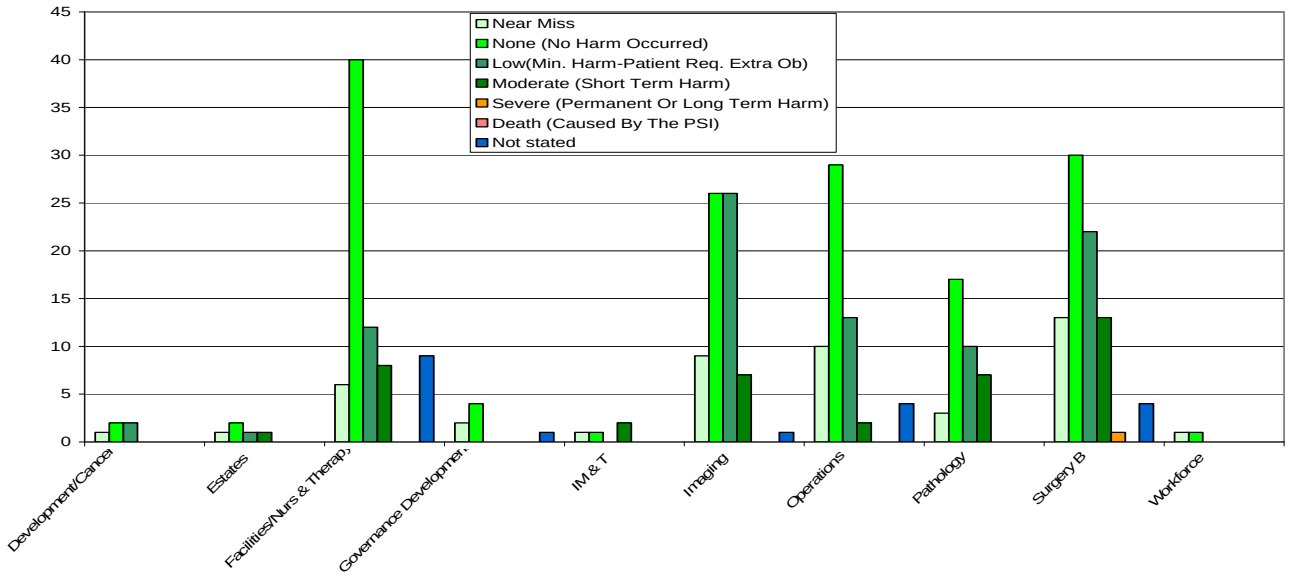
The top 6 most frequently reported categories remains consistent.

Graph 3.1c **Incidents** by reported impact by division within Q3 2011/12

<u>Large Divisions</u>



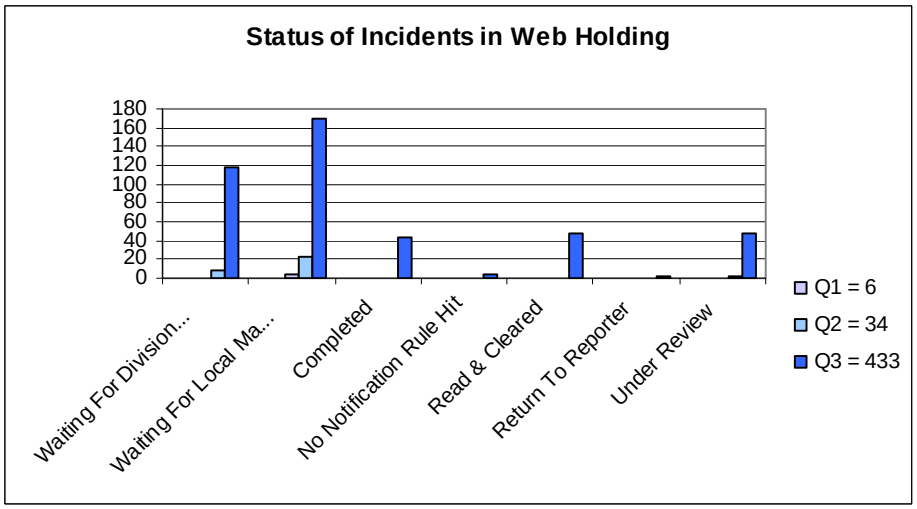
Smaller Divisions



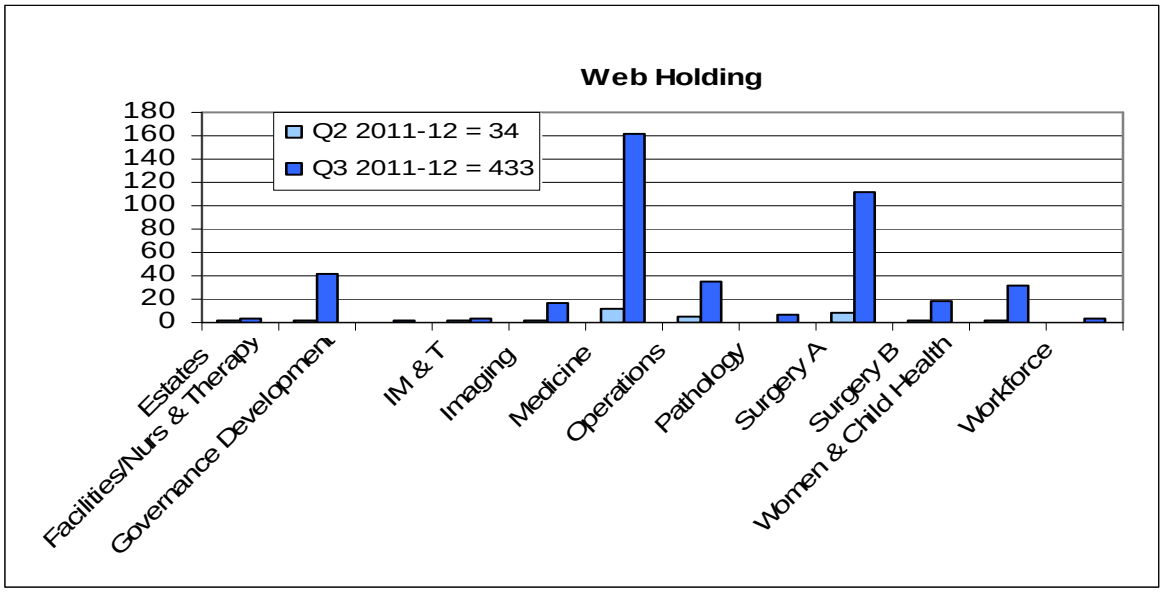
3.1.1 Web Holding

Following transition to the electronic reporting system within the hospital setting, incidents that are in the process of being "managed" are held in a virtual file before being merged into the live system. This file is called web holding.

Graph 3.1.1a Incidents waiting to be managed in web holding



Graph 3.1.1b Incidents in web holding by division



3.2 Complaints

During the reporting period the complaints team received 215 new complaints contacts. By means of comparison, 256 contacts were received in Q4 2010/11, 252 in Q1 2011/12 and 233 in Q2 2011/12.

First contact complaint: where the Trust's substantive (i.e. initial) response has not yet been made.

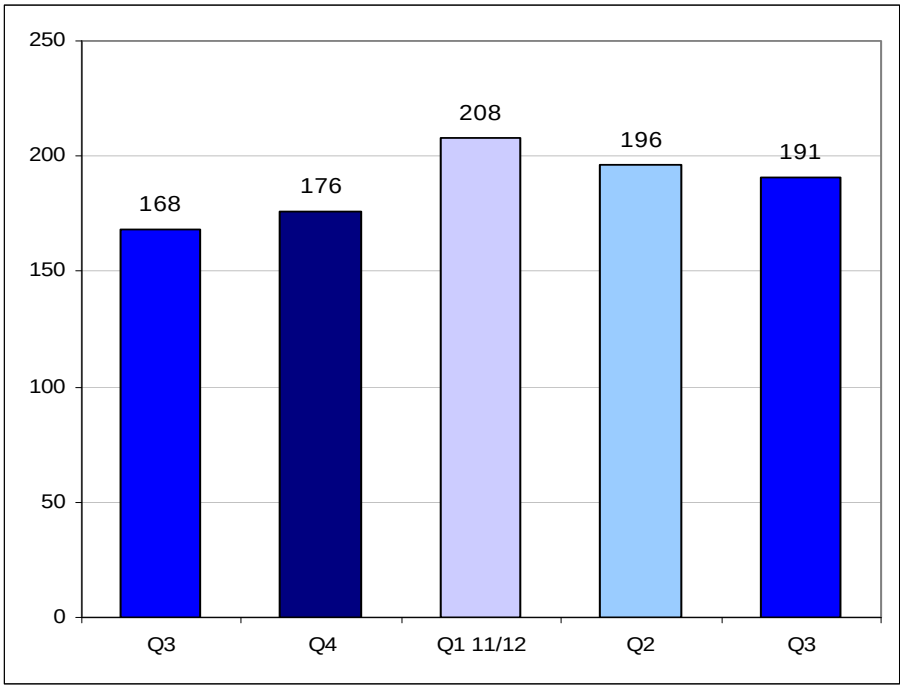
Table 3.2a Types of **Contact** during Q3

Types of Contact	Q3	Notes
Formal Complaints	189	Formal complaints with negotiated timescales
Can't Accept	0	Concerns not addressed (due to time elapsed since incident etc)
General Query/Feedback	13	Not dealt with formally (concerns/query addressed via letter)
GP/intra NHS Concerns	0	Concerns raised by GPs or other NHS organisations/staff members
Dealt with informally	1	Not dealt with formally (concerns/query addressed via phone or meeting)
Under Review	0	Pathway not finalised (e.g. reviewing records to establish whether a complaint can still be reviewed given time elapsed)
Withdrawn	12	Complaints are typically withdrawn if a relative has made the complaint, but patient consent cannot be obtained. Occasionally complaints are withdrawn as the complainant changes their mind about taking their concerns forward.

The following link complaint contacts were received:

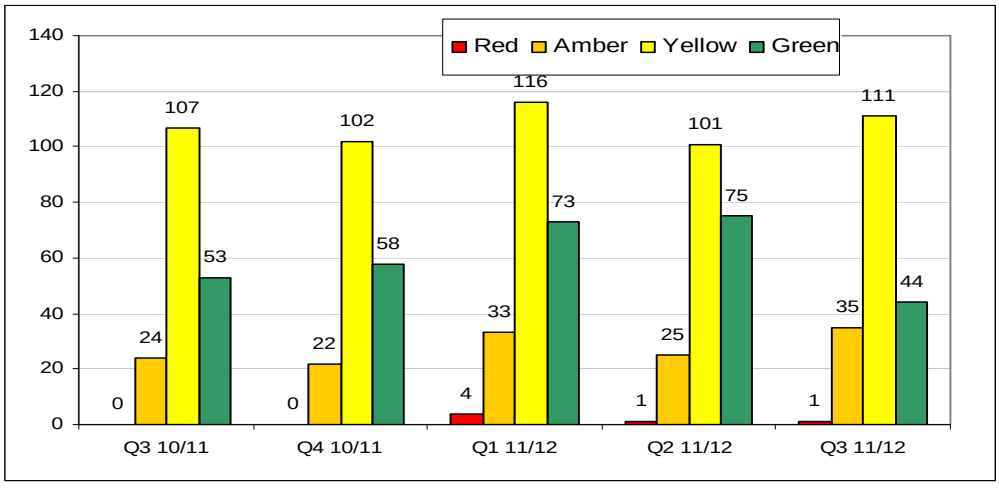
Types of Contact	Q1	Q2	Q3	Notes
Link Complaints	34	39	37	The complainant has received the substantive response to their complaint but has returned as they remain dissatisfied/or require additional clarification.

Graph 3.2a – Number of **formal complaints** received by quarter



The complaints were graded as below. The severity of the grading remains broadly consistent with previous quarters.

Graph 3.2b **Grading** of formal complaints (Q3 2010/11 – Q3 2011/12)

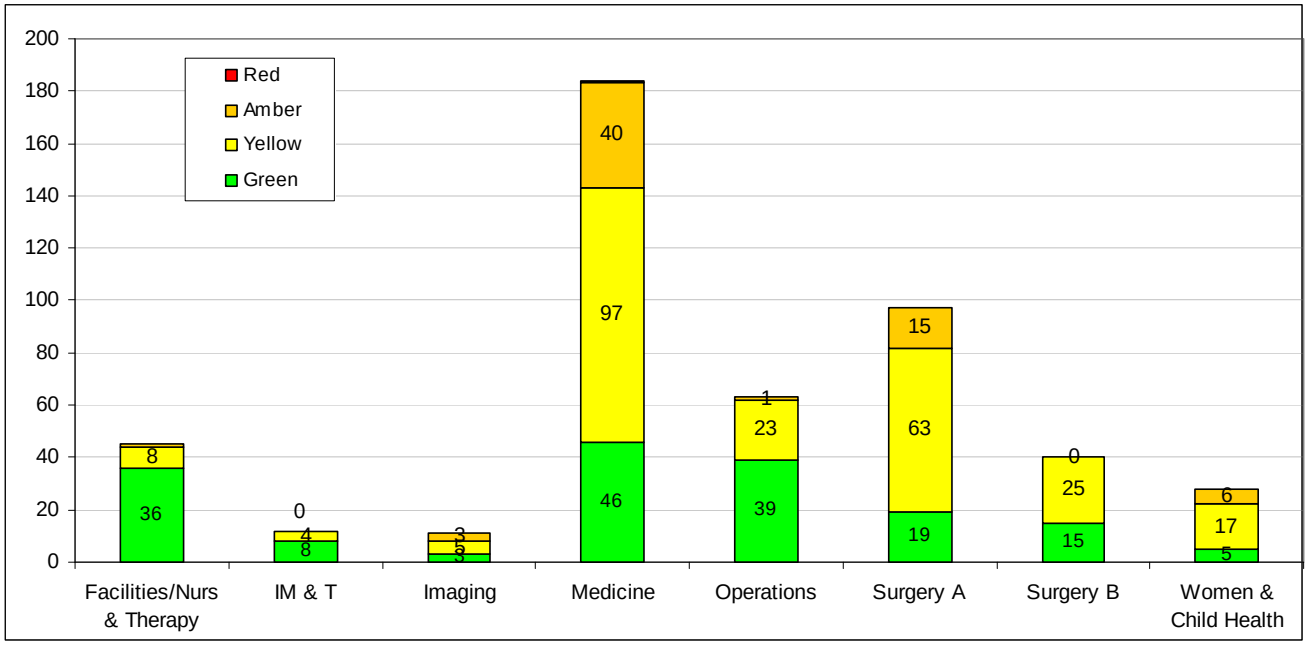


Action Plan Completion

All divisions are required to submit a copy of a completed action plan to the Complaints Department following the finalising of the Trust's investigation and response to the complainant. Monthly reports are being issued to relevant divisional managers containing details of any action plans yet to be submitted.

Graph 3.2c is a breakdown by division of action plans currently outstanding for complaints responded to up until the end of December 2011. The chart shows how many of each grade is outstanding.

Graph 3.2c Number of **action plans outstanding** by divisional lead (responses to end of Q3 2011/12)



The results show further increases in action plans outstanding when compared to previous reporting periods. This may be reflective of the current monitoring processes and communication with the divisions. Work will therefore be undertaken with the divisions to ensure that (i) action plans are completed in a timely manner and (ii) where action plans are completed in a timely, this is appropriate logged on the Complaints Department database.

Referral of Complaints to the Health Service Ombudsman

The Ombudsman notified 3 cases to the Trust during Q3.

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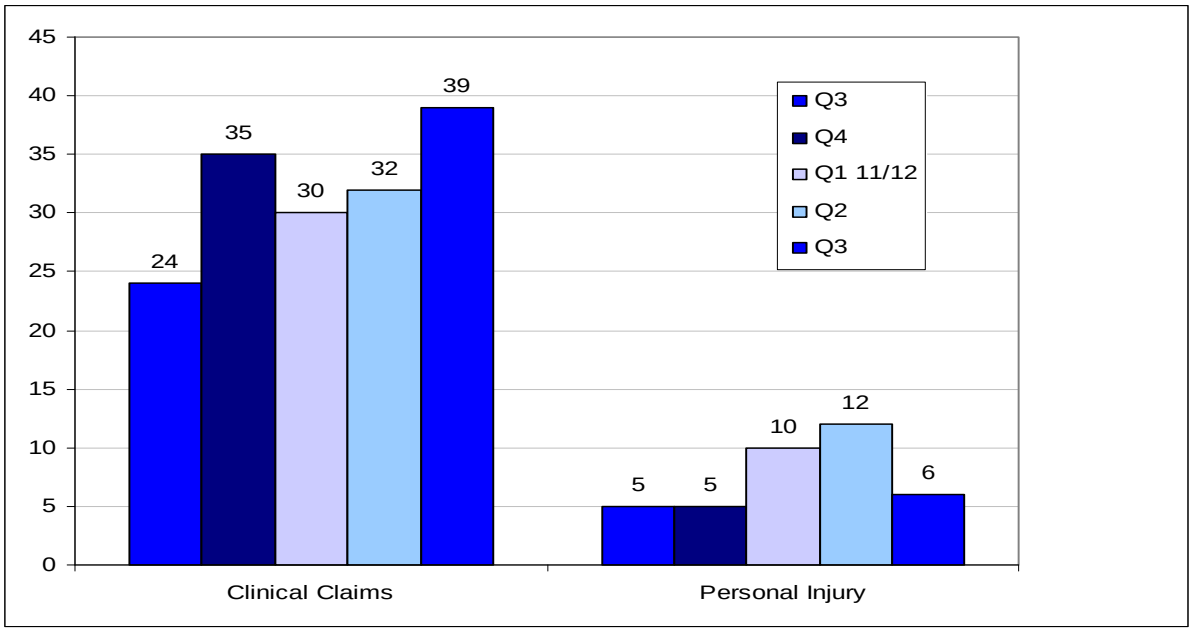
3.3 Claims

The claims received are as follows:

Graph 3.3a – **Claims** received by quarter



Of the 39 clinical claims received in Q3, there were 2 that had a reported clinical incident related to the case. 5 claimants had already raised their concerns via the complaints procedure.

Of the 6 personal injury claims received, none had a reported clinical incident related to the case. No claimants had previously raised their concerns via the complaints procedure. However, personal injury claims typically relate to staff injuries and staff are not able to raise their concerns via the NHS complaints procedure.

Table 3.3a **Categories** of claims

Allegation Category	Clinical Claims Q3	Personal Injury Q3
Burns/scalds/reactions	-	-
Delay in Treatment	3	-
Dissatisfied With Treatment	2	-
Drug Error	-	-
Failure Or Delay In Diagnosis	3	-
Failure to Recognise Complications	-	-
Fall/slip	-	3
Infection - Other	1	-
Lacerations/Sores	-	-
Late Diagnosis And Treatment	2	-

Lifting/moving/handling	1	1
Moving/falling Objects	-	2
Needlestick	-	-
Not Known	15	-
Operation Carried Out Negligently	1	-
Other	6	-
Toxic Fumes	-	-
Treatment Carried Out Negligently	5	-
Violence and Aggression	-	-

At present the Trust has 369 Clinical claims and 115 personal injury claims at various stages of the legal process.

Table 3.3b **Status** of all active claims

Status Type	Clinical Claims	Personal Injury Claims
Defence Served	2	-
Disclosure Of Records*	270	4
Early Stages	4	2
Letter Of Claim	25	81
Letter Of Response	3	-
Liability Admitted	5	13
Liability Being Assessed	9	5
Liability Denied	5	-
Negotiate Settlement	12	3
Part 36 Offer	8	1
Proceedings Issued/served	5	1
Settlement Made	19	5

***** It is worth noting that not all requests for disclosure of records progress into a claim.

Table 3.3c Claims by **Directorate/Division** (*excludes records disclosure*)

Division	Clinical Claims	Personal Injury Claims
Development/Cancer	0	0
Estates	0	22
Facilities	0	28
Finance	0	1

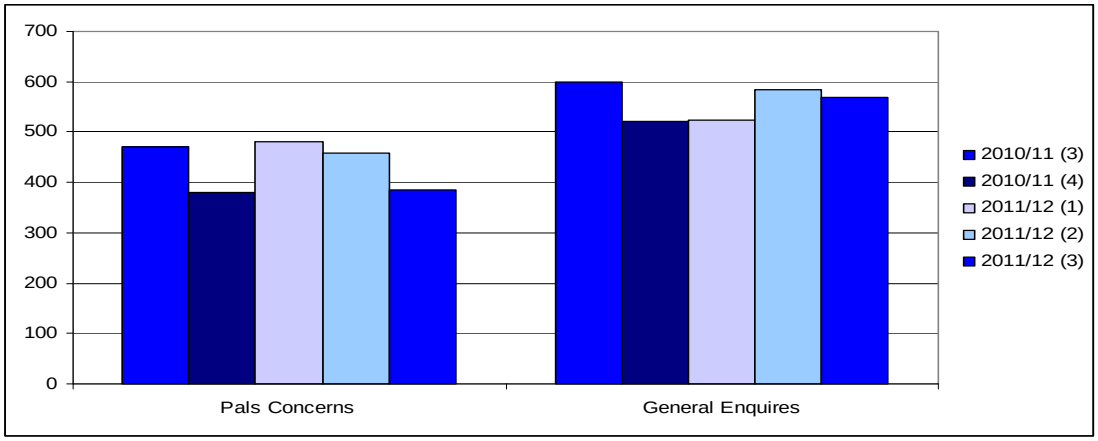
Division	Clinical Claims	Personal Injury Claims
Imaging	1	3
IM&T	0	1
Medicine	26	26
Not Known/Stated	8	7
Operations	0	1
Pathology	1	1
SCAH	0	1
Surgery A	28	10
Surgery B	9	5
Women & Child Health	27	5

4. PALS

The Patient Advice and Liaison Service (PALS) provides a one stop service for patient's/relatives and their carers to speak to someone who will listen to their issue of concern, provide support, information and advice. PALS work in partnership with Trust staff to improve patient experience.

The enquiries detailed within this report have been dealt with by the PALS team.

Graph 4.1a Trends of number of **enquiries** received (Q3 2010/11 – Q3 2011/12)



The following methods identify ways in which patient's, their relatives and carers can access the PALS service:

- Telephone (calls are centralised at City Hospital via a direct line)
- Email
- Fax
- Appointment to meet PALS Lead
- Face to face contact at the Patient Support Centre BTC
- Completing a 'have your say form' and posting it in red boxes provided at main reception areas on 3 sites
- Dedicated phone line for direct access to PALS for Rowley Regis Hospital patients/relatives/carers.

Table 4.1a **Top 10 categories** of issues raised with PALS Q3 2011-12

Category breakdown	Number of Contacts Q3
APPOINTMENTS	
Appointment Cancellation	12
Appointment Delay	15
Appointment Notification	3
Appointment time	16
Appointment Booking (Choose and Book)	0
Appointment (other)	1
ATTITUDE OF STAFF	
Admin	1
AHP	1
Ancillary	0
Doctor/Consultant	2

Category breakdown	Number of Contacts Q3
Nurse	9
CLINICAL TREATMENT	
Clinical Care	21
Clinical Treatment	10
Delay in Investigations	1
Delay in Results	3
Delay in Surgery	7
Delay in Treatment	5
Delay in Xray/Scan	5
Information – Condition	8
Medicines	4
Low Staffing levels	0
Support	1
Waiting time	0
Consent	1
COMMUNICATION	
Written	13
Verbal	19
ADMISSION/DISCHARGE/TRANSFER	
Admission Arrangements	0
Discharge Arrangements	11
Transfer arrangements	2
FORMAL COMPLAINTS	
Complaint advice	82
Complaint process	4
Complaint referral	10
Complaint Handling	0
Complaint response time	1
TRANSPORT	
Patient Transport Service	8
Car Park Charges	1
Car Park Condition	2
PERSONAL RECORDS	
Access	7
Content	4
Mislaid	0
GENERAL ENQUIRY	
General Advice	17
Information	12
Referral	0
Support Other ie benefits	5
NHS Services	4

5. Recommendations

The Board is recommended to NOTE the contents of the report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Board Assurance Framework – Quarter 3
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	29 March 2012

SUMMARY OF KEY POINTS:

The Quarter 3 update on the plans to address the gaps in control and assurance against the risks to the delivery of the Trust's annual priorities is attached.

The format of the report has incorporated recommendations from the 2010/11 Internal Audit review of the Board Assurance Framework (BAF), including the need to track any changes made since the previous version.

The Board is asked to note the encouraging progress with completing actions to address any gaps in control and assurance identified.

Following recent external reviews of the BAF, it is planned to refresh the approach to updating and reviewing the document to ensure it fulfils its function as a key document on which the Trust Board and other corporate bodies can draw on for assurance.

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

Approval	Receipt and Noting	Discussion
	✓	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Governance Board on 2 March 2012 and Quality & Safety Committee on 22 March 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Board Assurance Framework (BAF) 2011/12

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

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

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

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

KEY:

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

Cross Reference

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Equality & Diversity Update
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Pauline Richards, Head of Equality and Diversity
DATE OF MEETING:	29 March 2012

SUMMARY OF KEY POINTS:

This report summarises the Trusts progress in developing its Equality Objectives in line with our Public Sector Equality Duty [PSED], under the Equality Act 2010. We are required to set and publish specific and measurable Equality Objectives for the next four years which outlines how we will meet the requirements of the Equality Act 2010 year on year, by 6th April.

Key topics covered in the report include:-

- Proposed draft Equality Objectives
- Proposed draft Equality Objectives Action Plan

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

Approval	Receipt and Noting	Discussion
x		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the contents of the attached report and approve the proposed Equality Objectives.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality, safe care Workforce fit for future
Annual priorities	The Equality Objective is intended to support the achievement of annual priorities, enhancing user and staff experiences
NHS LA standards	Supports and enables compliance with NHSLA Risk Management Standards.
CQC Essential Standards Quality and Safety	Care standard/Outcome 1.
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

The Board receives an update on Equality and Diversity on a quarterly basis.

Report Title	***Equality & Diversity Update***
Meeting	***Trust Board***
Author	***Pauline Richards, Head of Equality and Diversity***
Exec Lead	***Rachel Overfield, Chief Nurse***
Date	***29th March 2012***

Introduction

This report summarises the Trusts progress in delivering the framework for Equality and Diversity (E&D) and continues with a summary of the implications of the recent changes in Legislation relating to Equality.

Currently, delivery of the Framework is monitored by the E&D steering group chaired by the Chief Nurse. There are three subgroups reporting into the E&D steering group; Workforce, Policies and Assessment and Independent Living each chaired by a senior manager. This structure provides leadership, monitoring and reporting functions to give assurances to Trust Board. This report will summarise the work undertaken by these groups

Since April 2011 and the partnership with Sandwell Community Trust, the Community ED lead has joined the Acute Trust service and work is in progress to streamline processes to deliver a corporate service.

The final part of the report identifies recent changes in Legislation. The Equality Act 2010 came into force on 1st October 2010 which draws together existing legislation relating to Equality. A gap analysis has been completed to determine how the Trust complies with the new arrangements

The change in legislation has resulted in the introduction of the Equality Delivery System [EDS] This supersedes the Single Equality Scheme and the report concludes with a summary of the Trusts responsibilities in relation to this.

Progress from Original Framework

Equality Impact Assessments [EqIA]

The Trust has a duty to ensure that its service and policies meet the requirements of the Equality act and this responsibility is delegated to managers of a service to ensure they are compliant. A Toolkit has been developed and implemented to support managers in completing assessments in line with the general duty.

A monitoring system is in place which ensures that all policies have a completed EqIA prior to ratification. Existing policies are EqIA at their review.

A central EqIA register has been developed and holds information on all services and policies that have successfully gone through the EqIA progress, to date there are 319 entries which include 155 Services and 164 policies. Whilst most policies have an EqIA, there remain a number of services still to have an EqIA.

All EqIA that have highlighted any issue/adverse impact have a full assessment undertaken and an action plan agreed to resolve or minimise the impact of the issue. This action is the responsibility of the Divisional teams to ensure that their services meet the requirements within the Act with the support of the ED team.

Education and Training

From April 2012 Equality & Diversity training will be formally offered as a stand alone module and consideration is being given as to whether it should be included in the mandatory training matrix. Existing training programmes such as Trust Induction, Conflict resolution, harassment & bullying will continue to

deliver components of E&D within their contents as well. EqIA education is delivered on a rolling basis for all relevant managers.

In addition to this the E&D team deliver E&D awareness training sessions throughout the organisation and over 1500 staff have attended in the last 9 months.

Since April 2011 and the partnership arrangements with the Sandwell Community, the training program has been revised to ensure it is relevant to all staff groups wherever they deliver service.

The Trust overall compliance stats for Equality and Diversity training has now improved to 45.97% which equates to 3527 staff.

Staff Support

The E&D team provides an advice and information service for all staff to support an understanding of the principles of E&D and how it impacts on their day-to-day work and behaviours. The team also provide a listening ear and individual support for staff members who are seeking help in relation to Equality & Diversity issues. The introduction of the Harassment Advisors has provided staff with additional support and signposting to discuss or explore individual areas of concern.

The outcome of a staff consultation via Hot Topics on the type of diversity staff support groups that staff wanted to have in the organisation showed that over 60% of staff who responded would prefer to have a single staff equality forum in place instead of the current diverse groups e.g. BME, LGBT, Disability. Further work is ongoing to agree the way forward with this.

Community Engagement

This activity is one of the most effective ways to capture genuine and meaningful information which is important to each community. It provides powerful feedback that can truly influence the way the Trust provides its services, interact with individuals and create environments where people feel valued, respected and at ease.

Listening to local communities will help us improve our service users' experiences, whether as an inpatient, an outpatient or a visitor. It also helps to build staff confidence and competence when caring for their patients.

The ED team 'outreach' to a wide variety of community groups with weekly sessions held with various community groups. People attending are asked to give their views on the care they have received with a particular emphasis on them as individuals and their diverse needs. There is an acceptance by respondents that it would be an impossible task for the hospital to meet all of their individual diverse needs and this is taken into consideration in their balanced responses.

A summary of the outcomes of the engagement sessions to date is reported through the Steering group and to the individual managers concerned with a request for action to address where possible. Questions asked are categorised into four areas; Hospital meals/food, Privacy and care, Environment/Cleanliness and Communication/language.

Examples of feedback include:

- ***Hospital meals/Food***

"The hospital has good intentions, but the reality is different". Comments referred to a lack of cultural intelligence on our part, often demonstrated in poor understanding of needs and preferences. Action taken to address this feedback has included incorporating chinese food into hospital menus.

- ***Privacy and care***

Not being encouraged to use bathrooms was cited by a number of respondents even when they were capable of using such facilities. Having a wash by the bed seemed to be the preference of nursing staff and not necessarily the patient. Action to address this is part of the privacy and dignity action plan.

- ***Environment/Cleanliness***

At one engagement event the feedback was quite positive; the general consensus was that cleanliness was excellent. Other events generated more discussions and difference in experience and expectations.

- ***Communication/Language***

This topic generates a great deal of discussion at every event so far! Comments like "staff don't want to understand you" and "doctors use terminology which is not understood" – require simple language. It was felt that mistakes are made because of lack of understanding and suggestion that patients' letters could ask the patient what support they need for language. Interpreting services have been reviewed and a new interpreting policy produced. Language line has been promoted significantly across all wards and a review of access in OPD's is currently underway.

Changes in Legislation

Summary

The Equality Act 2010 came into force on 1st October 2010; it has harmonised existing discrimination law and strengthened the law to support progress on equality. The Act established a new public sector Single Equality Duty which has replaced and simplified the three separate duties that organisation need to take into account as employers, when making policy decisions and in delivering services. Theses duties are gender, race and disability equality. The duty also extends protection to cover age, religion & belief, sexual orientation and gender reassignment.

As a public body organisation the Trust has a general duty to deliver a service with due regard to the need to:

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

The general duty is underpinned by a number of specific duties requiring the publication of equality monitoring data.

Following the implementation of the Equality Act 2010, a gap analysis was undertaken within the Trust to determine the current position against the requirement of the Act. In summary it revealed that the Trust is able to demonstrate good progress in meeting the requirements of the act however there are some areas that required further work to achieve full compliance. An action plan previously shared with the Trust Board is being implemented. The action plan is available if Trust Board members wish to see it. Key issues are:

- some services have not had EiA
- not all staff have been trained
- chaplaincy service inequitable, ie does not cover all religions
- access to breast feeding facilities
- absence of carers strategy
- very little work to date around policies etc to support staff and patients who are transsexual or undergoing gender reassignment.

Equality Delivery System [EDS]

In line with the implementation of Equality Act 2010, the Department of Health Equality Delivery Council has introduced the Equality Delivery System (EDS), a new framework intended to assist NHS organisations

achieve compliance of duties under the Equality Act. This will replace our current Single Equality Scheme (SES).

The Equality Delivery System (EDS) aims to "drive up equality performance and embed equality into the mainstream of NHS business".

The EDS is a set of nationally agreed objectives and outcomes comprising of 18 outcomes grouped under the following 4 objectives:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

Each NHS organisation is required to assess itself against the outcomes using lay assessors, community groups and staff. The outcome of the assessment should lead organisations to agree and publish E&D objectives.

Equality Objectives

Working closely with the SHA regional lead it has been agreed that given the tight timescale for implementing the Equality Delivery System [EDS], the outcome of our equality analysis would be submitted as a pilot initially. Adopting a pragmatic approach will enable us to better gauge our performance, provide learning and form the foundation of our roll-out program.

To avoid repetition and possible exhaustion of local service users, a Black Country Cluster (BCC) wide approach has been adopted to enlist local interest groups. SWBH holds the responsibility for developing and maintaining a database of these groups.

We have held grading workshops with our SWBH Assessors. The events included individual service users as well as community representatives such as Gender Matters, Birmingham Institute for the Deaf (BID), Sandwell Irish Centre, Rights & Equality Sandwell, Agewell and Jehovah Witness. The groups worked through a variety of evidence presented, this included service specific information and cross referenced to other evidence such as policies, CQC outcomes, Patient Experience Surveys, Staff Survey.

Feedback to date has been positive and included suggestions that could further improve patients' experiences and outcomes. It was generally felt that in order to have a grade that is reflective of the organisation performance against the EDS outcomes the evidence for goals 1 & 2 would need to be presented on a service by service basis, whereas for goals 3 & 4 the evidence could be presented and analysed from an organisational perspective – [see Appendix 1].

Criteria for Success

The success of the Equality Objectives is dependent on a number of factors which we will need to ensure is embedded in our delivery framework;

- Leadership support and buy in at all levels of the organisation,
- Engagement of staff, managers, local interests and relevant partner agencies,
- Resources to support the relevant activities
- Collaborative working within and without the organisation
- Training and staff development.

Our Equality Objectives

In developing our draft Equality Objectives we undertook a thorough consultation as discussed. All of our Equality Objectives have been drawn from the evidence and data currently collated on protected groups including our workforce.

These require approval by Trust Board and then at least annual review. Objectives will be published on the Trust Internet by 1st April along with up to date E&D data.

In line with the legislation our equality objectives must be specific and measurable and set out how progress will be measured.

The following are our proposed draft Equality Objectives:

Objective 1: Governance – ensure effective governance structure and processes are in place to support the delivery of equality, diversity and Inclusion.

Objective 2: Equality Data analysis – Improve the monitoring processes for equality data by protected characteristics for both service users and staff.

Objective 3: Leadership – ensure all senior leaders and managers have an annual objective as part of their Personal Development Reviews [PDRs] to embed equality, diversity and inclusion within their areas.

Objective 4: Service Delivery – ensure that our services are designed and delivered in ways which meet the needs of our service users, ensuring quality of outcomes and experiences.

Objective 5: Training and Development – ensure staff are culturally competent and confident in the provision of care promoting and maintaining dignity, respect and inclusion at all times.

A detailed action plan is attached as Appendix 2.

Summary

There is a great deal of activity taking place across the Trust, in relation to embedding equality and embracing diversity and Inclusion. Some of these have been highlighted within this report. These objectives support the Trust vision to 'improve the health and wellbeing of people … and provide the highest quality healthcare'. We recognise the on-going nature of this work and will continue to monitor and measure equality and the quality of outcomes based on the goals and outcomes which underpin the Equality Delivery System (EDS) and aligned with the Care Quality Commissioners equality standards.

The Trust Board is asked to approve the proposed draft equality objectives.

Appendix 1

EDS Objectives and Outcomes

The analysis of the outcomes must cover each protected group and be based on comprehensive engagement, using reliable evidence.

Objective	Narrative	Outcome
1. Better health outcomes for all	**The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results**	**1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities**
		1.2 Patients' health needs are assessed, and resulting services provided, in appropriate and effective ways
		1.3 Changes across services are discussed with patients, and transitions are made smoothly
		1.4 The safety of patients is prioritised and assured
		1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	**The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience**	**2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds**
		2.2 Patients are informed and supported so that they can understand their diagnosis, consent to their treatments, and choose their places of treatment
		2.3 Patients and carers report positive experiences of the NHS, where they are listened to and respected and their privacy and dignity is prioritised
		2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently
3. Empowered, engaged and well supported staff	**The NHS should increase the diversity and quality of working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs**	**3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades**
		3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing the same work in the same job being remunerated equally
		3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately
		3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all
		3.5 Flexible working options are made available to all staff, consistent with the needs of the patients, and the way that people lead their lives.
		3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population
4. Inclusive leadership at all levels	**NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions**	**4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond.**
		4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination
		4.3 The organisation uses the NHS Equality and Diversity Competency Framework to recruit, develop and support strategic leaders to advance equality outcomes.

Appendix 2

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Equality Objectives Action Plan
March 2012
Proposed DRAFT

Status Key:

	Dark Green/ Complete
	Light green/ On track will be completed by target date]
	Amber/ Unlikely to be completed by target date **On track**
	Red/ Uncompleted beyond target date]
	White/ Not yet commenced

Objectives	Action	Measure	Progress	Timeframe	By whom	Status
1. Establish Robust Governance structure and process to support the delivery of Equality, Diversity and Inclusion.	Review the existing governance structure and processes for Equality & Diversity within Organisation.	Robust governance structure and reporting processes in place to support the Trust Equality duties in relation to the Equality Act 2010.				
	Promote Governance structure and processes for E&D within the organisation	Staff are aware of the functions and Reporting processes for E&D governance structure within the organisation.				
2. Improve the Trust Equality Monitoring data for service Users **Improve the Trust Equality Monitoring data for Staff**	Work collaboratively with IM&T department to enable the capture of equality data monitoring by protected characteristic.	Quarterly progress reports submitted via E&D Governance reporting structure.				
	Raise awareness of the importance of data capture to staff and patients	Equality data information is available by increasing numbers of protected characteristics.				
	Work collaboratively with HR to improve our current level of Equality monitoring data for our workforce.	Quarterly progress reports will demonstrate improve equality data by protected characteristic for our workforce.				
	Analyse the workforce equality data by PCs to identify potential inequalities.	Trends identified are addressed within a specified timeframe and reported via the E&D Governance reporting structure.				
	Support promotional events to encourage staff to disclose equality data.	Equality Monitoring information of our workforce is available by increasing numbers of protected characteristics.				
3. Ensure Equality,	Ensure members of the Executive team	Equality and Diversity activities will				

Diversity & Inclusion is embedded at all levels throughout the Trust.	and senior manager actively champion Equality and Diversity across the Trust.	include support and involvement of Executive team members and senior managers where appropriate				
	All managers to have an annual objective to embed equality, diversity and inclusion within their area.	Annual Personal Development Reviews will demonstrate achievement against the E&D objective.				
	Equality Objectives to form part of the Business planning cycle and decision making locally.	Reduction in Equality Impact Assessment actions				
4. Ensure that services are designed and delivered in ways that meet the needs of our service users to ensure quality of outcomes and experiences.	Ensure all services, policies and function are Equality Impact Assessed [Equality Analysis]	A robust system in place supporting the Equality analysis outcomes of all services, policies and function.				
	Patient Experience Survey analysis informs and ensures high quality care delivery across the Trust.	Improved patient experiences and reduction in complaints.				
5. Ensure staff are culturally competent and confident in the provision of care delivery, promoting and maintaining dignity, respect and inclusion at all times.	All staff to attend mandatory training for Equality and Diversity	The overall percentage of staff compliant for equality and diversity training will increase quarterly to reach above 70% by Qtr 4 (March 2013).				
	Additionally staff training needs in relation to Equality & Diversity to be identified through Personal Development Review process.	Reduction in formal disciplinary cases and increase moral and take up of promotional opportunities by all staff.				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Staff Health and Well Being Update
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Overfield, Chief Nurse
AUTHOR:	Tamsin Radford, Consultant Occupational Health Physician.
DATE OF MEETING:	29 March 2012

EXECUTIVE SUMMARY:

The report identifies the on-going improvement the Trust is making with addressing the Health and Well-Being agenda, evidenced by feedback from the 2011 staff survey and improvements in sickness absence levels.

Key priorities for further action are identified as follows:

- A continued focus on the on-going management performance of sickness absence to ensure the achievement of reducing the level of sickness absence further towards internal and SHA targets in 2012
- The continued delivery of the Trust's staff health and well-being action plan, with a particular focus on needs assessment, evidence and application of NICE guidelines.
- Continued delivery of the Trust's sickness absence action plan to ensure compliance with the Strategic Health Authority sickness absence target of 3.39% by 31st March 2013.
- Promoting a new web based staff health and well-being communications package and improving provision of information to staff not on e-mail.
- Review of the sickness action plan with respect to community based services, where sickness levels are traditionally higher than that experienced within the acute part of the Trust.
- Piloting (in community adults division) and establishing a course to encourage employees with regular short term sickness absence to change their behaviour.
- Building on the successful accreditation of occupational health services by using their expertise to support managers and HR with difficult cases of sickness absence and "pockets" of high absence.
- Evaluation of health and well-being initiatives take up with respect to Diversity to ensure that the health needs of Trust employees are being addressed across all diversity strands.

REPORT RECOMMENDATION:

Ongoing delivery of the Health and Wellbeing and Sickness Absence Action Plans.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

- Trust Objective – To reduce Sickness Levels
- Workforce Efficiency Programme
- CQC standards concerning supporting staff

PREVIOUS CONSIDERATION:

Twice yearly update included on the Trust Board reporting cycle

SWBTB (3/12) 038 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

STAFF HEALTH AND WELL-BEING

Trust Board Update

February 2012

1. Introduction

1.1 The purpose of this paper is to inform the Trust Board of the actions taken and progress made by the Health and Wellbeing / Sickness absence operational committee, to continue to reduce levels of employee sickness absence and improve staff health and well-being.

2. Background - National

2.1 Research has illustrated that where NHS organisations prioritise staff health and well-being performance is enhanced, patient care improves, staff retention is higher and sickness absence is lower. In turn, agency staff costs are reduced and productivity improves.

The Boorman Review in 2009 set out the first widely accepted business case for embedding employee health and wellbeing within NHS organisations.

2.2 Since then Health and wellbeing for staff has been included in the Operating Framework for the NHS in England 2011/12 which states “The NHS remains committed to protecting and improving staff health and well-being and reducing unnecessary sickness absence” and includes the reduction of sickness absence rates in the NHS as a key indicator against which S.H.A.s and new clusters will be held to account.

2.3 In January 2012 the government accepted the latest recommendations set out in the NHS Future Forum second phase report, which recommends a strengthened responsibility on NHS organizations to improve the health and well-being of their staff, led by accountable leadership in partnership with staff.

The report recommends that NHS organisations should use NICE public health guidance and the Public Health Responsibility Deal pledges to guide how they support staff.

2.4 Nationally in the last twelve months the Department of Health has recommended changes to occupational health provision to complement these policies and developments in “Healthy Staff, Better Care for Patients: Realignment of Occupational Health Services to the NHS in England” which provides a vision for the provision of health and well-being services to the NHS and recommendations for change including quality based accreditation which was obtained by the Trust occupational Health department in 2011.

2.5 The Care Quality Commission has now recommended staff health and wellbeing for inclusion as one of their 29 indicators. It is likely to be included in their risk appraisal of NHS trust organisations and monthly feedback reports.

3. Background - local

3.1 The Trust's staff health and well-being agenda remains an integral part of the workforce strategy. It compliments and supports the Trust's wider organization development plans including the transformation plan and the workforce efficiency programme group.

3.2 The Staff Health and Well-Being / Sickness absence operational Committee is responsible for overseeing the implementation and action plan and reports to the Trust Governance Board through the Workforce Programme Efficiency group. The Chief Nurse (Executive Lead for Workforce) is the Board level staff health and well-being champion. The Trust employs a part time Health and Wellbeing co-coordinator who works within Occupational Health.

4. KEY CHANGES SINCE LAST REPORT (August 2011)

4.1 Terms of reference were revised for the committee in December 2011 to include Divisional General Manager and lead nurse representation and Trade Union input. The committee has taken over initial responsibility for sickness absence in addition to Health and wellbeing. Lesley Barnett (deputy director of workforce) now chairs the committee supported by the Head of Occupational Health, an HR manager and the health and Wellbeing co-coordinator. The committee alternates month to month between Health and Wellbeing issues and sickness absence reviews.

4.2 Due to the change in the key responsible personnel a new action plan was established by the new committee for 2012. This includes the following key aims

4.3 ESTABLISHING AND MAINTAINING A "SMART"ER HEALTH AND WELLBEING PROGRAMME

- Establish Quarterly Health and Wellbeing themes – Obesity, The aging Workforce, Mental Health and Drugs and Alcohol (reflecting areas indicated by NICE to be of major concern in the NHS workforce)
- Each theme to have a robust evidence base for its inclusion to include all local and national guidance and research
- Each theme to have a needs assessment done for the Trust staff to inform its objectives, events and communication plan
- SMART objective setting for each theme with data gathering (e.g. uptake of events) and analysis (e.g. how effective were they) informing future events
- Two way communications via a variety of media with a branded Health and Wellbeing Information strategy and feedback analysis.

Examples of 4.3 included for information in appendix 1

4.4 ACTIVELY ENGAGE WITH ALL STAFF TO ENSURE SICKNESS ABSENCE REDUCTION

- The three wards / departments with the highest rate of sickness absence invited to attend committee with management support
    - Information proformas completed by the line manager and discussed with core committee who offer advice and support if required
    - Department / ward asked to complete an action plan following discussion which is then regularly reviewed by committee until absence levels are acceptable or escalation to the Director of Workforce is recommended.
- Continue the rolling programme of sickness absence management training (updated to reflect new policy) and feedback to divisions on attendance.
- Plan and pilot self care course targeted at employees with repeated short term absences to improve their attendance
- Six weekly case conferences with HR and Occupational Health continue to review all cases of absence >3 months and ensure appropriate actions are underway with reporting back by HR managers to teams where process has not been followed to prevent recurrences or highlight training needs.

5. Progress to date

5.1 The key findings from the national staff survey specific health and well being questions (completed by staff at the end of 2011) are shown below and the dramatic increase in staff reporting the Trust providing health and wellbeing / lifestyle advice / support, and the performance against other acute Trusts should be noted here as a particular success of the health and wellbeing strategy to date.

	2010	2011	Average for acute trusts
% saying they have access to counselling services at their Trust	74	72	65
% saying they have felt unwell in the last 12 months as a result of work-related stress	29	20	29
% agreeing/strongly agreeing that “in general, my job is good for my health”	35	40	35
% agreeing/strongly agreeing that “my immediate manager takes a positive interest in my health and well-being”	35	38	38
Does your Trust provide Advice for staff on diet Advice for staff on alcohol consumption	 15 21	 42 36	 24 23

Advice for staff on exercise	41	66	36
Help for staff that want to stop smoking	68	79	72
Help with the cost of gym membership	36	48	27
Bicycle racks	46	65	70
Healthy food in canteens	53	62	57

5.2 Uptake figures for some of the activities offered to staff in 2011 were obtained but patchily and it is recognized by the new Leads that a more regular and robust data collection / presentation strategy is an integral part of the action plan for 2012. It will be included in future Trust Board reports as well as the quarterly Workforce dashboard reports to TMB and monthly updates to the Director of Workforce.

5.3 Events plan offered so far in 2012 is included for information in Appendix 2.

5.3 The Trust's average sickness rate over monitored over the preceding12 month period shows a positive downward trend, as evidenced in Appendix 3. This is consistent with a sustained improvement in sickness absence levels since 2009/10. The Trust's current average sickness absence period for the 12 month period as at February 2012 is 4.03 % which is above the current Strategic Health Authority target of 3.75 % for the year ending 31 March 2012.

5.4 Whilst there is clearly further work required, the Trust compares favourably with other local acute NHS employers as set out below using the most up to date benchmark data available (source, SHA Productive Workforce Metrix – December 2011):

Worcestershire Acute	4.09 %
George Eliott	4.20 %
Heart of England	4.07 %
Mid Staffordshire	4.93 %
South Warwickshire	4.18 %
Royal Wolverhampton	4.50 %
Uni Hosp Birmingham	3.93 %
Uni Hosp Cov & Warw	4.30 %
Walsall	3.98 %

5.5 An updated sickness absence policy has recently been approved and is now in the process of being fully implemented across the organization. The new policy introduces tighter 'triggers' for management action and an extended period within which staff with short-term sickness absence are kept under management review. The policy is accompanied by detailed management guidance notes and supported by a management training programme.

6. Staff Health and Well-Being Priorities

6.1 To continue to improve the health and well-being of the workforce continues to be a key strategic priority within the Trust's Workforce Strategy. Our plan of work includes:

- A continued focus on the on-going management performance of sickness absence to ensure the achievement of reducing the level of sickness absence further towards internal and SHA targets in 2012

- The continued delivery of the Trust's staff health and well-being action plan, with a particular focus on needs assessment, evidence and application of NICE guidelines.

- Continued delivery of the Trust's sickness absence action plan to ensure compliance with the Strategic Health Authority sickness absence target of 3.39% by 31st March 2013.

- Promoting a new web based staff health and well-being communications package and improving provision of information to staff not on e-mail.

- Review of the sickness action plan with respect to community based services, where sickness levels are traditionally higher than that experienced within the acute part of the Trust.

- Piloting (in community adults division) and establishing a course to encourage employees with regular short term sickness absence to change their behaviour.

- Building on the successful accreditation of occupational health services by using their expertise to support managers and HR with difficult cases of sickness absence and "pockets" of high absence.

- Evaluation of health and well-being initiatives take up with respect to Diversity to ensure that the health needs of Trust employees are being addressed across all diversity strands.

7. Conclusion

7.1 Good progress is being made against the Health and Wellbeing and sickness absence action plans despite the early stage of the new plan and structure. It is essential that the factors affecting staff attendance and well-being continue to maintain a high profile and continue to have visible Board level support.

7.2 Staff survey findings and hot topics / survey feedback show the staff value the health and wellbeing interventions on offer. It is recognized that more detailed data on uptake and results will be needed in 2012 to inform any future decisions the Board will make on resource implications and sustainability of the initiatives currently offered.

7.3 A range of interventions support the reductions in sickness absence within the Trust and these will need to continue to ensure sickness absence targets are met.

8. Recommendations

8.1 The Trust Board is asked to receive and note this paper.

Appendix 1

JUSTIFICATION FOR HEALTH AND WELLBEING LOOKING AT OBESITY IN JANUARY-MARCH 2012

THE COST OF THE PROBLEM

The Health Select Committee (HSC) reported that the cost of obesity in England is up to £3.7 billion per year – this includes treating obesity, treating the consequences of obesity, the costs of premature death and sickness absence. The cost of obesity plus overweight is estimated at between £6.6 and £7.4 billion per year (1).

Conditions proven to be linked with obesity include-

- type 2 diabetes
- coronary heart disease (CHD)
- hypertension
- various cancers
- osteoarthritis
- Back problems
- Sleep Apnoea

THE NEED IN OUR TRUST

38% of our staff live in the Birmingham area where rates of obesity are 26.4% - within the worst quartile in the country. A further 36% live in Sandwell where rates are worse at 28.7%. If our staff are representative of the population as a whole this would mean approximately 1400 of those 5100 staff are obese – plus an unknown percentage of those 1800 who live outside these two areas.
Source - http://www.apho.org.uk/default.aspx?RID=49802

OBESITY LEADS TO SICKNESS ABSENCE

Ferrie and colleagues studied over 5500 British civil servants, taking baseline anthropometric measures and questionnaire data. Sickness absence for both short (less than seven days) and medically certified (beyond seven days) spells per year were recorded. the researchers concluded that:

- obesity was a significant predictor of short-term and long term absence in women and
- both overweight and obesity were significant predictors of short-term absence in men.(2)

OBESITY LEADS TO WORK DISABILITY AND LIMITATIONS

Body mass index is a strong predictor of early work disability. Although being modestly overweight has little impact on mortality, it predicts severe functional impairment. One study concluded that the award of disability pensions could be prevented by effective weight management (3)

In a study undertaken in an NHS obesity clinic-

- 17% of this population were unemployed or on incapacity benefit
- 50% had taken time off for health problems which they attributed to their
- weight
- 25% had difficulty wearing work uniforms, 30% personal protective equipment
- 13% had difficulty with the arrangement of their desk and their computer
- 17% also had difficulties attending emergencies(4)

The impact of obesity on work limitations was confirmed by Hertz et al., who found that obese workers experienced higher rates of work limitations compared to normal weight workers (6.9% vs 3.0%)(5)

THE NICE GUIDELINES INDICATE THAT-.

- onsite catering should promote healthy food and drink choices (for example by signs, posters, pricing and positioning of products)
- physical activity should be promoted through active travel plans, encouraging staff to use stairs, and providing showers and secure bike parking (6)

(1)www.radcliffe-oxford.com/.../Williams%20chapt%2004-109a6e80rdz.pdf
(2) Ferrie JE, Kivimaki M, Head J. Weight and weight gain: implications for sickness absence in British civil servants over a fi ve-year period from the late 1980s. Track 3 work-related health problems and healthcare needs. www.eupha.org.html/2005
3)Rissanen A, Heliovaara M, Knekt P et al. Risk of disability and mortality due to overweight in a Finnish population. BMJ 1990; 301 (6756): 835–7.
(4) Williams NR, Malik N. Obesity and work: perceptions of a sample of patients attending an NHS obesity clinic. Occupational Health. October 2005.
(5) Hertz RP, Unger AN, McDonald M et al. The impact of obesity on work limitations and cardiovascular risk factors in the US workforce. J Occup Environ Med. 2005; 46 (12): 1196–203.
(6)http://guidance.nice.org.uk/CG43

Obesity quarter objectives

- To provide appropriate healthy eating literature at all food and drink outlets across the Trust by end of quarter with a maintenance plan
- To engage 200 staff in an exercise class, gym membership or Slimwell during the quarter
- Target areas with limited access to e-mail or time to access e-mail by circulating information via the DGM to a nominated “champion” in each division
- To hold one face to face teaching session on issues around obesity at each site by end of quarter and evaluate the feedback from it to inform future events
- Promote membership of the gym and increase membership number by end of quarter
- To deliver an obesity “fact of the week” via staff comms each week throughout the quarter.
- For occupational health to refer all suitable cases to the local physical exercise scheme for rehabilitation and to record this to provide total numbers and case mix at the end of the quarter
- To provide an article for Heartbeat on obesity
- To continue to measure and prove a sustained increase in take-up of lunchtime walks

APPENDIX 2
Obesity Quarter events plan

1) Staff Health Screening

All staff were invited to attend at one of three days, across all hospital sites, as a drop in session. A forty minute, personal interview with a health trainer was also offered within the screening session and free literature on all aspects of a healthy lifestyle was given out during the day.
UPTAKE FIGURES – awaited from My Time Health

The results of the staff health screening days will be analysed at the end of the quarter to inform future needs assessments. Staff that attended the sessions were also asked to complete a brief (five minute) questionnaire on obesity awareness Questionnaires will be analysed at the end of the quarter to give some indication as to the knowledge staff already have surrounding obesity\ healthy eating \diet and exercise and whether this has changed due to the communications plan.

2) Slimwell Weight Management Promotional Event

Two promotional events were held across Sandwell and City sites during mid January. Literature provided by The British Heart Foundation on healthy eating, smoking cessation, healthy lifestyle choices and physical exercise programmes were given out to staff during the event. The Obesity Awareness Questionnaire was again presented during the events.
UPTAKE FIGURE – available at end of quarter (April)

3) Sandwell Physical Activity Referral Scheme

Staff that present to Occupational Health and well being Services, who are obese or overweight, are given the option to be referred to The Sandwell Physical Activity Referral Scheme. This programme is by referral basis only and will be evaluated at the end of the quarter for numbers of staff referred onto the programme.

4) Physical Exercise Programmes

Liaison with the Management Team, of the Active Health Club Gym, has been productive with a special staff New Years Membership at just £ 12.50 per month.

Currently exercise classes offered to staff include: Boxercise, Aerobics and Yoga. Zumba classes will recommence mid February. A new running club is available for all staff.

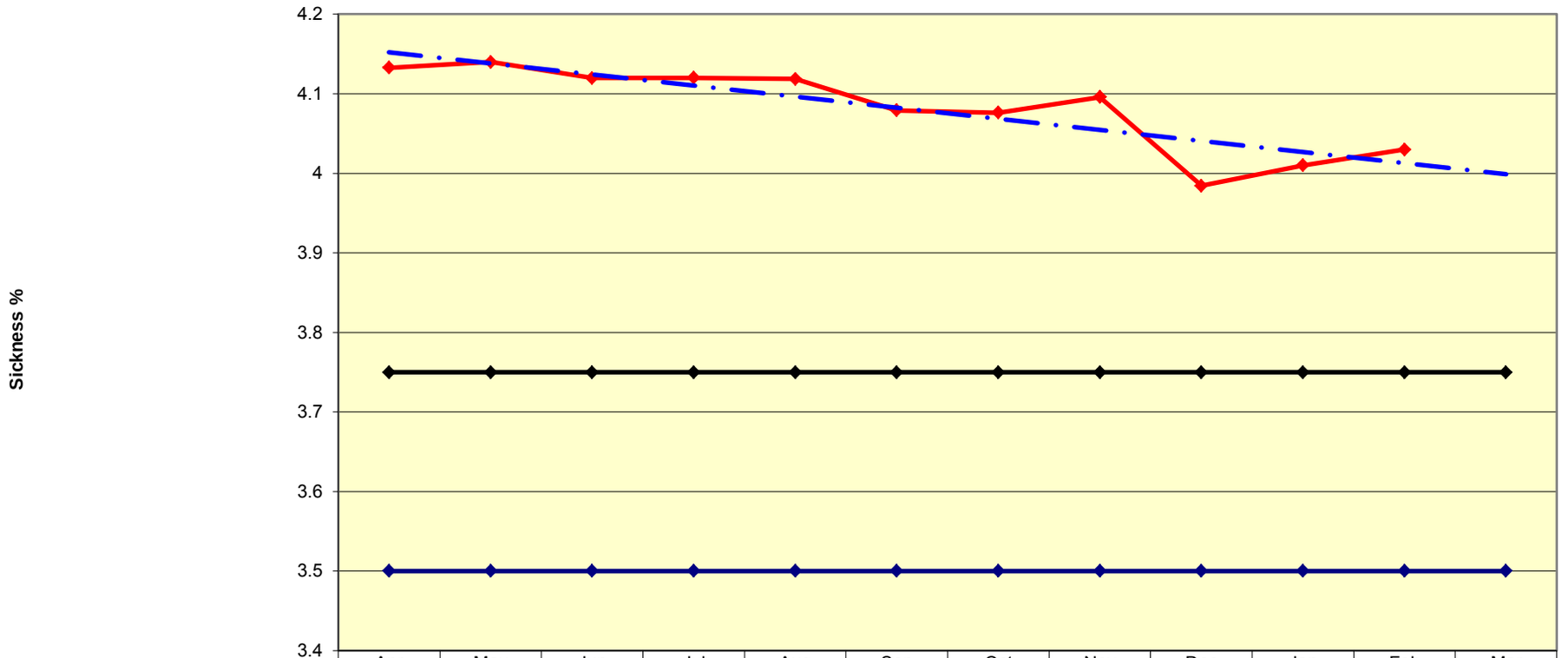
Corporate membership benefits have been negotiated with both Sandwell and Birmingham Councils. Both councils are offering 20% discount to all staff employees on their Leisure Membership Packages. It is proposed to offer free taster passes, for both schemes, during mid February.

The Cycle to Work scheme has also been promoted
UPTAKE FIGURES – available at end of quarter

Appendix 3

Combined R12M Graphs

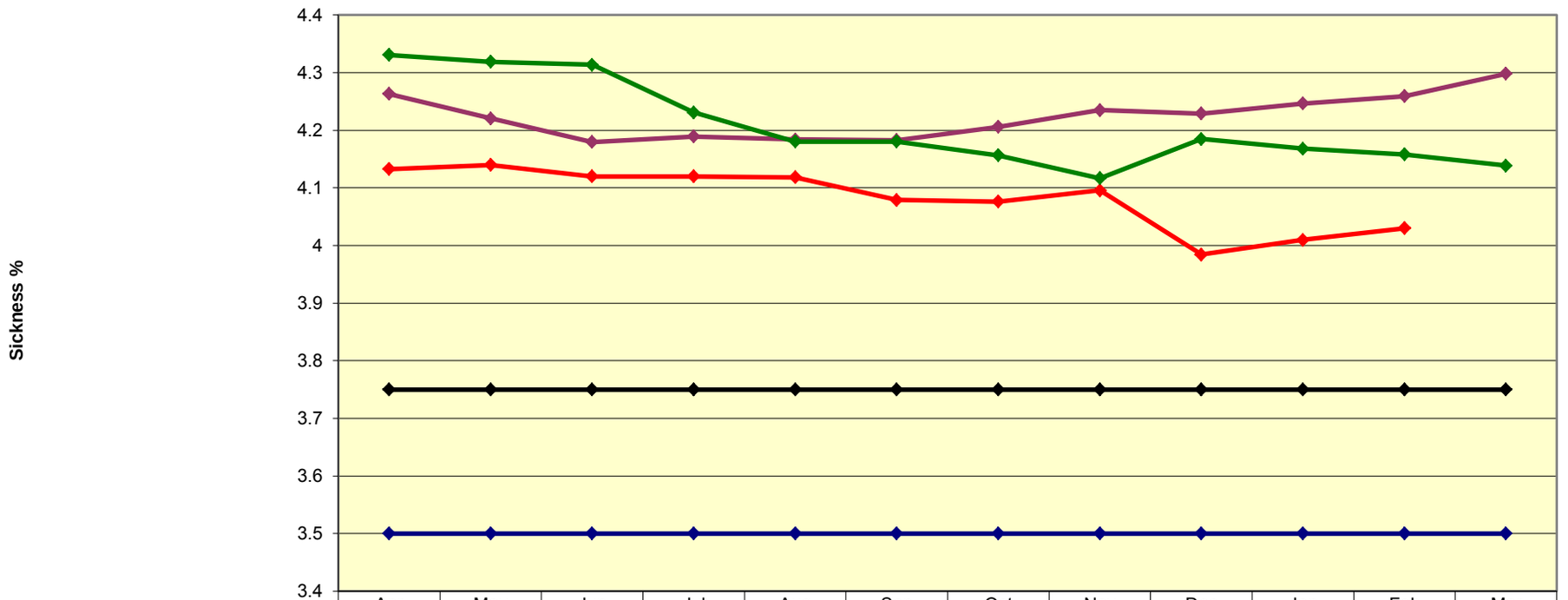
Current R12M with Trendline



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12 - Internal Target	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5
2011/12 - Trust Combined %	4.1326614	4.1397753	4.1198686	4.1200055	4.1185739	4.0790571	4.0761928	4.095862	3.9844161	4.01	4.03	
2011/12 - SHA Target	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75

Month

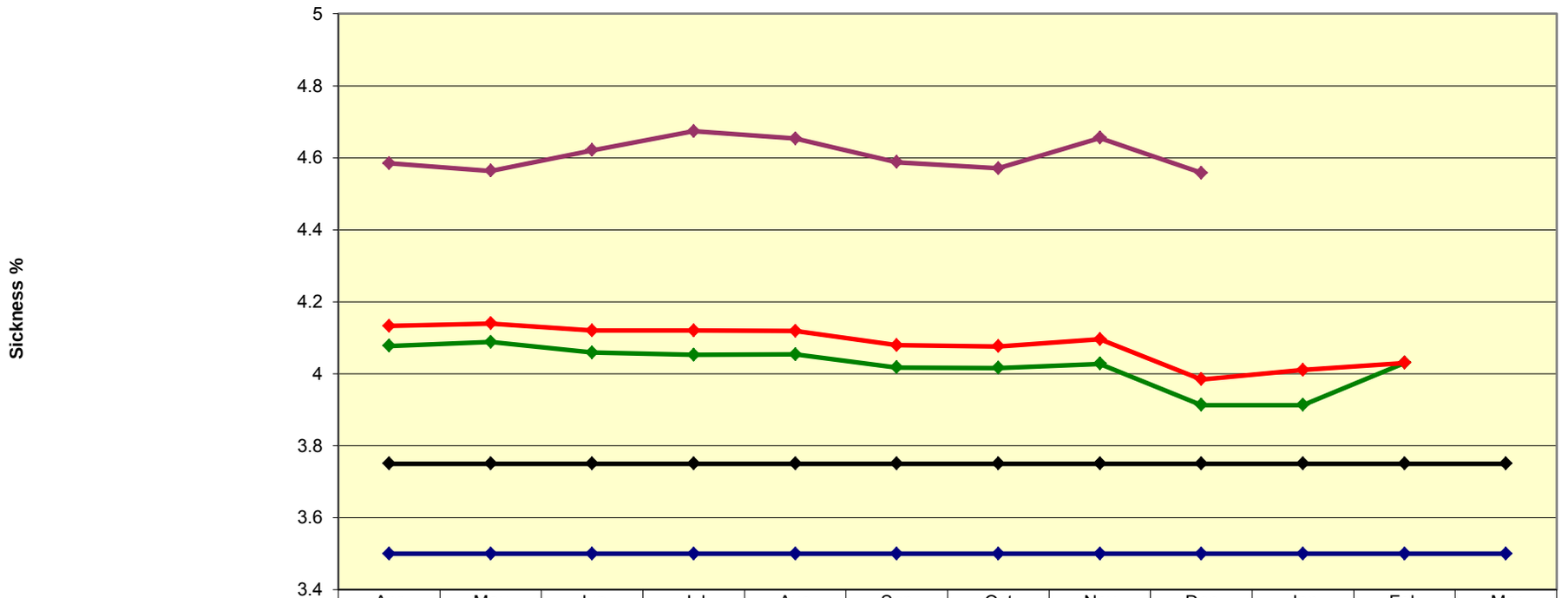
R12M Trust Sickness - Comparative Years



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12 - Internal Target	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5
2011/12 - Trust Combined %	4.1326614	4.1397753	4.1198686	4.1200055	4.1185739	4.0790571	4.0761928	4.095862	3.9844161	4.01	4.03	
2009/10 - Trust combined %	4.263095	4.2206362	4.1799023	4.1894002	4.1841692	4.1828282	4.2059438	4.2351638	4.2290948	4.2464591	4.2591335	4.2983541
2010/11 - Trust combined %	4.3308059	4.3189296	4.3139003	4.2311854	4.1805272	4.1804056	4.1568029	4.1168684	4.1847931	4.1681356	4.1583587	4.1388906
2011/12 - SHA Target	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75

Month

R12M Trust Sickness v SHA Target



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12 - Acute	4.0770451	4.0877969	4.0586679	4.0524771	4.0534988	4.0170829	4.0159079	4.027557	3.9126723	3.9129126	4.03	
2011/12 - Community	4.5843663	4.5636667	4.6206726	4.673748	4.6531282	4.5879802	4.5705627	4.6553696	4.5577723			
2011/12 - Internal Target	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5
2011/12 - Trust Combined %	4.1326614	4.1397753	4.1198686	4.1200055	4.1185739	4.0790571	4.0761928	4.095862	3.9844161	4.01	4.03	
2011/12 - SHA Target	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75

Month

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – February 2012
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	29 March 2012

SUMMARY OF KEY POINTS:

The report provides an update on the financial performance of the Trust for February 2012.

For February, the Trust generated a "bottom line" surplus of £541,000 which is £89,000 higher than the planned position (as measured against the DoH performance target).

For the year to date, the Trust has a surplus of £1,534,000 which is £168,000 better than the planned position

Capital expenditure for the year to date is £6,188,000 and the cash balance at 29th February was £44.0m.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 20 March 2012 and Fi9nance & Performance Management Committee on 22 March 2012.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – February 2012

EXECUTIVE SUMMARY

• For the month of February 2012, the Trust delivered a "bottom line" surplus of £541,000 compared to a planned surplus of £452,000 (as measured against the DoH performance target).

• For the year to date, the Trust has a surplus of £1,534,000 compared with a planned surplus of £1,366,000 so generating an positive variance from plan of £168,000.

•At month end, WTE's (whole time equivalents), including the impact of agency staff, were 165 below planned levels. This compares with a position last month of 225 below plan. Total pay expenditure for the month, inclusive of agency costs, is £454,000 below the planned level.

• The month-end cash balance was approximately £28.6m above the planned level.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	89	168	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	(14)	(318)	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	454	2,887	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(293)	(2,545)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	165	78	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	26,518	26,518	>= Plan	> = 95% of plan	< 95% of plan

Note: positive variances are favourable, negative variances unfavourable

Performance Against Key Financial Targets

Target	Year to Date Plan £000	Year to Date Actual £000
Income and Expenditure	1,366	1,534
Capital Resource Limit	20,937	6,188
External Financing Limit	---	26,518
Return on Assets Employed	3.50%	3.50%

2011/2012 Summary Income & Expenditure Performance at February 2012	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	379,667	31,357	31,184	(173)	344,768	343,165	(1,603)	378,636
Other Income	40,589	3,124	3,122	(2)	35,461	36,404	943	40,066
Operating Expenses	(396,689)	(32,214)	(32,053)	161	(358,916)	(358,574)	342	(395,594)
EBITDA	23,567	2,267	2,253	(14)	21,313	20,995	(318)	23,108
Interest Receivable	25	2	13	11	23	104	81	104
Depreciation & Amortisation	(13,269)	(1,106)	(1,014)	92	(12,163)	(11,758)	405	(12,889)
PDC Dividend	(5,803)	(484)	(484)	0	(5,319)	(5,319)	0	(5,803)
Interest Payable	(2,156)	(180)	(180)	0	(1,976)	(1,976)	0	(2,156)
Net Surplus/(Deficit)	**2,364**	**499**	**588**	**89**	**1,878**	**2,046**	**168**	**2,364**
IFRS/Impairment Related Adjustments	(557)	(47)	(47)	0	(512)	(512)	0	(557)
SURPLUS/(DEFICIT) FOR DOH TARGET	**1,807**	**452**	**541**	**89**	**1,366**	**1,534**	**168**	**1,807**

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

Sandwell and West Birmingham Hospitals NHS

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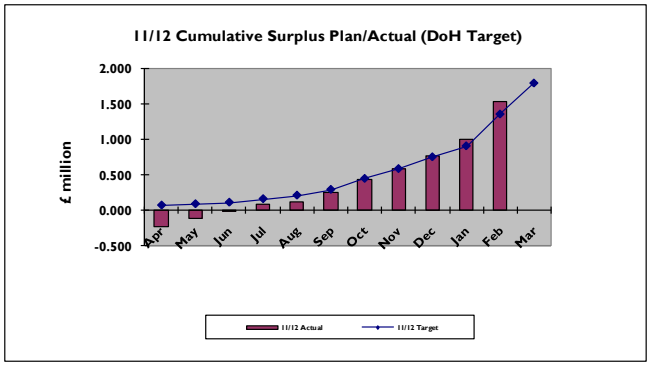
Financial Performance Report – February 2012

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Net bottom-line performance delivered an actual surplus of £541,000 in February against a plan of £452,000. The resultant £89,000 positive variance moves the year to date position to £168,000 above targeted levels.

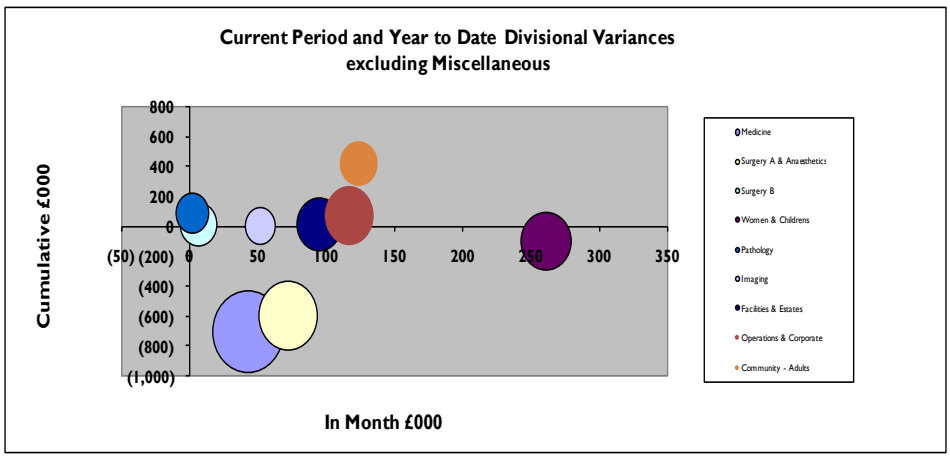


Divisional Performance

• For February, the only adverse variance is within the non operational area and this is largely the result of a cautious approach being taken on commitments which cannot be attributed to divisional performance.

• Performance against main SLAs is ahead of plan for January (the latest month for which fully costed data is available) although it should be recognised that there has been a further phased reduction in planned levels of activity and income which may be a contributory factor in this improved position.

• The main areas with improving budgetary performance during February include Women & Childrens (primarily driven by improved SLA income), Community – Adults and Corporate Services.



The tables adjacent and below show no significant in month adverse variances from plan and surpluses being generated in a number of areas. Ongoing year to date deficits continue for the Divisions of Surgery A, Womens & Child Health and Medicine, although at a reduced level.

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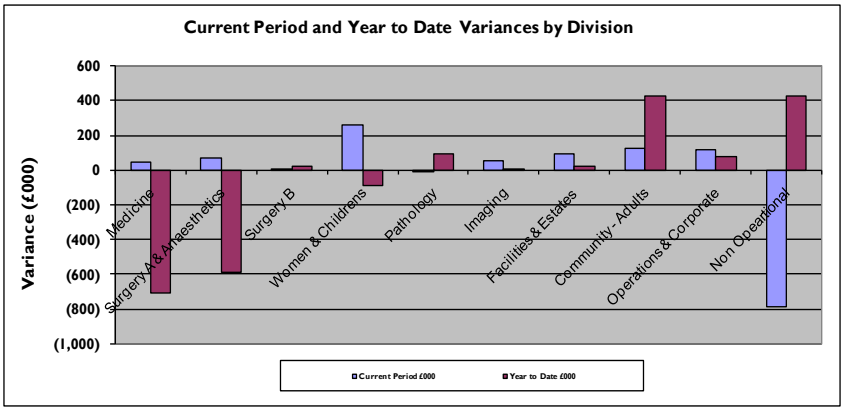
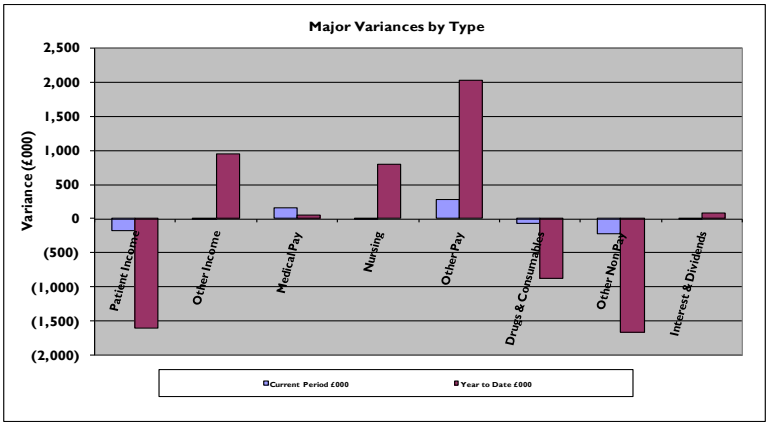
Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine	43	(703)
Surgery A & Anaesthetics	72	(591)
Surgery B	6	21
Women & Childrens	261	(92)
Pathology	2	92
Imaging	51	7
Facilities & Estates	95	20
Community - Adults	124	428
Operations & Corporate	117	75
Non Opeartional	(786)	427



For February, overall patient related income shows a small adverse variance (main SLA performance being offset by adverse variances elsewhere) along with non pay but a significant positive position against plan for pay.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	(173)	(1,603)
Other Income	(2)	943
Medical Pay	166	53
Nursing	11	801
Other Pay	277	2,033
Drugs & Consumables	(74)	(882)
Other Non Pay	(219)	(1,663)
Interest & Dividends	11	81



Sandwell and West Birmingham Hospitals NHS

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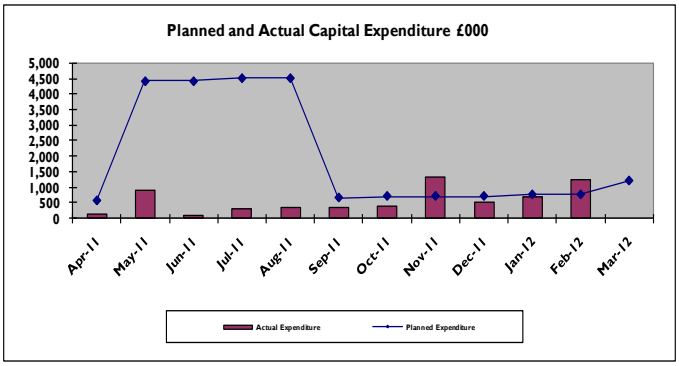
Capital Expenditure

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

•February expenditure was slightly higher than planned for the month at £1.2m primarily related to statutory standards and medical equipment.

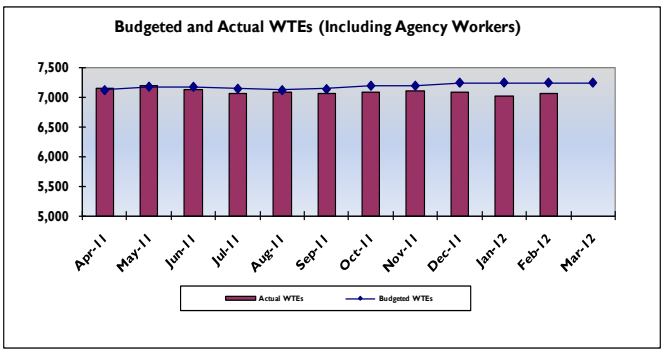


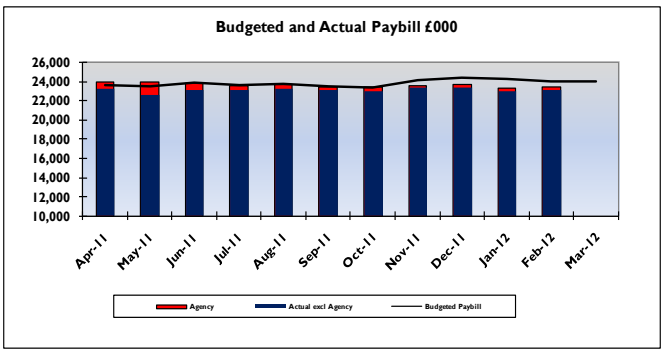
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 165 below plan for February compared with 225 below plan in January. Excluding the impact of agency staff, wte numbers are around 272 below plan. Actual wtes have increased by approximately 58 compared with January.

• Total pay costs (including agency workers) are £454,000 lower than budgeted levels for the month , particularly on medical, scientific & therapeutic and support staff groups.

• Expenditure for agency staff in February was £431,000 compared with £404,000 in January, an average of £518,000 for the year to date and a February 2011 spend of £598,000. The biggest single group accounting for agency expenditure remains medical staffing.





Sandwell and West Birmingham Hospitals NHS

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Financial Performance Report – February 2012

Pay Variance by Pay Group

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

Analysis of Total Pay Costs by Staff Group

	Year to Date to February					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	69,523	66,451		3,019	69,470	53
Management	14,161	13,732		0	13,732	429
Administration & Estates	29,315	27,241	1,171	762	29,173	142
Healthcare Assistants & Support Staff	28,346	25,895	2,051	153	28,099	247
Nursing and Midwifery	80,737	75,839	3,085	1,013	79,936	801
Scientific, Therapeutic & Technical	40,755	38,805		751	39,556	1,199
Other Pay	36	20			20	16
Total Pay Costs	262,873	247,982	6,306	5,697	259,986	2,887

NOTE: Minor variations may occur as a result of roundings

Balance Sheet

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

• Cash balances at 29th February are approximately £44.0m which is around £1.9m higher than at 31st January.

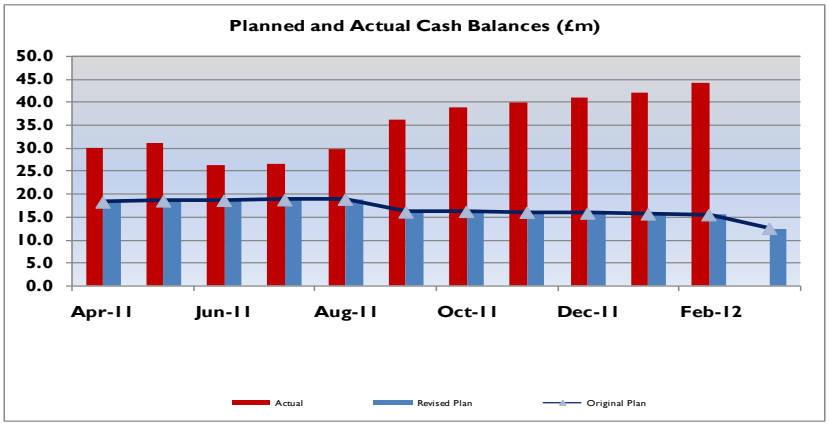
Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at 1st April 2011 £000	Balance as at February 2012 £000
Non Current Assets	Intangible Assets	1,077	992
	Tangible Assets	216,199	210,297
	Investments	0	0
	Receivables	649	690
Current Assets	Inventories	3,531	3,791
	Receivables and Accrued Income	12,652	15,518
	Investments	0	0
	Cash	20,666	44,033
Current Liabilities	Payables and Accrued Expenditure	(33,513)	(47,120)
	Loans	0	(2,000)
	Borrowings	(1,262)	(1,250)
	Provisions	(4,943)	(3,597)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	0	(6,000)
	Borrowings	(31,271)	(30,440)
	Provisions	(2,237)	(2,237)
		181,548	182,677
Financed By			
Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	36,573	36,156
	Donated Asset Reserve	2,099	0
	Government Grant Reserve	1,662	0
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(28,075)	(22,768)
		181,548	182,677

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – February 2012



Cash Forecast

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

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT February 2012

ACTUAL/FORECAST	Feb-12 £000s	Mar-12 £000s	Apr-12 £000s	May-12 £000s	Jun-12 £000s	Jul-12 £000s	Aug-12 £000s	Sep-12 £000s	Oct-12 £000s	Nov-12 £000s	Dec-12 £000s	Jan-13 £000s	Feb-13 £000s
Receipts													
SLAs: Sandwell PCT	**16,812**	15,399	15,091	15,091	15,091	15,091	15,091	15,091	15,091	15,091	15,091	15,091	15,091
HoB PCT	**7,394**	7,410	7,262	7,262	7,262	7,262	7,262	7,262	7,262	7,262	7,262	7,262	7,262
Associated PCTs	**5,524**	5,691	5,577	5,577	5,577	5,577	5,577	5,577	5,577	5,577	5,577	5,577	5,577
Pan Birmingham LSCG	**1,876**	1,839	1,802	1,802	1,802	1,802	1,802	1,802	1,802	1,802	1,802	1,802	1,802
Education & Training	**1,257**	1,457	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255
Loans													
Other Receipts	**3,680**	2,976	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Total Receipts	**36,543**	34,773	33,488	33,488	33,488	33,488	33,488	33,488	33,488	33,488	33,488	33,488	33,488
Payments													
Payroll	**14,444**	16,411	13,044	13,044	13,044	13,044	13,044	13,044	13,044	13,044	13,044	13,044	13,044
Tax, NI and Pensions	**9,402**	9,175	8,693	8,693	8,693	8,693	8,693	8,693	8,693	8,693	8,693	8,693	8,693
Non Pay - NHS	**2,095**	2,500	2,450	2,450	2,450	2,450	2,450	2,450	2,450	2,450	2,450	2,450	2,450
Non Pay - Trade	**7,211**	8,763	8,325	7,325	7,325	7,575	7,575	7,575	7,575	7,575	7,575	7,575	7,575
Non Pay - Capital	**889**	5,414	750	500	500	1,000	1,000	1,000	500	500	500	500	500
PDC Dividend		2,928						2,900					
Repayment of Loans		1,000						1,000					
Interest		34						30	30	30	30	30	30
BTC Unitary Charge	**398**	396	415	415	415	415	415	415	415	415	415	415	415
Other Payments	**189**	250	200	200	200	200	200	200	200	200	200	200	200
Total Payments	**34,628**	46,871	33,876	32,626	32,626	33,376	33,376	37,306	32,906	32,906	32,906	32,906	32,906
Cash Brought Forward	**42,118**	44,033	31,935	31,547	32,409	33,271	33,383	33,495	29,677	30,259	30,841	31,423	32,005
Net Receipts/(Payments)	**1,915**	(12,098)	(388)	862	862	112	112	(3,818)	582	582	582	582	582
Cash Carried Forward	**44,033**	31,935	31,547	32,409	33,271	33,383	33,495	29,677	30,259	30,841	31,423	32,005	32,587

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

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – February 2012

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	5.5%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	98.5%	4
Return on Assets	Surplus before dividends over average assets employed	4.4%	3
I&E Surplus Margin	I&E Surplus as % of total income	0.5%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	28.2	4
Overall Rating			**3.0**

Risk Ratings

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

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

•I&E Surplus Margin is lower than would normally be expected due to relatively low levels of surplus being delivered.

External Focus

• The latest DoH leadership bulletin, whilst praising the service for maintaining or improving performance against quality targets as well as remaining on track to deliver the required financial savings this year, goes on to emphasise the need to meet the productivity and efficiency targets which must be made for the service to ensure a sustainable baseline. It goes on to point out that "a health system built for growth could not survive in the financial period we have entered where we must learn – and are learning – to live within our means".

• The NHS review of Quarter 2 performance continues to report a healthy aggregate surplus. SHAs and PCTs are forecasting a combined surplus of £1,190 million (1.2 percent of total NHS revenue resources), this compares to a £1,165 million surplus, forecast at quarter 1 (Q1). The review goes on to identify that, although the NHS has made a good start to the QIPP period and reports the delivery of substantial savings in the first half of 2011/12, it faces significant challenges in the second half of the year. It points out that achieving the additional £3.4 billion of savings the NHS expects to make by March 2012 will require continued and sustained focus.

•Although some specific problem areas remain, both the Black Country Cluster and Birmingham and Solihull Cluster continue to report that expected year end financial performance will be in line with updated control totals.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – February 2012

Conclusions

• Measured against the DoH target, the Trust generated an actual surplus of £541,000 during February bringing its financial performance for the first eleven months of the year to an overall surplus of £1,534,000.

•The Trust's year to date performance against both its Department of Health control total (i.e. the bottom line budget position it must meet) and the statutory accounts target shows a positive variance of £168,000 against the planned position.

• The £541,000 surplus in February is £89,000 better than planned for the month.

• Year to date capital expenditure is £6,188,000 which remains significantly lower than plan. Expected expenditure on Grove Lane land is now expected to amount to only around £3.75m for the year with higher than originally planned expenditure being required in 2012/13.

•At 29th February, cash balances are approximately £28.6m higher than the cash plan which is around £2.1m greater than the position at 31st January. This includes receipt of an £8m DoH capital expenditure loan planned to be used to fund land acquisition in Grove Lane.

• The only material adverse variance in month is within non operational areas which is the result of recognition of some uncertain commitments which cannot be attributed to divisional positions.

• Monitoring of divisional performance will continue as the Trust approaches the end of the financial year to ensure that DoH financial targets are delivered. However, focus will now switch further onto the next financial year with particular emphasis on the need to deliver significant savings from the Transformation Programme.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report; and

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

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management
DATE OF MEETING:	29 March 2012

SUMMARY OF KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2011– February 2012.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Financial Management Board, Trust Management Board on 20 March 2012 and Finance and Performance Management Committee on 22 March 2012.

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - FEBRUARY 2012 - EXCEPTION REPORT

AREA	PERFORMANCE				COMMENTS
	National Indicator(s)		Local Indicator(s)		
	Current	Year to date	Current	Year to date	
Cancer	●	●			The Trust has met, in month (January) and year to date performance thresholds for each of the 9 (national) headline, 2-week, 31-day and 62-day cancer indicators.
Cancelled Operations	●	●	●	●	The overall percentage of Cancelled Operations increased to 0.8% overall during the month of February, the year to date cancellations remain at 0.6%. There were no breaches of the 28-day guarantee reported.
Delayed Transfers of Care	●	●			During the month (February) Delayed Transfers of Care remained stable at 3.5% overall. Approximately 75% of delays are Local Authority related. Year to date Delayed Transfers of Care (5.5%) remain in excess of the 3.5% performance threshold.
Stroke Care	●	●	●	●	Data for the month of February indicates that the percentage of patients who spent at least 90% of their hospital stay on a Stroke Unit has been maintained at 80% or more since July 2011. TIA (High Risk) Treatment (within 24 hours of initial presentation) during February was 73% (threshold 60%), improving year to date performance to 50%. In month and year to date improvement in performance against a range of local indicators is also evident.
Accident & Emergency	●	●			A/E 4-hour waits - performance for the month of February reduced to 92.7%, although improved significantly during the month of March to date (1st - 19th inclusive) to 97.6%. Throughout year to date performance has been maintained in excess of 95%.
	●	●			Accident & Emergency Clinical Quality Indicators - for the purpose of performance monitoring the indicators are grouped into two groups, timeliness and patient impact. Organisations will be regarded as achieving the required minimum level of performance where robust data shows they have achieved the thresholds for at least one indicator in each of the two groups. During February the Trust failed to meet targets for any of the 5 indicators, although continues to meet 3 of the indicators, at least one in each of the 2 groups for the year to date. During the month of March (to date) 3 of the 5 indicators are being met.
Infection Control	●	●			There were 9 cases of C Diff reported across the Trust during the month of February, within the trajectory also of 9 for the month. The overall number (86) for the year to date also remains within the trajectory of 100. There was 1 case of MRSA Bacteraemia reported during the month. Year to date 2 cases of MRSA Bacteraemia have been reported compared with a trajectory of 6.
Referral to Treatment	●	●	●	●	All 5 National and 3 Local high level RTT Performance Indicators were met in month (February) and year to date. The exceptions by specialty were Trauma & Orthopaedics and Plastic Surgery, where 69.3% and 75.6% respectively of admitted patients commenced treatment within 18 weeks of referral (target 90%).
Cervical Cytology			●	●	The Turnaround Time of Cervical Cytology requests has been less than 9 days for each month for the year to date.
Same Sex Accommodation	●	●			There were 8 Breaches of Same Sex Accommodation reported during the month of February, all related to the admission of 1 patient to 1 ward. These are the first breaches to have been reported since August.
Mortality			●	●	The Hospital Standardised Mortality Rate (HSMR) for the Trust for the most recent 12-month cumulative period (ending November 2011) is 97.7, compared with a Peer (SHA) rate of 102.5.
Sickness Absence			●	●	Overall Sickness Absence has been reasonably stable for each of the last 5 months, averaging 4.33%, comprising 3.23% long term sickness and 1.10% short term sickness. Sickness Absence for the months of January and February average 4.37% (target for Q4 = <3.50%).
Learning & Development			●	●	PDR compliance for the year to date remains approximately 73%, with 5105 staff having received an appraisal during the period April - February inclusive. Overall Mandatory Training compliance at the end of February is reported as 71.9%.
CQUIN	●	●			Acute Schemes - the only scheme currently off trajectory is 'Alcohol Screening' where performance during February is reported as 66%, this is exclusive of patients attending the Emergency Department, as agreed with commissioners. The target for March is 80%. Provisional data for the Patient Experience (Personal Needs) CQUIN indicates a score of 70.8, compared with a target of 69.3.
	●	●			Community Schemes - performance trajectories for all schemes were met during February with the exception of Smoking Cessation (delivery), where a target of 90% is set for smokers to be seen by agreed services and to have received an offer of brief intervention and onward referral to cessation services. Performance (85.8%) during February for this scheme is slightly off trajectory for the period. Provisional data for the Patient Experience CQUIN indicates a score of 92.97 compared with a target of 69.00.
	●	●			Specialised Commissioners Schemes - all schemes are met for the year to date with the exception of Access to Chemotherapy Out of Hospital which is aimed at increasing the volume of chemotherapy / anti-cancer drug deliveries made either at the patient's home or in a community setting closer to the patient's home. To date 411 home deliveries have been made, compared with a trajectory for the period of 430, although actual numbers increased further during the early part of the month to 450, with the expectation that the end of year target will be met. For Screening of Retinopathy of Prematurity performance was 95.5% to date for the period of assessment.
Referrals			●	●	For the period April - January inclusive overall referrals (excluding Obstetrics) are approximately 8200 (5.4%) fewer and GP Referrals (excluding Obstetrics) are approximately 5700 (5.6%) fewer than the corresponding period last year. Overall Referrals from Sandwell, HOB and Other (non-Sandwell / HOB) PCTs are 3890(5.0%), 1 (0.0%) and 3970 (9.1%) less respectively for the 10 months year to date than for the same period last year.
Activity			●	●	Overall Elective activity for the month is well in excess of the plan for the month and remains in excess of plan for the year to date by 9.4%.
			●	●	Non Elective activity is slightly (1.6%) below plan for the month and 7.4% less than plan for the first 11 months of the year.
			●	●	Outpatient New and Review activity continues to exceed the plan for the year to date by 7.7% and 10.2% respectively. The Follow Up to New Outpatient Ratio for the year is 2.67, compared with a ratio derived from plan of 2.61.
			●	●	A/E Type I activity during the month of February was 11.4% greater than plan, and is 0.45% greater than plan for the year to date. Type II activity is 3.0% greater than plan for the month, and remains in excess of plan for the year to date by 4.2%.
Ambulance Turnaround			●	●	The proportion of ambulances waiting greater than 30 minutes worsened to 46% during February (West Midlands average 37.3%) during the month. There were 203 instances recorded of ambulances with a turnaround time in excess of 60 mins.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary performance assessed against the NHS FT Governance Risk Rating (FT Compliance Report)
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning & Performance Management and Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	29 March 2012

SUMMARY OF KEY POINTS:

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

Service Performance (February):
There were 2 areas of underperformance during the month of February, A&E 4-hours waits and A&E Clinical Indicators. The weighting attributed to these indicators is such that the average score for the Trust for the **month** reduced to 2.36 (UNDERPERFORMING).

Formal assessment of Acute Trust's performance by the Department of Health is quarterly. For the period January – February inclusive, the A&E 4-hour wait performance is 94.1% and attracts a score of 2, although performance against the A&E Clinical Indicators for this period remains below each of the identified thresholds. The average score for this period improves to 2.50 (PERFORMING).

Financial Performance (February):
The weighted overall score has increased (improved) to 2.93 and is classified as PERFORMING. Underperformance is indicated in 2 areas; Better Payment Practice Code (Value) and Creditor Days.

Foundation Trust Compliance Summary report:

Within the Service Performance element of the Risk Rating there was 1 area of underperformance reported within the framework during the month of February, this was A&E 4-hour waits, where performance reduced to 92.70% (95.19% year to date), which attracts a score of 1.0.

No scores were identified within the period for the other 4 elements of the Risk Rating. As such the overall score for the month is 1.0, which attracts an AMBER / GREEN Governance Rating.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Finance and Performance Management Committee on 22 March 2012.

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

Operational Standards and Targets

Indicator		Weight	Thresholds		Quarter 2 2011	Score	Weight x Score	Quarter 3 2011	Score	Weight x Score	January 2012	Score	Weight x Score	February 2012	Score	Weight x Score
			Performing	Underperforming												
A/E Waits less than 4-hours		1.00	95.00%	94.00%	95.02%	3	3.00	95.06%	3	3.00	95.50%	3	3.00	92.70%	0	0.00
A/E Unplanned re-attendance rate	{Patient Impact Group}	2.00	=<5.00%	>5.00%	8.62%	3	6.00	7.97%	3	6.00	8.05%	3	6.00	8.13%	0	0.00
A/E Left Department without being seen rate			=<5.00%	>5.00%	4.70%			4.93%			4.78%			6.17%		
A/E Time to Initial Assessment - 95th centile	{Timeliness Group}		=<15mins	>15mins	23.00			20.00			17.00			18.00		
A/E Time to treatment in department (median)			=<60mins	>60mins	56.00			54.00			60.00			64.00		
Cancelled Operations - 28 day breaches		1.00	5.0%	15.0%	0%	3	3.00	<5%	3	3.00	<5%	3	3.00	<5%	3	3.00
MRSA Bacteraemia		1.00	0	>1.0SD	0	3	3.00	1	3	3.00	0	3	3.00	1	3	3.00
Clostridium Difficile		1.00	0	>1.0SD	19	3	3.00	25	3	3.00	9	3	3.00	9	3	3.00
18-weeks RTT Admitted 95 Percentile(weeks)		0.50	<=23.0	>27.7	<=23.0	3	1.50	<=23.0	3	1.50	20	3	1.50	<=23.0*	3	1.50
18-weeks RTT Non Admitted 95 Percentile(weeks)		0.50	<=18.3	>18.3	<=18.3	3	1.50	<=18.3	3	1.50	15	3	1.50	<=18.3*	3	1.50
18-weeks RTT Incomplete Pathway 95 percentile (weeks)		0.50	<=28.0	>36.0	<=28.0	3	1.50	<=28.0	3	1.50	17	3	1.50	<=28.0*	3	1.50
18-weeks RTT 90% Admitted		0.75	=>90.0%	85.0%	=>90.0%	3	2.25	=>90.0%	3	2.25	93.8	3	2.25	=>90.0%*	3	2.25
18-weeks RTT 95% Non -Admitted		0.75	=>95.0%	90.0%	=>95.0%	3	2.25	=>95.0%	3	2.25	97.0	3	2.25	=>95.0%*	3	2.25
Cancer - 2 week GP Referral to 1st OP Appointment		0.50	93.0%	88.0%	94.2%	3	1.50	94.7%	3	1.50	95.6%	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms		0.50	93.0%	88.0%	95.8%	3	1.50	94.4%	3	1.50	94.4%	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers		0.25	96.0%	91.0%	99.2%	3	0.75	99.4%	3	0.75	99.5%	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)		0.25	94.0%	89.0%	98.6%	3	0.75	99.7%	3	0.75	99.0%	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)		0.25	98.0%	93.0%	100.0%	3	0.75	100.0%	3	0.75	100.0%	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)		0.25	94.0%	89.0%	100.0%	3	0.75	100.0%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers		0.50	85.0%	80.0%	86.8%	3	1.50	87.3%	3	1.50	85.7%	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening		0.50	90.0%	85.0%	100.0%	3	1.50	96.5%	3	1.50	97.9%	3	1.50	>90.0%*	3	1.50
Stroke (Stay on Stroke Unit)		1.00	80.0%	60.0%	86.30%	3	3.00	88.70%	3	3.00	83.60%	3	3.00	86.00%	3	3.00
Delayed Transfers of Care		1.00	3.5%	5.0%	7.20%	0	0.00	<5.00%	2	2.00	3.50%	3	3.00	3.50%	3	3.00
Sum		**14.00**														
Average Score							**2.79**			**2.93**			**3.00**	* projected		**2.36**

Scoring:	
Underperforming	**0**
Performance Under Review	**2**
Performing	**3**

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

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

Financial Indicators				SCORING			2011 / 2012			2011 / 2012			2011 / 2012		
Criteria	Metric	Weight (%)		3	2	1	December	Score	Weight x Score	January	Score	Weight x Score	February	Score	Weight x Score
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	0.00%	3	0.15	0.00%	3	0.15	0.00%	3	0.15
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	0.19%	3	0.6	0.24%	3	0.6	0.37%	3	0.6
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	5.39%	3	0.15	5.43%	3	0.15	5.53%	3	0.15
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	0.00	3	0.6	0.00	3	0.6	0.00	3	0.6
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	5.58%	3	0.15	5.56%	3	0.15	5.52%	3	0.15
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45
Underlying Financial Position	Underlying Position (%)	10	5	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	0.44%	3	0.15	0.43%	3	0.15	0.43%	3	0.15
	EBITDA Margin (%)		5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	5.58%	3	0.15	5.56%	3	0.15	5.52%	3	0.15
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	85.00%	2	0.05	84.00%	2	0.05	93.00%	2	0.05
	Better Payment Practice Code Volume (%)		2.5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	88.00%	2	0.05	84.00%	2	0.05	96.00%	3	0.075
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	1.18	3	0.15	1.16	3	0.15	1.17	3	0.15
	Debtor Days		5	Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	13.86	3	0.15	18.31	3	0.15	14.13	3	0.15
	Creditor Days		5	Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	40.98	2	0.1	46.62	2	0.1	43.48	2	0.1
						Weighted Overall Score			2.90			2.90			2.93

*Operating Position = Retained Surplus/Breakeven/deficit less impairments

Assessment Thresholds	
Performing	> 2.40
Performance Under Review	2.10 - 2.40
Underperforming	< 2.10

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Vascular Surgery Reconfiguration: The Business Case For Change
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	29 March, 2012

SUMMARY OF KEY POINTS:

In response to national and NHS West Midlands Strategic Health Authority (SHA) standards we have been asked to work jointly with University Hospitals of Birmingham NHS Foundation Trust (UHBT) to look at options to develop a single clinical team for Vascular Surgery and as part of this to consolidate major inpatient surgery on one site. From this work we have identified a preferred option which results in our inpatient Vascular Surgery service and vascular Interventional Radiology service being transferred to the new Queen Elizabeth Hospital with Vascular Surgery day case and outpatient services continuing to be provided at City and Sandwell Hospitals.

The purpose of this report is to:

- Present the Business Case for Change to the Trust Board

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to:

1. **APPROVE** the business case for change and the preferred option for Vascular Surgery reconfiguration.

2. **NOTE** the implications for the transfer of staff to UHBFT to support the transferred activity. This may be under a mix of TUPE and SLA (Service Level Agreement) arrangements. These arrangements have yet to be formally agreed between ourselves (SWBH) and UHBFT and so are considered a risk to the Trust at this stage. In particular consultant job plans for the Vascular Surgeons need to be confirmed as soon as possible in order to have clarity as to whether the consultant contracts should transfer to UHBFT under TUPE or be retained by us with an SLA with UHBFT for the activity at UHBFT.

3. **AGREE** the transfer of activity to UHBFT from July 2012 in order to meet SHA and clinical timescales but subject to transfer arrangements, including TUPE and SLAs, for staff being agreed and put in place within this timescale and with agreement that if this is not the case the implementation date is delayed.

A
ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Corporate Objective 2: High Quality Care
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Peer review visit in October 2010 by West Midlands Quality Review Service (WMQRS) with a report from the visit being published in January 2011

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

Financial	**X**	The financial analysis of the preferred option demonstrates that without a funding solution, the Trust would face a full year pressure of £2.24 million arising from the difference between full income (full PbR) losses net of releasable cost. Through the LDP (local delivery plan) negotiations with commissioners, the in-year impact has been limited to £1.4m with this value accommodated within the overall settlement for 12/13. In other words the system plan can accommodate this financial movement.
Business and market share	**X**	Continued provision of Vascular Surgery day case surgery and outpatient clinics along with emergency cover arrangements for the Emergency Departments, at both City and Sandwell Hospitals should minimise the potential for catchment loss.
Clinical	**X**	Clinical case for change in order to improve clinical outcomes
Workforce	**X**	A number of staff will need transfer all or some of their time to UHBFT to support the transferred activity. This is likely to be under a mix of TUPE and SLA arrangements. The detail of these arrangements has yet to be formally agreed between SWBH and UHBFT.
Environmental		
Legal & Policy		
Equality and Diversity	**X**	Equality Impact Assessment Screening undertaken.
Patient Experience	**X**	Reconfiguration will result in improved patient outcomes but will mean some patients and visitors

		will need to travel further.
Communications & Media	**X**	Agreement from Joint Health Scrutiny Committee that formal public consultation is not required for this service change but that robust and ongoing engagement and communication with patients is important.
Risks		As set out in the report

PREVIOUS CONSIDERATION:

Previous progress reports relating to Clinical Service Reconfiguration – last report February 2012.

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

VASCULAR SURGERY RECONFIGURATION
THE BUSINESS CASE FOR CHANGE
MARCH 2012

EXECUTIVE SUMMARY

Introduction

In response to national and NHS West Midlands standards we have been asked to work jointly with University Hospitals of Birmingham NHS Foundation Trust (UHBT) to look at options to develop a single clinical team for Vascular Surgery and as part of this to consolidate major inpatient surgery on one site. From this work we have identified a preferred option which results in our inpatient Vascular Surgery service and vascular Interventional Radiology service being transferred to the new Queen Elizabeth Hospital with Vascular Surgery day case and outpatient services continuing to be provided at City and Sandwell Hospitals.

The purpose of this report is to:

- Present the Business Case for Change to the Trust Board
- Seek approval for the preferred option and agreement to implement this from July 2012.

Context

The clinical team have reviewed the local clinical drivers for change in the context of the national and regional standards for Vascular Surgery including the requirement to serve a population of 800,000. Based on this the following benefits have been identified for the proposed reconfiguration:

- 24/7 access to a specialist Vascular Surgery clinical team,
- A critical mass of patients (i.e. population of 800 000) that will enable the clinical team to develop greater specialisation and undertake more complex procedures which based on national outcome data will improve clinical outcomes.
- Establishment of a centre of excellence which will undertake appropriate clinical trials, research, support specialist training, have access to high quality facilities and technology and attract high calibre specialist staff.
- A 24/7 IR service to support Vascular Surgery and the potential to extend this at a later date to support all specialities in both Trusts.

The preferred option was identified as most closely meeting these benefits as well as maintaining local access where clinically appropriate, meeting the capacity required and being deliverable within the timescale required by the Strategic Health Authority (SHA).

Preferred Option

In summary the Preferred Option is an integrated service with UHBFT with vascular surgery inpatients and vascular Interventional Radiology (IR - inpatients and day cases) being provided at the new Queen Elizabeth Hospital (QE Hospital) and vascular surgery day cases and outpatients continuing to be provided at City and Sandwell Hospitals (SWBH).

Based on activity levels for the first 9 months of 2011/12 it is estimated that this will result in 664 patients needing to be treated at the QE Hospital rather than in SWBH.

Changes to Income and Expenditure Associated with Preferred Option

The financial analysis of the preferred option (summarised in the table below) demonstrates that without a funding solution, the Trust would face a full year pressure of £2.24 million arising from the difference between full income (full PbR) losses net of releasable cost. The estimate of income losses is based on a straight line adjustment of month's 1-9 actual activity in 2011/12. At this stage some of the costs can only be estimates based on assumptions. Through the LDP (Local Delivery Plan) negotiations with commissioners, the in-year impact has been limited to £1.4m with this value accommodated within the overall settlement for 12/13. In other words the system plan can accommodate this financial movement.

Summary of Estimated Impact on Revenue Costs and Income:

	Transfer of inpatient vascular & all IR vascular work to UHBFT
Lost Income	
Vascular	-2,373,906
Interventional Radiology	-971,416
Total Lost Income	**-3,345,322**
Savings	
Pay	
Vascular	486,019
Interventional Radiology	143,220
Total Pay Savings	**629,239**
Non Pay	
Vascular	303,428
Interventional Radiology	169,600
Total Non Pay Savings	**473,028**
Total Savings	**1,102,267**
Net Surplus/Deficit (+/-)	**-2,243,055**

This analysis has changed from the one presented to the Executive Team in January, which showed a net deficit of £1.9million primarily as a result of:

- Reduced activity in 2011/12 and therefore reduced income
- Reduced number of IR sessions transferring to UHBFT
- Reduced savings from ward nursing costs as further analysis showed the need to retain additional posts to meet minimum staffing ratios.

As the requirement for additional cost savings has been mitigated, financing the changes has been identified, although there may be some additional opportunities once consultant job plans are confirmed. The timescale for implementation (SHA requirement by September 2012 and clinical requirement by July 2012 to avoid the change at junior doctor rota changes and high annual leave period) mean that we

need to have approval from Trust Board by the end of March so that we can start the required staff consultation period in line with TUPE in April. There is no additional capital cost associated with the preferred option. The reconfiguration will result in the closure of some inpatient beds and loss of theatre sessions which will facilitate the closure of D30 ward and Theatre 1 at City Hospital.

Net Additional Activity Consequences of Preferred Option

The table below summarises the net activity changes from the reconfiguration.

Category		Comments
Inpatients		
Elective	**- 276**	Vascular Surgery & Vascular IR activity transferred to QE Hospital
Day Case	**- 55**	Vascular IR activity transferred to QE Hospital
Emergency	**-333**	Vascular Surgery & Vascular IR activity transferred to QE Hospital
Outpatients		
New	**0**	No change as outpatients still provided at SWBH
Review	**0**	No change as outpatients still provided at SWBH
Other	**0**	
A&E Attendances	**0**	No change as patients will still attend SWBH Emergency Departments.
Other (please specify)	**0**	

Funding Source for Change

The financial analysis of the preferred option and net impact has been resolved as part of the LDP discussions for 2012/13. This has been incorporated into the Trust's financial plans going forward with these being presented to the Trust Board on 29th March 2012.

Source	Tick	Comments
Baseline Budgets	✓	Identified savings to be removed from baseline budgets
Tariff Income	✓	Will reduce in line with activity reductions
Cost Savings (Internal Divisional)	✓	For both Surgery A & Imaging
Cost Savings (External to Division)	✓	Facilities
Other (please specify)		

Qualitative Benefits

Benefit	
Reduced Length of Stay	✓
Reduction in HCAIs	
Reduced Readmission Rates	
Reduction in Review Appointments	
Local Service	✓
Other Patient Welfare	✓

The following benefits have been identified for the proposed reconfiguration:

- 24/7 access to a specialist Vascular Surgery clinical team,
- A critical mass of patients (i.e. population of 800 000) that will enable the clinical team to develop greater specialisation and undertake more complex procedures which based on national outcome data will improve clinical outcomes.
- Establishment of a centre of excellence which will undertake appropriate clinical trials, research, support specialist training, have access to high quality facilities and technology and attract high calibre specialist staff.
- A 24/7 IR service to support Vascular Surgery and the potential to extend this at a later date to support all specialities in both Trusts.

Recommendations

The Trust Board is recommended to:

- APPROVE the business case for change and the preferred option for Vascular Surgery reconfiguration.

- NOTE the implications for the transfer of staff to UHBFT to support the transferred activity. This may be under a mix of TUPE and SLA (Service Level Agreement) arrangements. These arrangements have yet to be formally agreed between ourselves (SWBH) and UHBFT and so are considered a risk to the Trust at this stage. In particular consultant job plans for the Vascular Surgeons need to be confirmed as soon as possible in order to have clarity as to whether the consultant contracts should transfer to UHBFT under TUPE or be retained by us with an SLA with UHBFT for the activity at UHBFT.

- AGREE the transfer of activity to UHBFT from July 2012 in order to meet SHA (Strategic Health Authority) and clinical timescales but subject to transfer arrangements, including TUPE and SLAs for staff being agreed and put in place within this timescale and with agreement that if this is not the case the implementation date is delayed.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

VASCULAR SURGERY RECONFIGURATION
THE BUSINESS CASE FOR CHANGE
MARCH 2012

1. INTRODUCTION

In order to ensure future clinical sustainability, we have undertaken a number of clinical service reconfigurations over the last 3 years and identified a number of other clinical services with the potential need for reconfiguration ahead of the opening of the Midland Metropolitan Hospital (the single site new Acute Hospital) in 2016/17. In addition NHS West Midlands is looking at whether there are any clinical services which due to their specialist nature may require an element of consolidation within the SHA to ensure the critical mass necessary to develop and retain specialist skills and deliver the best clinical outcomes.

As reported previously, in response to national and NHS West Midlands standards we have been asked to work jointly with University Hospitals of Birmingham NHS Foundation Trust (UHBT) to look at options to develop a single clinical team for Vascular Surgery and as part of this to consolidate major inpatient surgery on one site. These proposals are likely to result in our inpatient Vascular Surgery service and vascular Interventional Radiology service being transferred to the new Queen Elizabeth Hospital with Vascular Surgery day case and outpatient services continuing to be provided at City and Sandwell Hospitals.

A joint project group with UHBT has been established along with an internal project team with representatives from the clinical teams in Vascular Surgery and Interventional Radiology to undertake the detailed planning work and analysis around the impact on our services. Our internal project team developed the Clinical Case for Change which was approved by our Clinical Service Reconfiguration Programme Board in early December. The Clinical Case for Change also presented the proposed service model which has been developed jointly with clinical leads from UHBT.

The purpose of this report is to:

- Present the Business Case for Change to the Trust Board
- Seek approval for the preferred option and agreement to implement this from July 2012.

2. STRATEGIC CONTEXT

2.1 Clinical Case for Change

The Clinical Case for Change has been set out in a separate document and so this report summarises the key points. NHS West Midlands developed proposals to consolidate AAA (Abdominal Aortic Aneurysm) screening and inpatient services in Vascular Surgery to cover populations of 800 000. The Trust's current Vascular Surgery service does not cover a population of this size.

The clinical team have reviewed the local clinical drivers for change that explain the local importance of the national and regional requirement to serve a population of 800,000. These are:

- The need to reduce morbidity and mortality rates nationally and locally. Strong volume outcome data at a national level is showing benefits for patients receiving their arterial intervention

(operation or interventional radiology procedure) at hospitals dealing with high volumes of arterial interventions with 24/7 cover from a team of specialists dedicated to the treatment of patients with vascular disease and the availability of experts to deal with complications as and when they occur.

- The need to provide 24/7 rapid access to diagnostics, IR and emergency surgery. This is not possible within our existing teams of 3 Consultant Vascular Surgeons (hence the current joint on call rota with UHB) or 3 Consultant Interventional Radiologists (we don't currently provide a 24/7 service). The national recommendation is that a 24/7 on-site vascular on call rota for vascular emergencies needs to be at least 1in 6 (i.e. minimum of 6 specialists on the rota) to provide adequate care.
- Vascular Surgery is emerging as a separate speciality rather than a sub speciality within the umbrella of General Surgery and consultants who have not undertaken specialist training in Vascular Surgery no longer have sufficient experience or skills in modern Vascular Surgery techniques to offer an emergency vascular service other than initial assessment and triage of patients.
- The current inability to provide critical mass (population of 800,000) whereby the clinical team are able to undertake more complex procedures and greater specialisation.
- The need to establish a recognised centre of excellence and support/undertake appropriate clinical trials.
- The difficulty in attracting high calibre staff to smaller units without critical mass populations.
- The need to develop a suitable training environment for clinical staff specialising in Vascular Surgery.
- The need to undertake AAA screening and detect and treat aneurysms earlier.
- The inability to provide sustainable services which meet required national standards.
- Maintaining safe and affordable clinical services in an increasingly challenging financial climate, through strong clinical networks.

2.2 Compliance With Trust Priorities

The Trust was subject to a peer review visit in October 2010 by West Midlands Quality Review Service (WMQRS) with a report from the visit being published in January 2011. The extract below is the report's summary about our current Vascular Surgery service:

The vascular service, based at City Hospital, was well-organised and provided a comprehensive approach to the care of patients with vascular disease. Patient information and clinical guidelines were very good and clear. The range of services offered and team-working within the service were both excellent.

However, it was noted as a concern that whilst the Trust shared a joint emergency Vascular Surgery consultant rota with UHBT, inpatient vascular surgery had been consolidated at City Hospital and one clinical team worked across both City and Sandwell Hospitals the Trust's Vascular Surgery service only covers a population of 600 000 rather than the recommended 800 000. The report's comment to commissioners in relation to this was:

A clear plan for moving to a catchment population of 800,000 with a single in-patient site was not yet in place. This will be needed in order to meet the expected Quality Standards and for approval for Abdominal Aortic Aneurysm Screening Programme.

The proposal to reconfigure Vascular Surgery Services is in line with our strategic objective to provide safe high quality care.

2.3 Current Vascular Surgery Service Provision

Following the reconfiguration of our Vascular Surgery service in July 2007 to provide a single clinical team with one inpatient unit, our existing service comprises:

- A single clinical team with three Vascular Surgery consultants providing a largely consultant and specialist nurse delivered service.
- Inpatient services are at City Hospital with 18 beds across two wards but with ward consultations to other specialities at both City and Sandwell Hospitals.
- Day Case surgery and Out patient clinics including Diabetic foot clinics at City and Sandwell Hospitals
- Weekly Multi-Disciplinary Team meeting at City Hospital
- A joint consultant on call rota with the Vascular Surgery team at UHBT which provides 24/7 emergency cover to City and Sandwell Hospitals as well as UHBT.

Our current vascular related Interventional Radiology (IR) service comprises:

- A single clinical team of 3 consultant Interventional Radiologists
- All vascular related IR (day case and inpatient) undertaken at City Hospital.

It should be noted that vascular related IR accounts for circa 30% of our total IR workload with the remaining 70% supporting other specialities including Gastroenterology, Urology, Obstetrics etc. We do not currently provide a 24/7 IR service.

The tables below set out our current activity levels in Vascular Surgery (table 1) and the vascular element of IR (table 2).

Table 1: Vascular Surgery Activity (Excluding IR Procedures)

	2009/10	**2010/11**		**Estimate for 2011/12 (Based on Months 1-9)**		**Estimate For 2012/13**	
	Both Sites	Swell	City	Swell	City	Swell	City
Day Cases	189	37	169	53	199	53	199
Elective Inpatients	198	0	178	0	191	0	191
Emergencies	194	38	160	39	191	39	191
Outpatient with Procedure	448	102	195	108	176	108	176
Outpatients	4,809	1,317	2,973	1,272	2,791	1,272	2,791
Trust Total	5,838	5,169		5,019		5,019	

Table 2: Vascular IR Activity

	2009/10	2010/11		Estimate for 2011/12 (Based on Months 1-9)		Estimate For 2012/13	
	Both Sites	Swell	City	Swell	City	Swell	City
Day Cases	19	8	40	0	55	0	55
Elective Inpatients	128	5	110	3	83	3	83
Emergencies	59	20	40	59	45	59	45
Trust Total	206	223		244		244	

Note: Whilst these IR procedures are vascular (and therefore circa 30% of total IR work) the activity appears across a number of specialties particularly where it is emergency activity. The assumption is that all of this activity would be lost to the Trust.

2.4 Proposed Service Model

A proposed service model for Vascular Surgery has been identified and was presented as part of the Clinical Case for Change. This new service model is:

- A single Vascular Surgery clinical team covering both Trusts.
- All inpatient Vascular Surgery (elective and emergency) centralised at the new QE Hospital on a single ward. This would also include patients admitted under the Vascular Surgeons but not requiring an operation.
- All pre-assessment clinics for Vascular Surgery elective inpatients undertaken at the new QE Hospital for clinical safety purposes (i.e. to ensure availability of test results, bloods etc) and to ensure patients are familiar with the hospital and clinical team.
- Rehabilitation following Vascular Surgery is undertaken locally in line with agreed pathways, including at Rowley Regis Hospital, Sandwell Hospital, City Hospital and Mosely Hall as well as in patient's homes.
- Vascular Surgery day case, 23 hour surgery and outpatient activity continues to be provided locally in our Trust (BTC and Sandwell Hospital sites).
- The on call consultant rota for Vascular Surgery continues to cover both Trusts.
- Emergency Vascular Surgery patients presenting at City or Sandwell Hospitals will be assessed by the relevant on site clinical team (usually the Emergency Department team) and a referral made via telephone to the on call Vascular Surgery consultant who on the basis of the information presented, will decide whether the patient should be transferred directly to the Vascular Surgery ward at QE or whether the consultant needs to assess the patient at the presenting hospital in order to decide whether the patient is clinically stable enough to transfer or requires stabilisation/surgery at the presenting hospital prior to transfer.
- Vascular Surgery consultants drop elective commitments when on call and so are readily available to assess and treat emergency patients at an early stage.
- A single AAA screening service across SWBHT, UHBT and Heart of England Foundation NHS Trust (HEFT) but with local delivery.
- Both Trusts would seek to further develop the local services at City and Sandwell Hospitals, as part of a combined single Vascular Surgery service, including exploring

- the feasibility of developing vascular access to renal dialysis, currently provided at UHBT by renal surgeons,
- other ambulatory services affecting the Sandwell & HOB catchment populations.

The clinical discussions and planning work to date have highlighted the interdependency between Vascular Surgery and vascular related IR (undertaken by specialist Consultant Radiologists). A significant number of patients with vascular disease receiving diagnostic angiograms are found to have disease that can be treated at the time through an angioplasty procedure rather than subsequently with a surgical operation. Angiograms and angioplasties are primarily undertaken on a day case basis. Whilst the Consultant Interventional Radiologist performs the procedure they require the onsite back up of a Consultant Vascular Surgeon so that if the disease is more complicated or an unexpected complication arises, immediate advice or surgery can take place. As a result the clinical team have identified that if the proposed service model for Vascular Surgery is implemented the following change will also be required:

- All elements of vascular IR work including vascular angiography and angioplasty (day case and inpatient) needs to be undertaken at the new QE Hospital in order to have robust on site emergency Vascular Surgery consultant cover. This would equate to circa 30% of total IR workload.

This will have the benefit of allowing the introduction of a 24/7 Interventional Radiology (IR) service for these patients. Currently this is provided at the QE Hospital but not in our Trust. It was hoped that a potential benefit from Vascular Surgery reconfiguration would be to work collaboratively with the UHBT IR service to develop a 24/7 IR service model that supports all specialities in both Trusts and that best meets the needs of both organisations and takes account of UHBFT being a designated Major Trauma Centre. This has not been feasible in the short term and so in order not to delay the Vascular Surgery reconfiguration, it has been agreed to only include arrangements for SWBH IR staff to undertake vascular IR work at UHBFT in these proposals with SWBH IR consultants remaining part of the SWBH Radiology on call rota. It has been agreed that there will be ongoing discussion with UHBFT to look at options to support a 24/7 IR service for SWBH in the medium/longer term.

3. PLANNED OUTCOMES AND BENEFITS

As part of developing the Clinical Case for Change the project team have identified the following benefits for this proposed reconfiguration:

- 24/7 access to a specialist Vascular Surgery clinical team,
- A critical mass of patients (i.e. population of 800 000) that will enable the clinical team to develop greater specialisation and undertake more complex procedures which based on national outcome data will improve clinical outcomes.
- Establishment of a centre of excellence which will undertake appropriate clinical trials, research, support specialist training, have access to high quality facilities and technology and attract high calibre specialist staff.
- A 24/7 IR service to support Vascular Surgery and the potential to extend this to support all specialities in both Trusts.

The joint project group will undertake further work to develop a detailed Benefits Realisation Framework based on the above benefits and to be used as part of evaluating the change post implementation.

4. OPTIONS

4.1 Long List of Potential Options

A number of potential options have been considered over the last year or so but the outcome has been that only one option appears to best meet the regional standards. The other potential options considered and reasons for not pursuing these are summarised in table 3 below.

Table 3: Long List of Options

	Potential Option	Main Points of Consideration	Outcome
1.	Do Nothing i.e. retain current service provision	Does not meet standard of a single clinical team with one inpatient unit serving a population of 800 000. IR would be unable to meet the requirement for a 24/7 emergency service with existing consultant numbers but workload would not justify a further 3 consultant posts.	Not a viable option but include in business case as a base case comparator only.
2.	Integrated service with UHBFT with inpatients and vascular IR at QE and day cases and outpatients retained in SWBH.	Meets the clinical drivers for change. Option of inpatient unit at SWBH not viable because of the range of specialist services at QE which require on site vascular surgery 24/7.	Viable option and preferred option for Vascular Surgery consultants. Concern about financial impact in terms of loss of income and contribution to overheads and therefore ability to release costs to cover this loss.
3.	Integrated service with UHBFT with all vascular surgery and vascular IR at QE and no activity retained in SWBH.	Does not fit with national guidance which recommends retaining outpatient access locally. Also doesn't fit with long term RCRH vision of local access for patients for at least outpatient and day case services.	Not considered a viable option – loss of income would be even greater.
4.	Integrated service with another provider and include a single inpatient unit.	SHA preferred position is for SWBH and UHBFT to integrate as provides the required catchment population for both services. Previous discussions held with Walsall Hospitals NHS Trust but did not have full clinical support and no progress made resulting in change to consultant on call rota and move away from joint rota with Walsall to one with UHBFT. Consideration given to exploring a joint services with the newly created Black Country Vascular Surgery service at Dudley Group of Hospitals NHSFT or Heart of England NHS FT.	Not considered viable based on previous discussion with Walsall, and the SHA preferred position of a joint service with UHBFT and required timescale.

4.2 Short Listed Option

The only option considered viable within the required timescale and meting the wider SHA requirements is therefore an integrated service with UHBFT with inpatients and vascular IR at QE Hospital and day cases and outpatients retained in SWBH at both City and Sandwell Hospitals. The remainder of the Business Case therefore focuses on this option with Do Nothnig presented for comparative purposes only.

5. NON FINANCIAL OPTION APPRAISAL

5.1 Non Financial Evaluation Criteria and Scores

The benefits were used as the criteria for the non financial evaluation of the options along with three additional criteria of access, capacity and deliverability. The SWBH Vascular Surgery Project Team agreed the weighting for each criteria (3 being the highest and 1 the lowest) and the range of scores (5 most fully meets the criteria to 0 does not meet the criteria). The Project Team then scored the each option against each criteria and these were then averaged to give the scores below.

Table 4: Option Scores

		Option Scores			
Benefit Description	**Maximum Score Possible (weight x max score)**	**Option 1** Do Nothing/ Minimum	**Option 2** Integrated service with UHBFT: Inpatients & vascular IR at QE Day cases & outpatients retained in SWBH.	**Option 3** Integrated service with UHBFT: All vascular surgery & vascular IR at QE.	**Option 4** Integrated service with another provider and include a single inpatient unit.
24/7 access to a specialist Vascular Surgery clinical team.	15 (3x5)	7.5	10.5	10.5	3
A critical mass of patients- i.e. population of 800 000.	15 (3x5)	2.25	10.5	11.25	7.5
Establishment of a centre of excellence.	10 (2x5)	2	7	7	2.5
A 24/7 IR service.	10 (2x5)	2	7	7	0
Access i.e. travel times/ ease of travel and/or time to diagnosis/ treatment.	10 (2x5)	6.5	6	4	1.5
Capacity i.e. ease of availability of clinical space i.e. beds, theatre sessions, IR sessions.	15 (3x5)	9	8.25	6.75	2.25
Deliverability i.e. ease with which options can be delivered within required timescales i.e. project target timescale of July 2012 & the SHA requirement of Sept 2012.	15 (3x5)	7.5	9	7.5	0
Total Score	90	36.75	58.25	54	16.75

The non-financial evaluation therefore scored option 2 *Integrated service with UHBFT with inpatients and vascular IR at QE and day cases and outpatients retained in SWBH* as the preferred option with 65% of the possible maximum score.

5.2 Consultation

As a Trust, we undertake any clinical service reviews likely to result in reconfiguration in accordance with national guidance as set out in *Changing for the Better* (DoH 2008). A key element of this guidance is that the focus should be on improving the quality of services and should be clinically led. In addition The Health Act 2006 (Section 242) requires NHS organisations as soon as they start to develop change proposals to involve patients and the public in planning service changes and decisions affecting the operation of those services. In line with this requirement we seek to work with service users regarding proposed changes and in the development of options.

With regard to the proposed changes to Vascular Surgery we are handing patients who attend our Vascular Surgery clinics a letter explaining the proposed changes and asking for their comments and concerns. Whilst clinic staff are encouraging patients to complete these vary few have been returned. Therefore, in addition a member of our communications team has carried out a number of interviews with existing patients in our Vascular Surgery service in outpatient clinics at City and Sandwell Hospitals. The feedback to date is summarised in the table below:

Table 5: Summary of Patient Feedback

	Patients interviewed at City Hospital	**Patients interviewed at Sandwell Hospital**
Patients who provided feedback	14	4
Patients who were happy with changes	7	0
Patients unhappy with changes	7	4
Patients who cited distance as negative factor	8	4
Patients who cited site layout as negative factor	4	0
Patients who voiced appreciation of current service and staff	5	2
Patients who would prefer to merge with a nearer hospital	0	1

Whilst this is a relatively small sample of patients some of the themes raised related to:

- Familiarity with City or Sandwell Hospitals and staff
- Additional distance and time to QE Hospital and how this would make it difficult for visitors – this was especially the case for Sandwell patients.

This reinforces the importance of keeping local provision of services where clinically appropriate as in Option 2 where day cases and outpatients will continue to be provided at City and Sandwell Hospitals.

We will continue to interview more patients and intend to use the feedback from patients to help develop the detail of our proposed service model and implementation plan.

We held a staff engagement event in the summer involving circa 50 front line clinical staff involved in the delivery of Vascular Surgery services. The output of this event has helped to shape the proposed service model and will also be used in developing the implementation plan alongside more detailed staff engagement in issue/task specific working groups.

In terms of formal consultation in relation to the proposed Vascular Surgery service reconfiguration our assessment suggested that it is not be appropriate to undertake a formal consultation process, based on the following:

- the clear case for change and consolidation of Vascular Surgery Services at both a national and local level,

- the emerging national evidence about improved patient outcomes from Hospitals providing a larger volume of arterial interventions,
- the improved 24/7 service that a single Vascular Surgery service based at the QE Hospital could offer,
- the numbers of patients that would be affected by this change are circa 900 a year.

We presented this position to the Sandwell and Birmingham Joint Health Scrutiny Committee in December 2011 and they confirmed their support for this approach.

5.3 Equality Impact Assessment

The requirement to undertake an Equality Impact Assessment is contained within the Race Relations (Amendment) Act 2000. This requires listed public authorities to conduct an assessment of the impact of their current or intended policies, programmes and service delivery for any disadvantageous experiences or outcomes to black and minority ethnic groups and to take action to remove inequalities.

In addition, the Disability Discrimination Act 2005 has placed a duty to promote disability equality on all public sector authorities. This duty includes arrangements for impact assessment with regards to disadvantageous experiences or outcomes of people with disabilities. The Equality Act 2006 creates a duty to promote equality between men and women which includes conducting impact assessments for gender equality and a requirement to take account of religion and sexual orientation in the provision of education and services.

The assessment of impact is undertaken through the implementation of a robust Equality Impact Assessment (EqIA). The EqIA is a systematic way of assessing whether any of the proposed service model options could potentially have a differential impact on diverse groups covered by Equality legislation. The initial screening for EqIA on Vascular Surgery reconfiguration has demonstrated that a full EqIA will need to be undertaken. This is because the changes in service provision will affect the elderly and disabled groups in particular as they are likely to have to travel further for inpatient treatment and this may impact on their ability to plan and change their usual travel arrangements to hospital. Currently there are no direct buses from West Bromwich or City Hospital to Queen Elizabeth Hospital and many vascular patients are unable to walk far without experiencing incapacitating symptoms relating to their clinical condition. They may therefore need assistance with travel and possibly walking if they are required to walk more than a short distance. This may cost patients more in financial terms than it does now. Work on the full EqIA has commenced along with work to undertake an initial EqIA screening on the impact for staff who may be required to transfer from SWBH to UHBFT- e.g. travel arrangements and changes in current shift patterns etc (this will be undertaken by the workforce group).

6. ESTIMATED CAPITAL COST AND FUNDING

6.1 Capacity

The proposed activity analysis (see below) has been used to determine the additional capacity required at the QE Hospital, the inpatient and vascular IR capacity that can be released from SWBH and the vascular surgery day case, outpatient and rehabilitation capacity that needs to be retained at City and Sandwell Hospitals. This is summarised in table 6.

Table 6: Capacity Changes

	Acute Inpt Beds[1]	Rehab Beds		Day Case Theatre sessions		Inpt Theatre Sessions	Vascular IR sessions	Outpatient Clinics[2]	
	City	*City*	*Sandwell*	*City*	*Sandwell*	*City*	*City*	*City*	*Sandwell*
Current	15	Tbc	Tbc	2	2	4	3	5.5	2.5
Post Reconfiguration	0	Tbc	Tbc	2	2	0	0	5.5	2.5
Capacity Released	15	0	0	0	0	4	3	0	0
Additional Capacity at QE	11	0	0	0	0	4	3	0	0

Notes:

1.The release of 15 beds will be through closure of beds on D25 and D21. This will facilitate the closure of ward D30 at City Hospital with the current beds from this ward transferring to D21. The release of 4 theatre sessions will facilitate the closure of Theatre 1 at City Hospital. The financial analysis below includes the direct revenue cost savings from the reduction of 15 beds and 4 theatre sessions.

2. The plan is to transfer the pre-admission clinic for Vascular Surgery inpatients from City to UHBFT however UHBFT when this happens this will reduce City outpatient clinics by 1 and increase QE outpatient clinics by 1 but UHBFT do not have capacity for this in the short term and so the clinic will remain at City Hospital until this capacity is available.

This service change does not require capital work to facilities or equipment.

7. ESTIMATED REVENUE COSTS AND INCOME (FULL YEAR EFFECT)

Table 7 below summarises the financial impact of the preferred option.

Table 7: Estimated Impact on Revenue Costs and Income

	Option 1: Do Nothing	Option 2: Transfer inpatient vascular and all IR vascular work to UHB
Lost Income		
Vascular	0	-2,373,906
Interventional Radiology	0	-971,416
Total Lost Income	**0**	**-3,345,322**
Savings		
Pay		
Vascular	0	486,019
Interventional Radiology	0	143,220
Total Pay Savings	**0**	**629,239**
Non Pay		
Vascular	0	303,428
Interventional Radiology	0	169,600
Total Non Pay Savings	**0**	**473,028**
Total Savings	**0**	**1,102,267**
Net Surplus/Deficit (+/-)	**0**	**-2,243,055**

The financial analysis of the preferred option (summarised in the table above) demonstrates that without a funding solution, the trust would face a full year pressure of £2.24 million arising from the difference between full income (full PbR) losses net of releasable cost. The estimate of income losses is based on a straight line adjustment of month's 1-9 actual activity in 2011/12. At this stage some of the costs can only be estimates based on assumptions.

At this stage some of the costs can only be estimates based on assumptions, for example:

- The release of consultant PAs, until job plans are further reviewed and agreed.
- The partial transfer of some staff time across to UHBT which would require agreement with UHBT and funding via an SLA.
- Details of on call arrangements also need to be agreed and could again impact on the financial analysis.

Through the LDP (Local Delivery Plan) negotiations with commissioners, the in-year impact has been limited to £1.4m with this value accommodated within the overall settlement for 12/13. In other words the system plan can accommodate this financial movement.

Discussions to date with UHBFT suggest they are planning on the assumption of receiving full tariff for any increase in activity resulting from the reconfiguration and requiring this level of income to deliver the additional activity. To date UHBFT have not shared their detailed financial analysis/plans.

The Specialised Commissioning Team have confirmed that they will be responsible for commissioning the more specialised Vascular Surgery activity from 2012/13 and whilst they have not formally confirmed the HRGs this will apply to or expected activity levels by PCT they have informally shared the likely HRGs and their assumption that full tariff will apply. Based on this our initial analysis suggests that circa 80 cases will be commissioned by Specialised Commissioning Team and so the majority of Vascular Surgery activity will continue to be commissioned by local Clinical Commissioning Groups (CCGs).

8. STAFFING NUMBERS (FULL YEAR EFFECT)

The proposed reconfiguration of Vascular Surgery and Vascular IR will involve changes to staffing numbers within both services. This will involve an element of TUPE. The table below summarises the staff groups involved in the provision of inpatient Vascular Surgery and vascular IR along with the proposed impact of the transfer on them.

Table 8: Impact on Staff

Staff Group	Likely Impact on Workload	Proposed Change to Work	TUPE or SLA subject to confirmation
Ward nurses on D21	60-80% transfers to UHBFT Rest of workload (ENT) remains on D21	Transfer staff to UHBFT in line with TUPE.	TUPE
Ward nurses on D25	20+% transfers to UHBFT Rest of workload (other surgical specialities)remains on D25	Staff to remain with SWBH primarily on D25.	None
Vascular Surgery Clinical Nurse	Circa 10% of workload relates to inpatient VS activity.	Undertake VS inpatient work at UHBFT and attend MDT.	SLA with UHBFT for 10% of workload &

Specialists	Rest of workload relates to outpatient clinics and supporting other inpatient specialities & will remain at SWBH.		honorary contracts with UHBFT.
Vascular Surgery Surgical Care Practitioner	Over 80% of work relates to inpatient activity in terms of pre admission clinics and co-ordination of lists etc. Aim is for this activity to transfer to UHBFT in the longer term but no capacity for preadmission clinics at present.	Continue preadmission clinics at SWBH for interim. Attend UHBFT for inpatient theatre lists & MDT.	In the interim SLA with UHBFT for % of workload that transfers & honorary contract with UHBFT. TUPE may apply in longer term.
Vascular Surgery Consultants	Inpatient theatre lists, ward rounds, MDT transfer to UHBFT. Estimated to equate to circa 30% of job plans. Emergency cover remains as now. Day time emergency cover will be at UHBFT. Exact % transferring to UHBFT needs to be calculated once job plans confirmed Day case lists, outpatient clinics, ward consultations for other specialities and joint VS and stroke MDT remain at SWBH	Undertake inpatient theatre lists, ward rounds, MDT, day time emergency cover at UHBFT. Clarity required around amount of time for teaching and research that will be undertaken at UHBFT. Remainder of work to be undertaken at SWBH.	TUPE may apply if majority of time is at UHBFT. If majority of time is at SWBH, SLA with UHBFT for agreed % of time & honorary contracts with UHBFT. Retain current arrangement for on call cover.
VS Junior Doctors	Middle Grades – no longer based at SWBH. FY1s – day time work at UHBFT & on call at SWBH	Middle Grade posts lost to SWBH / transferred to UHBFT Day time work at UBFT	Not required Depends on who is allocated posts
Consultant Anaesthetists	Vascular Surgery Inpatient lists transfer to UHBFT	Pick up other sessions at SWBH Or Undertake sessions at UHBFT to retain skills	None Or SLA with UHBFT for 4 sessions per week & time for ward visits & honorary contracts with UHBFT.
Theatre staff	Vascular Surgery Inpatient lists transfer to UHBFT	Pick up other sessions at SWBH	None

Therapist time	Vascular Surgery Inpatients transfer to UHBFT	Pick up other sessions/activity at SWBH	None
Consultant Interventional Radiologists	Vascular IR work transfers to UHBFT. Other work and on call remain at SWBH. Includes joint VS and stroke MDT.	Undertake Vascular IR sessions (3 per week) at UHBFT and attend VS MDT to provide capacity and retain skills.	SLA with UHBFT for 4 sessions per week & honorary contracts with UHBFT.
Radiology Nursing Staff	Vascular IR work transfers to UHBFT. Other work remains at SWBH.	Undertake Vascular IR sessions (3 per week) at UHBFT to provide capacity and retain skills.	SLA with UHBFT for 6 sessions per week & honorary contracts with UHBFT.
Radiographers	Vascular IR work transfers to UHBFT. Other work remains at SWBH.	Undertake Vascular IR sessions (3 per week) at UHBFT to provide capacity and retain skills.	SLA with UHBFT for 3 sessions per week & honorary contracts with UHBFT.

In relation to Consultants in Vascular Surgery - a review of job plans is currently in progress and required before % of time that will transfer to UHBFT can be confirmed. Until this is available it is not possible to confirm whether TUPE may apply.

8.1 TUPE

For TUPE to apply the way that the vascular surgery service is provided post-transfer does not need to be identical but needs to be "fundamentally or essentially the same" as the way it is currently carried out. The information provided within this business case indicates that this will be the case.

Where the work transfers to two providers it is likely that the provider that takes on the greater part of the activities will inherit liability for all of the employees who support the vascular surgery work. The plan that UHBFT will house the in-patient beds is a clear indicator that UHBFT will inherit the liability for the employees who support this work i.e. Vascular Surgery inpatients. The employment of those "assigned" to the vascular surgery inpatient service will therefore transfer to the new provider on their existing terms. TUPE does not clearly define what is meant by "assigned" and it is therefore a factual question, taking into account a number of factors, one of these being the percentage of time spent working in the service being transferred. It is however a risk to only use a percentage test to assume TUPE applies as there have been cases where employees who spent 80% of their time working for a service that was been transferred were held not to transfer due to other relevant factors. As a result there is a delay in confirming the definitive numbers in relation to who would TUPE across. The fact that an employee performs some of their duties for another service (i.e. the nursing staff) does not preclude them from transferring.

Other factors that are being considered in relation to staff being assigned to the work are:

- The value given to the time spent by employees to the service transferring
- Provisions of employment contracts - particularly in relation to duties
- How the cost to the Trust of the employee is allocated between different services i.e. if their cost is allocated to the vascular surgery service then this would be an indication that they are assigned to that service.

Employees that are only temporarily assigned to the service i.e. possibly those on secondment or employees on temporary contracts, may not transfer. In deciding whether staff are "temporarily assigned" we need to look at factors including the length of the assignment and whether a date has been set for their return or re-assignment to another part of the Trust.

We have analysed activity levels on the wards at City Hospital which admit Vascular Surgery inpatients and this clearly evidences vascular surgery activity on D21 averaging between 60-80% and on D25 averaging 20+% . As a result it can be assumed that 60- 80% of ward based nursing time on D21 is linked to Vascular Surgery patients.

The number of staff potentially subject to TUPE are summarised in table 9 below but are still subject to confirmation. They will leave a staffing ratio of at least 1.14 for the remaining beds on D21 and D25 and will allow at least the minimum staff numbers per shift.

Table 9: Staff (wte) Changes Resulting From Option 2

Banding Level	Current/ Do Nothing	Option 2: 15 Bed Ward reduction (staffing ratio1.14)
8a	0	0.00
7	0	1.00
6	0	1.00
5	0	9.52
4	0	0.00
3	0	1.00
2	0	4.70
Total Workforce Numbers		**17.22**

The Trust has an obligation to inform and consult in respect of "affected employees". It is noted that this will not only include those staff that will transfer but also their colleagues in the Trust who will not transfer but those whose jobs might be affected by the transfer (and post transfer). The TUPE Regulations are not explicit with regards to when the obligation to inform staff should be activated but the employer must provide information "long enough before the relevant transfer to enable consultation with representatives of the affected employees". Due to the number of employees and the complexity of the transfer, the earlier that the information can be provided the better.

The consultation needs to be meaningful and union engagement and representation is essential. Informal communication with the Trade Union leads has already been initiated but this will need to take place formally upon the approval of the Business Case for Change by the Trust Board. On discussion with our Trust solicitors they have advised that 90 days would be an appropriate consultation period prior to the changes being implemented. With a view of the implementation date being July 2012 this would suggest formal consultation can commence by week commencing 9th April and run till 9th July 2012. If the timeline for Business Case approval shifts this will have a direct impact on the timeline for consultation and implementation, as the consultation period needs to be concluded before the changes are implemented.

A joint workforce group with UHBFT has been set up to work through the detail for staff whom may transfer to UHBFT.

9. ACTIVITY (EXPRESS ON FULL YEAR BASIS)

The tables below summarise activity changes under the Do Nothing scenario (table 10) and the preferred reconfiguration option (table 11).

Table 10: Do Nothing/Current: Combined Vascular and Vascular IR Activity Table

Activity Type	**2010-11 Outturn**	**2011-12 Plan**	**2011-12 Forecast Outturn (without investment as stated in Option)**	**Full Year Forecast Outturn (with investment as stated in option)**
Elective In-Patients	288	262	276	276
Day Cases	254	200	307	307
Emergency In-Patients	258	265	333	333
Excess Bed Days	972	1022	845	845
New Out-Patients	1869	1761	1,687	1687
Review Out-Patients	2421	2295	2,376	2376
Outpatient with Procedure	297	403	284	284

Table 11: Reconfiguration: Combined Vascular and Vascular IR Activity Table

Activity Type	**2010-11 Outturn**	**2011-12 Plan**	**2011-12 Forecast Outturn (without investment as stated in Option)**	**Full Year Forecast Outturn (with investment as stated in option)**
Elective In-Patients	288	262	276	0
Day Cases	254	200	307	252
Emergency In-Patients	258	265	333	0
Excess Bed Days	972	1022	845	0
New Out-Patients	1869	1761	1687	1687
Review Out-Patients	2421	2295	2376	2376
Outpatient with Procedure	297	403	284	284

10. INVESTMENT APPRAISAL

Not Applicable.

11. RISK ASSESSMENT AND MANAGEMENT

The project team have developed and maintained a risk log. The key business and clinical risks are highlighted in tabled 12 and 13 below.

Tables 12: Business Risks

Risk	**Option Scores**	**Mitigation**

	Do Nothing	Reconfiguration	
Releasable cost savings significantly less than transferred/ lost income.	***Medium 3*** (it is likely commissioners will commission inpatient vascular surgery from a recognized centre over time)	***High 4*** (Business Case currently has a gap of £ 2.24 m)	Business Case includes analysis of cost savings. Through the LDP negotiations with commissioners, the in-year impact has been limited to £1.4m with this value accommodated within the overall settlement for 12/13. In other words the system plan can accommodate this financial movement.
Loss of outpatient and day case VS activity from Sandwell population to DGoH	***Medium 2*** (it is likely that as the service at DGoH develops Sandwell residents may choose there as an alternative to traveling to City Hospital for inpatient treatment)	***Medium 3*** (it is likely that as the service at DGoH develops Sandwell residents may choose there as an alternative to traveling to QE Hospital for inpatient treatment)	Service model retains outpatient and day case surgery at City and Sandwell Hospitals. The majority of emergency activity presents by ambulance and is likely to continue to be taken to the nearest ED as often the diagnosis is not clear at the stage the ambulance service assess the patient. Business Case does not assume a catchment loss.
TUPE is found not to apply to all of the identified posts in the Business Case and therefore SWBH retains the cost of these posts/any redundancy costs	***Low 0*** Short term (as TUPE not required) ***Medium 2*** (Longer term as any unplanned transfer of activity, see risk above, will reduce staff requirements and SWBH will need to manage the financial impact of this.)	***High 4*** (staff numbers likely to transfer under TUPE have been shared with UHBFT but has yet to be agreed. UHBFT ward staff ratios appear to be lower than those on D21. In addition consultant job plans not confirmed and so not yet clear whether TUPE will apply.)	Joint working group with UHBFT and sharing of staff numbers. Analysis of staff workload in line with TUPE guidance. Both Trust's are taking legal advice on the outputs of this. Consultant job plans have been requested.
UHBFT do not agree SLA/funding support for SWBH staff to undertake Vascular Surgery and Interventional Radiology work at UHBFT in order to provide capacity for the additional activity at UHBFT and retain skills.	***Low 0*** Short term (as activity will remain in SWBH.) ***Medium 2*** (Longer term as any unplanned transfer of activity, see risk above, will reduce staff requirements	***Medium 3*** (staff time likely to transfer under SLA to create capacity & retain skills has been shared with UHBFT but has yet to be agreed.) UHBFT ward staff ratios appear to be lower than	Joint working group with UHBFT and sharing of staff numbers.

Risk	Option Scores		Mitigation
	Do Nothing	Reconfiguration	
	and/or impact on skills which in turn will impact on recruitment & retention. SWBH will need to manage the financial impact of this.)	those on D21. In addition consultant job plans not confirmed and so not yet clear whether TUPE will apply.)	

NB: In line with Trust Business Case guidance each option has been given a score on a scale of 0 to 5 for each identified risk which reflects both the likelihood of the risk occurring and the consequences (financial and operational) if it does occur where 0 represents no risk/no consequences and 5 represents high risk/significant consequences.

Tables 13: Clinical Risks

Risk	Option Scores		Mitigation
	Do Nothing	Reconfiguration	
Delay to approval and/or implementation of transfer of VS inpatients to UHBFT with possible delay to start of AAA Screening Programme	***High 4*** as AAA Screening Programme requires transfer to have taken place.	***Medium 3***	Business Case for Change being presented for approval in March with planned implementation date of July. Transfer needs to have taken place by September in line with SHA requirements for AAA Screening
Loss of IR skills and staff as a result of loss of vascular work	***Medium 2***	***Low 1***	Service model includes SWBH IR staff having access to vascular work at UHBFT
UHBFT post transfer decide to discontinue local day case lists, outpatient clinics and emergency cover at SWBH	***Does not Apply***	***Low 1***	Service model jointly agreed with UHBT including a set of underlying principles. SWBH retain consultant contracts. SLA will be put in place for required services and cover.
Transfer of emergency patients to QE Hospital for emergency treatment/surgery	***Low 1***	***Low 1***	Continue current arrangement of a joint on call rota. Currently emergency patients transferred to on call consultants host hospital (via ambulance) unless too unstable. Consultants will be free of elective commitments when on call and therefore more readily avaialble to consult with referring EDs or travel to referring ED if patient too unstable to transfer.
Lack of Vascular Surgery experience in theatre team to	***Low 1***	***Low 2***	Consultants to be made aware of risk. Explore option of anaesthetists

Risk	Option Scores		Mitigation
	Do Nothing	Reconfiguration	
manage any emergency surgery prior to transfer			undertaking elective VS inpatients sessions at UHBFT. Ensure theatre trays available in SWBH. Likely to be very low numbers.

NB: In line with Trust Business Case guidance each option has been given a score on a scale of 0 to 5 for each identified risk which reflects both the likelihood of the risk occurring and the consequences (financial and operational) if it does occur where 0 represents no risk/no consequences and 5 represents high risk/significant consequences.

12. PREFERRED OPTION

The only option considered viable in terms of meeting the clinical drivers for change is an integrated service with UHBFT with inpatients and vascular IR at QE Hospital and day cases and outpatients retained in SWBH at both City and Sandwell Hospitals. The Business Case has therefore focused on this option with Do Nothing presented for comparative purposes only.

13. CASHFLOW PHASING OF PREFERRED OPTION

Table 14: Cashflow Phasing for Preferred Reconfiguration Option

	Current Year (include Part Year Effect) (specify) £000s	Year 2 (specify) £000s	Year 3 (specify) £000s	Year 4 (specify) £000s	Year 5 (specify) £000s	Subsequent years £000s
Capital Expenditure (-)	0	0	0	0	0	0
Income (+)	-2,509	-3,345	-3,345	-3,345	-3,345	-3,345
Revenue Expenditure (-)	0	0	0	0	0	0
Cost Savings (+)	827	1,102	1,102	1,102	1,102	1,102
Net Cash Flow (+/-)	**-1,682**	**-2,243**	**-2,243**	**-2,243**	**-2,243**	**-2,243**

14. PROPOSED TIMETABLE

A detailed implementation plan will be developed once the reconfiguration has been approved by the Trust Board and UHBFT at their Board meetings in March.

The next key steps and their proposed dates are:

- Engagement with patients - Started December 2011 - ongoing
- Further discussion with lead commissioners including GPs – Started December 2011 -ongoing
- Further analysis and presentation of the updated Business Case to SIRG– March 2012
- SWBH Trust Board approval – March 2012
- UHBFT approval – March 2012
- Develop a communication plan for the implementation phase - April 2012
- Commence formal staff engagement – April 2012
- Develop an implementation plan – April 2012
- Implementation, subject to approval of the Business Case - July 2012.

Development of the AAA screening programme is part of a national programme, is being co-ordinated by the SHA and as such is a separate although related project. The proposed implementation date for this is October 2012 in line with the national programme.

15. CONCLUSION

This paper sets out the Business Case for Change for Vascular Surgery reconfiguration. The only option considered viable in terms of meeting the national and local clinical drivers for change is an integrated service with UHBFT with inpatients and vascular IR at QE Hospital and day cases and outpatients retained in SWBH at both City and Sandwell Hospitals. The Business Case has therefore focused on this option with Do Nothing presented for comparative purposes only.

The financial analysis of the preferred option demonstrates that without a funding solution, the Trust would face a full year pressure of £2.24 million arising from the difference between full income (full PbR) losses net of releasable cost. Through the LDP negotiations with commissioners, the in-year impact has been limited to £1.4m with this value accommodated within the overall settlement for 12/13. In other words the system plan can accommodate this financial movement.

It should be noted that the estimate of income loss is based on a straight line adjustment of month's 1-9 actual activity in 2011/12. Also at this stage some of the costs can only be estimates based on assumptions and these will be confirmed as part of the ongoing discussions around the impact on staff workload and in particular the arrangements for staff time to transfer along with the workload to UHBFT, through a mixture of TUPE and SLA arrangements. It should also be noted that the transfer of staff time and costs have been highlighted as a high business risk at this stage because whilst there has been a joint working group with UHBFT and discussion around these arrangements a formal agreement is not yet in place.

16. RECOMMENDATION

The Trust Board is recommended to:

- APPROVE the business case for change and the preferred options for Vascular Surgery reconfiguration.

- NOTE the implications for the transfer of staff to UHBFT to support the transferred activity. This may be under a mix of TUPE and SLA (Service Level Agreement) arrangements. These

arrangements have yet to be formally agreed between ourselves (SWBH) and UHBFT and so are considered a risk to the Trust at this stage. In particular consultant job plans for the Vascular Surgeons need to be confirmed as soon as possible in order to have clarity as to whether the consultant contracts should transfer to UHBFT under TUPE or be retained by us with an SLA with UHBFT for the activity at UHBFT.

- AGREE the transfer of activity to UHBFT from July 2012 in order to meet SHA (Strategic Health Authority) and clinical timescales but subject to transfer arrangements, including TUPE and SLAs for staff being agreed and put in place within this timescale and with agreement that if this is not the case the implementation date is delayed.

Jayne Dunn
Redesign Director RCRH

APPENDIX 1

DOCUMENT HISTORY

Version	Date	Author	Summary of Changes	Presented To
Version 1: (final)	22nd March 12	Jayne Dunn (Redesign Director, Right Care Right Here, SWBH)	Updated to take account of feedback from CEO and Executive Directors.	Trust Board: 29/3/12
Version 1: (final draft)	20th March 12	Jayne Dunn (Redesign Director, Right Care Right Here, SWBH)	Updated to take account of feedback from Executive meeting on 12/3/12 including: • link to LDP discussions for 2012/13 • need for confirmation & agreement re staff transfer arrangement including TUPE prior to implementation.	CEO & Executive Directors: 20/3/12
Draft 2	8th March 12	Jayne Dunn (Redesign Director, Right Care Right Here, SWBH)	Updated to take account of: • Revised activity & financial analysis • Non financial scoring of options • Feedback from patient engagement • Update on TUPE & implications for staff • Risk section • Comments from SWBH Vascular Surgery Reconfiguration Project Team meeting on 5/03/12	Executive meeting held instead of SIRG: 12/3/12
Draft 1	5th Jan 12	Jayne Dunn (Redesign Director, Right Care Right Here, SWBH) Mike Beveridge (DGM Surgery A) Shaun Power (SFM) Jackie Morton (DGM Imaging)	Initial Draft of Document using SWBH Business Case template and based on work undertaken by the SWBH Vascular Surgery Reconfiguration Project Team and finance meetings.	Executive Management Team 10/1/12

APPENDIX 2

REFERENCES

Department of Health (29/07/2010) *Letter on Service Reconfiguration* (Gateway reference number: 14543)

National Confidential Enquiry into Patient Outcomes and Death. (2005). *Abdominal aortic aneurysm: A service in need of surgery?(*Available at: http://www.ncepod.org.uk/2005report2/Downloads/AAA_report.pdf)

The Royal College of Radiologists: *Standards in Vascular Radiology.* London (2011) ref BFCR(11)6

The Vascular Society of Great Britain and Ireland(2011): The Provision of Services for Patients with Vascular Disease 2012. Review date 2015. The Vascular Society of Great Britain and Ireland at the Royal College of Surgeons 35-43 Lincoln's Inn Fields London WC2A 3PE

The Vascular Society of Great Britain & Ireland. (2009). *The provision of services for patients with vascular disease.*

The Vascular Society of Great Britain & Ireland. (2007). *The provision of emergency vascular services*. (Also available at: http://www.bsir.org/files/File/C_Provision_of_Emergency_Vascular_Services_Final_Doc.pdf)

West Midlands Quality Review Service (January 2011) *Review of Urgent Care, Critical Care, Stroke (Acute Phase) & TIA and Vascular Services for the Heart of Birmingham and Sandwell Health Economies*

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Right Care Right Here Progress Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director, 'Right Care, Right Here'
DATE OF MEETING:	29 March 2012

SUMMARY OF KEY POINTS:

The paper provides a progress report on the work of the *Right Care Right Here* Programme as at the end of February 2012.

It covers:

- Progress of the RCRH Programme including activity monitoring for the period April-December 2011.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Monthly progress report to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT MARCH 2012

INTRODUCTION

The Right Care Right Here Programme is the partnership of SWBH, HoB tPCT, Sandwell PCT and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. This brief paper provides a progress report for the Trust Board on the work of the Programme as at the beginning of March 2012. It summarises the Right Care Right Here Programme Director's report and the RCRH Service Redesign Report that were presented to the Right Care Right Here Partnership Board in March.

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

PROJECT PERFORMANCE

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

At this stage it appears that across Inpatients and Outpatients our acute activity is showing a downward trend but remain above the 2011/12 trajectory and significantly higher than the 2016/17 trajectory. Our Emergency Department Attendances are higher than the 2010/11 end of year level and 2011/12 trajectory but at Sandwell Hospital there continues to be a downward trend. Further work is required to ensure maintenance of these trends and ongoing progress towards the 2016/17 position. It is anticipated that the re-commissioning work (see below) will help to achieve this as will the cross cutting work streams in our Transformation Programme.

In summary activity trends for April-December show:

- Inpatient Activity: Our Acute Occupied Bed Days (OBDs; in Summary A, figure 1) are 7.6% below 2010/11 levels but 15% above the 2011/12 trajectory and 48% above the 2016/17 trajectory. This is a slight increase on the previous report and relates to an increase in emergency inpatient OBDs which are 7.9% lower than last year but 18% above the 2011/12 trajectory and 41% above the 2016/17 trajectory. Our elective inpatient OBDs continue to show a downward trend and are 9% below last year, 6% below the 2011/12 trajectory and 41% above the 2016/17 trajectory (Summary A, figures 4 and 5).

- Community OBDs (in Summary B, figure 3) are 10% below 2010/11 levels and 18% below the 2011/12 trajectory. This is a slight improvement on the previous report likely to be due to the opening of the intermediate care/re-ablement beds at Rowley Regis Hospital in October.

- Emergency Department Attendances: Our Emergency Department (ED) attendances (in Summary A, figure 2) are 1.6% above the 2010/11 end of year level, and 6% above the 2011/12 trajectory. The RCRH Programme have undertaken a quarterly trend analysis (Summary 3 in Appendix 1 - figures 1 and 2, but please note the text box is inaccurate) looking at the quarterly trends in ED attendances split between City and Sandwell Hospitals. This shows that for quarter 3 (September-December 2011) ED attendances in the Trust were 2% above the same period in 2010/11 including 7% lower at Sandwell Hospital and 2% higher at City Hospital (which includes the Emergency Department in the Birmingham Midlands Eye Centre).

- The Urgent Care Centre attendances (in Summary B, figure 2) are 15% above 2010/11 end of year level, 92% above the 2011/12 trajectory and 34% above the 2016/17 trajectory.

- Outpatient Attendances: Our acute Outpatient Activity (in Summary A, figure 3) is 4.5% below the 2010/11 end of year level and 0.2% above the 2011/12 trajectory. It is 123% above the 2016/17 trajectory.

- Community Outpatient Activity (including our community and new Community Provider activity, in Summary B, figure 1) remains below the 2010/11 end of year level by 4.8% but is still 220% above the 2011/12 trajectory although still some way (49%) from the 2016/17 trajectory.

- Referrals to acute services have shown a further reduction and are now 8% below the 2010/11 level (in Summary B, figure 4). this is an increase on the previously reported position and is likely to result in an increase in outpatient activity in later months.

MEDICAL ENGAGEMENT EVENT

A further Medical Engagement Event was held on 8th February. This was well attended by both consultants from our Trust and GPs. The following common themes for improvement emerged from the event:

- Patient Communication
- Diagnostics
- Reduced variation/consistency of care
- Clinician Communication
- Administrative System Issues
- IM&T
- Access to Services

The outputs from the event will be distributed across PCT cluster/GP CCG commissioners and the Trust to feed into the redesign and transformation agenda. We are holding more detailed discussions with our local Clinical Commissioning Group (CCG) about the best way to jointly take these agendas forward. The RCRH Clinical Group will also be discussing how to develop the further clinical work required to address these areas.

TRANSFER OF ACTIVITY (RE-COMMISSIONING)

Work has continued to deliver and monitor the schemes in the Re-commissioning Programme for 2012/13. The LDP agreement set a target of re-commissioning activity worth £16.2million and to date the Trust and PCTs have identified schemes that will result in the transfer of activity worth £13.8million over a full year. For the period April – January 2012 there has been a transfer of activity worth £1.3 million. This is a deterioration of the previously reported position primarily due to the marked increase in emergency admissions and Emergency Department attendances during January. It should be noted that a number of schemes commenced in the Autumn and so are expected to deliver more fully in 2012/13.

The RCRH Programme has reviewed the re-commissioning process in 2011/12 and has made the following observations:

What has worked well:

- Overall agreement
- Risk sharing
- Early identification of potential schemes
- Broad-based impact of schemes against overall target
- Recognition of respective contributions to overall agenda
- Clear progress with clinical care pathway review and service re-design in some areas
- Joint monitoring of overall delivery for those schemes that were implemented

What should be improved:

- Detailed business/project plans behind specific schemes

- Separate timely delivery mechanisms for partner organisations
- Detailed joint performance monitoring of delivery, including project evaluation
- Wider 'fit' of schemes into overall system, e.g. where re-ablement schemes operated by community, mental health and/or local authority providers impact upon the wider system
- Shift away from bottom-line contract monitoring to a more sophisticated, scheme by scheme/line by line contracting governance focus.

This assessment has been fed in to the Clinical Commissioning and Governance Group overseeing the process for the LDP discussions with the Trust. The intention is to agree a revised risk sharing agreement and associated delivery programme for re-commissioning as a key outcome of this year's LDP. This will include arrangements to ensure a more focussed approach to implementation and is likely to include implementation of the approved RCRH care pathway and speciality reviews.

RCRH ACTIVITY AND CAPACITY MODEL

The RCRH Activity and Capacity Model has formed the basis for our both long term plans (including the Outline Business Case for the Midland Metropolitan Hospital) and the PCTs' long term commissioning plans. The model was last updated in 2010/11 (version 5.3) and we are in the process of producing an updated version as part of their Foundation Trust application and transformation plan process. This will result in version 5.6 of the model and will incorporate a new set of base year data, a number of changes to key assumptions and a review of the scope of the areas of service provision under consideration.

A full revision of the RCRH Activity and Capacity model is also overdue and the RCRH Programme Team has started discussions within the local health economy to develop the next phase of this work. The intention is to build on the updated version that we are producing (version 5.6) and in addition to replace the current software platform for the model as this is now struggling to cope with the number and complexity of the changes that need to be incorporated. This will require some investment of resource during the current financial year and there is provision for this investment within the current RCRH Programme budget. As part of the full revision wider engagement with other partner organisations, particularly Birmingham Community Healthcare and the two Local Authorities will be vitally important in developing assumptions and framing key outputs from a revised model.

RECOMMENDATIONS

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.

Jayne Dunn
Redesign Director – Right Care Right Here
20th March 2012

APPENDIX 1 - RCRH Activity Summaries

Personal :: Summary PBR reports_v2

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

Fig 1 - Summary SWBH Actual Acute OBD's From Apr to Dec 2011 Compared to AC Model 11/12 And 10/11 Out Turn

At Month 9 all inpatients OBD's are 7.6% below 10/11 out turn and 15% above modelled A&C 11/12 trajectory. We are 46% above modelled 16/17 trajectory. Overall trend is declining.

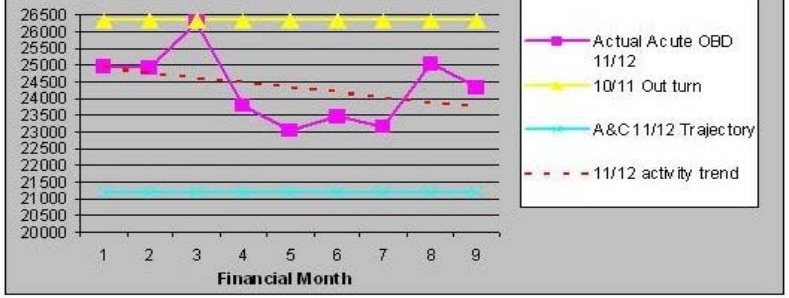


Fig 2 - Summary ED Actual Attendance From Apr to Dec 2011 Compared To A&C Model and 10/11 Out Turn

ED Attendances are 1.6%(2288) below 10/11 outturn and 6% (8121) above modelled 11/12 trajectory. The overall trend is appears to be declining.

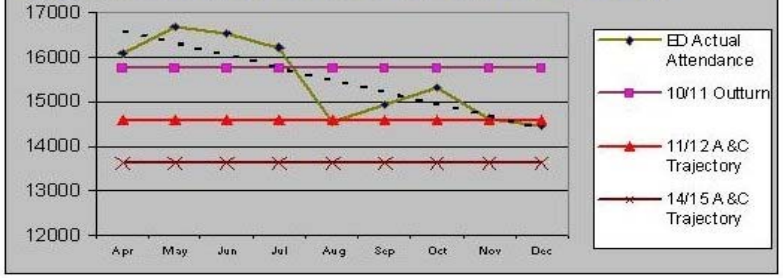
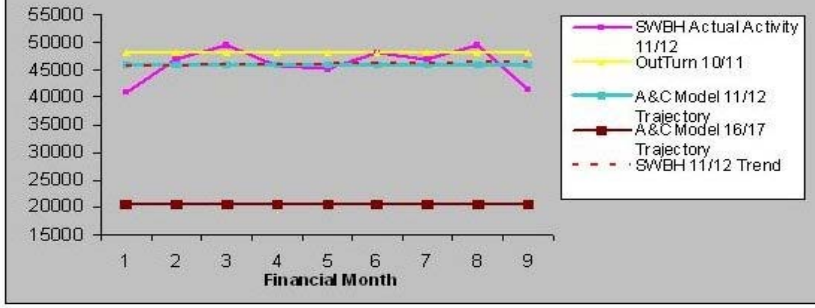


Fig 3 - Summary Outpatients From Apr to Dec 2011 Compared to AC Model 11/12 And 10/11 Out turn

At Month 9 outpatient activity is 4.6% less than 10/11 outturn and 0.2% above modelled 11/12 Trajectory. We are 129% above modelled 16/17 A&C trajectory. Trend is relatively static.



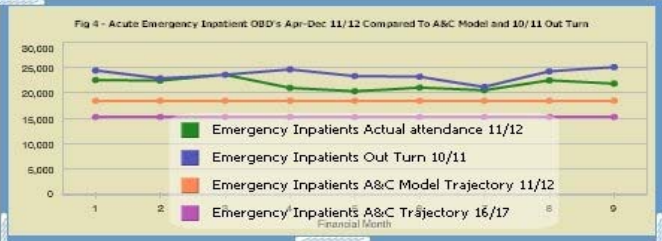


Fig 4 – At Month 9 Non Elective (emergency) OBD's are 7.9% (16,700) lower than 10/11 Outturn and 18% (29,500) above modelled 11/12 A&C trajectory. We are 41% (44,000) above 16/17 trajectory to date.

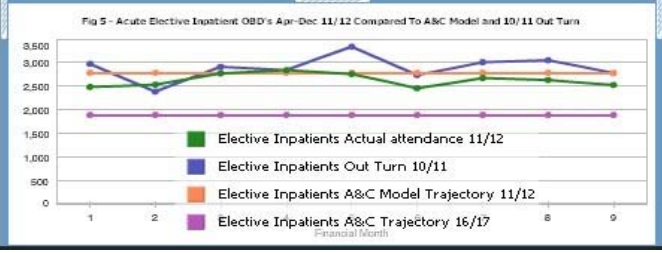


Fig 5 – Elective Inpatient OBD's are 9% (2352) below 10/11 outturn and 6% (1385) below 11/12 A&C trajectory. We are 39% above modelled 16/17 trajectory. Elective inpatient activity appears to be trending upwards despite activity being below modelled trajectories and outturn.

Summary PBR Community reports

Summary B - RCRH Programme Board Reports For Community Sector From Apr-Mar 2011/2012

Fig 1 Summary Community Outpatients From Apr-Dec 2011 Compared to A&C Model and 10/11 Out Turn

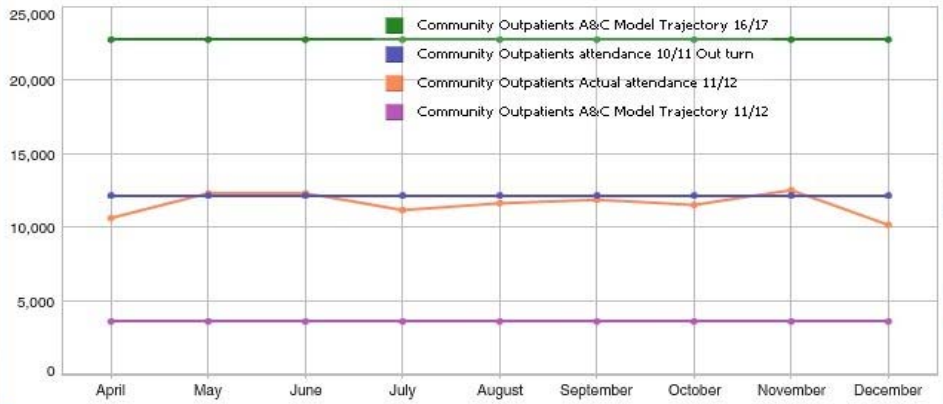


Fig 1 – At Month 9 community outpatient attendance is 4.8% less than 10/11 outturn. In comparison to the A&C model it is 220% above 2011/12 Trajectory and 49% less than 2016/17 trajectory.

Fig 2 – Urgent Care Centre attendance is 15% (10,230) above 10/11 outturn. Urgent care activity appears to be trending up and we are 34% above 16/17 Trajectory and 92% above 11/12.

Fig 3 – Community OBD's are 11% below 10/11 outturn and 18% below modelled trajectory for 11/12. Please note that McCarthy ward at Rowley Regis closed in May 2011 and a new enablement ward (Henderson ward) opened in September 2011.

To meet 11/12 trajectory we need to introduce 16,154 new OBD's .Community OBDS includes Henderson Ward and the following: Leasowes IC Centre,Barthalomew Lodge Nursing Home,Waterside Nursing Home,Greenhaven Care Home,Moseley Hall,Riverside Lodge,RCRH Exemplar projects

Fig 4 – Show referral activity which includes GP as well as other types. At month 9 referrals are 8% (12,166) below last years out turn.

Fig 2 Summary UCC Attendance From Apr-Dec 2011 Compared to A&C Model and 10/11 Out Turn

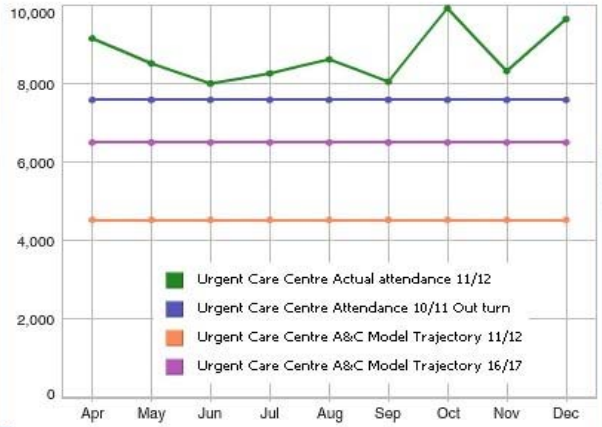


Fig 3 Summary Community OBD's From Apr-Dec 2011 Compared to A&C Model and 10/11 Out Turn

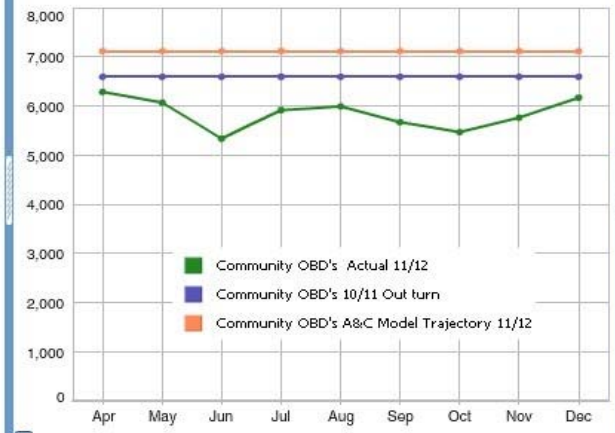
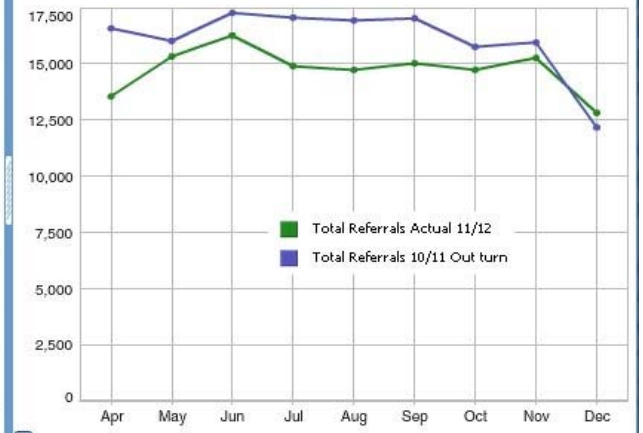


Fig 4 Summary Referrals From Apr-Dec 2011 Compared to 10/11 Out Turn



Personal :: urgent_care quarterly

Summary C - RCRH Quarterly Programme Board Reports For Urgent Care From Apr-Dec 2010/11

Fig 1 - ED Attendance At City and Sandwell From Apr-Dec 2010/2011 (last 21 months)

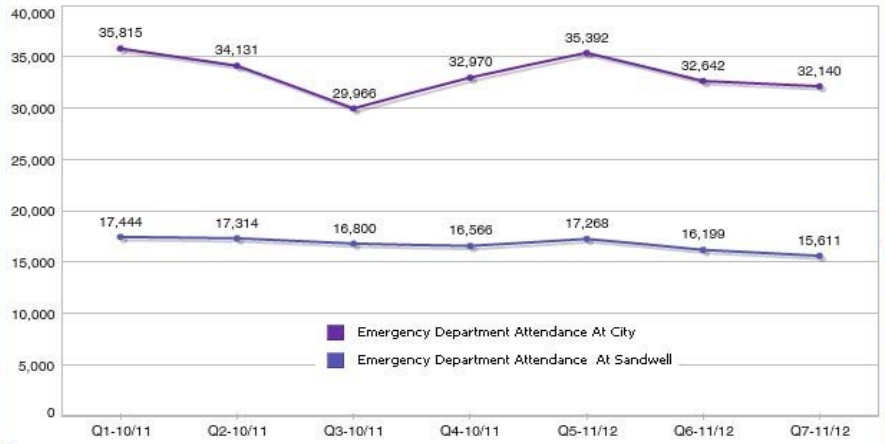


Fig 2 - SWBH ED Quarterly Attendance From Apr-Dec 2010/2011 compared to A&C Model

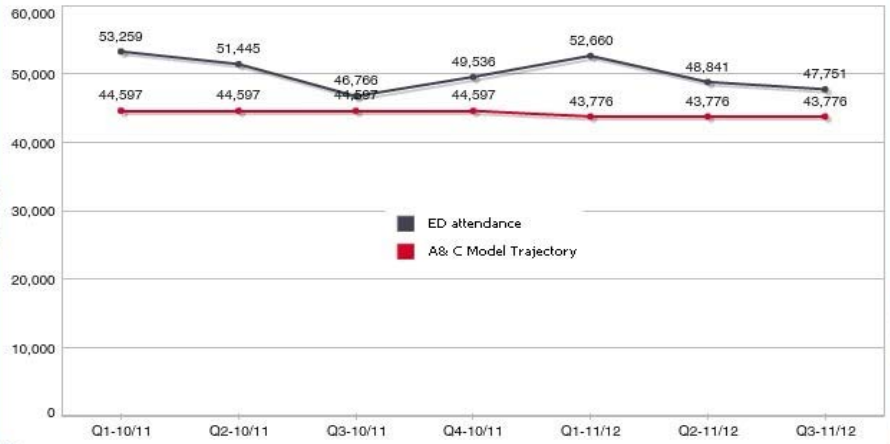


Fig 3 - Urgent Care Centre Attendance From Apr-Dec 2010/2011 compared To A&C Model

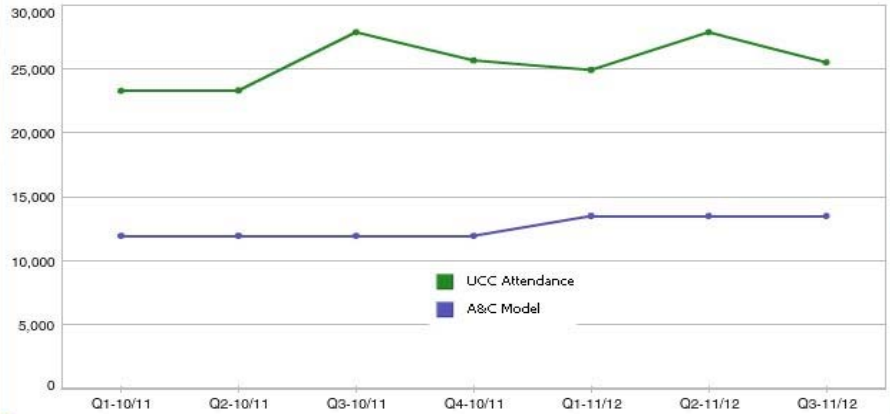


Fig 1 – This chart shows Emergency Department attendance at City and Sandwell Hospital over the last seven quarters. From Q3 10/11 to Q1 11/12 the trend appears to have risen at City Hospital and then began to drop as from Q2 11/12. At Q3 11/12 City Hospital ED attendance is 0.3% above the same period last year and Sandwell Hospital are 4.8% less.

Fig 2 – This chart shows SWBH ED attendance over the last seven quarters. At Q3 11/12 ED Attendance is 1.4%(2218) lower than the same period last year. Overall we are 13% above modelled A&C trajectory.

Fig 3 – Shows urgent care centre activity over the last seven quarters. We are 101 % above modelled A&C trajectory and 5% above same period last year.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD (PRIVATE SESSION)

DOCUMENT TITLE:	The Birmingham & Solihull Partnership Compact
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy & Organisational Development
AUTHOR:	Mike Sharon, Director of Strategy & Organisational Development
DATE OF MEETING:	29 March 2012

SUMMARY OF KEY POINTS:

The Birmingham & Solihull Partnership Compact sets out some principles and ways of working which all organisations have signed up to. It then proposed the establishment of a shared programme of work that is dependent on the practical application of these principles.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked for its endorsement to sign up to the principles and workplan proposed in the Compact.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Care Closer to Home
Annual priorities	
NHSLA standards	
CQC essential standards of quality and safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

None.

NHS

Birmingham and Solihull

Uniting for Healthier Birmingham and Solihull

THE BIRMINGHAM & SOLIHULL PARTNERSHIP COMPACT

Version Control		
Version No & Author	Date	Activity
V1 Peter Spilsbury Director of Commissioning Development BSOL Cluster	13/2/12	For discussion & agreement CEO Forum
V2.1 Peter Spilsbury	29/2/12 05/3/12	Updated via comments received at CEO Forum
V3 Peter Spilsbury	20/3/12	Updated via comments received from LAs – agreed at CEO Forum 20.3.12

Birmingham City Council

Solihull Metropolitan Borough Council

Partners to Agreement

CEO Forum Membership:	
Providers	
Sandwell & West Birmingham Hospitals NHS Trust	John Adler - CEO
Royal Orthopaedic Hospital NHS Foundation Trust	Donal O'Donoghue - CEO
Birmingham & Solihull Mental Health NHS Foundation Trust	Sue Turner - CEO
Heart Of England NHS Foundation Trust	Mark Newbold - CEO
University Hospital Birmingham NHS Foundation Trust	Dame Julie Moore - CEO
Birmingham Children's Hospital NHS Foundation Trust	Sarah-Jane Marsh - CEO
Birmingham Community HealthCare NHS Trust	Tracy Taylor- CEO
Birmingham Women's NHS Foundation Trust	Ros Keeton - CEO
West Midlands Ambulance Service NHS Trust	Anthony Marsh - CEO
Local Authorities	
Birmingham City Council	Peter Hay – Strategic Director
Solihull Metropolitan Borough Council	Dave Martin – interim DASS
Clinical Commissioning Groups	
Sandwell and West Birmingham CCG	Dr Nick Harding – CCG Chair
Northeast Birmingham CCG	Dr Tony Ainsworth – CCG Chair
Birmingham Health Commissioning Group	Dr Gavin Ralston – CCG Chair
Solihull Health CCG	Dr Anand Chitnis – CCG Chair
Birmingham South Central CCG	Dr Andrew Coward – CCG Chair
Commissioner:	
Birmingham and Solihull NHS Cluster	Denise McLellan - CEO

1 Introduction

The Chairs , Chief Executives and Leaders across NHS and social care in Birmingham and Solihull have agreed to establish a **'Compact'** that sets out their commitment to partnership working to deliver improved health and wellbeing for the citizens they serve.

This Compact sets out some principles and ways of working which all organisations have signed up to. It then goes beyond principles to establishing a shared programme of work that is dependent on the practical application of these principles. The Compact is about action and living the principles rather than simply espousing them.

Whilst to an important extent the improvement of all health services and social care depends on partnerships, the Compact is deliberately focussed on a selected group of services/populations where all organisations involved are agreed that without partnership working we will fall drastically short of our objectives and in so doing undermine the continuation of sustainable health and social care services into the future.

The Compact has been developed at a time when there are major constraints on the availability of public funding and where the NHS is being asked to manage all improvements in quality and capacity within existing resources and local government is being asked to manage with significantly reduced funding. We are agreed that this can only be managed if all parties work in collaboration to find better ways of using the resources that are entrusted to us in combination.

2 The Overall Strategy

We will improve the wellbeing, health and healthcare of the population we serve by providing rapid and easy access to high quality, evidence-based care and support, tailored to individual needs and in the most appropriate setting.

This will be done by:

Prevention and early intervention - prioritising proven ways of preventing ill-health or diminished well-being and systematic, targeted early intervention in health and care problems for individuals.

Supporting people - supporting people to best manage their own health and wellbeing with excellent information, increased choices and greater individual control over decisions about the use of resources.

Care closer to home - enhancing and making more consistent the range, availability and quality of services in primary care and in community settings.

Joined up care - seeking out every opportunity to take practical steps to join up services as experienced on a day-to-day basis by patients, carers and families (integrated care).

Highest quality and "right" sized hospital care - working with our hospitals and partners, ensuring that - where further concentration of services into "centres of excellence" is the right things for patients - we deliver that jointly and that we make appropriate reductions in hospital capacity as community alternatives and better early intervention in ill-health change the pattern of demand.

Innovation and Market Shaping - we will make Birmingham and Solihull a"powerhouse" for innovation in healthcare, building on the strength of our excellent local providers of care to develop new services; the strength of our academic partners in evaluating them; the proven openness of all partners to do things differently; the commitment of our new Clinical Commissioning Groups to reshape primary care; and the opportunities our vibrant and diverse populations present for radical service redesign.

Agreed ways of working - we will focus on agreeing with clinicians and patients evidence-based pathways of care across primary, community and hospital, and on measuring and reporting against those so that we and our population can know that all parts of our healthcare system are delivering high quality, clinically effective care.

We have a shared understanding of the ways in which this strategic vision is intended to change the landscape of health and social care in Birmingham and Solihull. In the future, compared to now, this will be characterised by:

- Social care and health monies being used more for prevention rather than being limited to crisis support. We will see GPs and joined up teams able to "prescribe" reablement support as well as drugs and NHS referrals. We will seek the near elimination of delayed discharges.
- A reduction in the proportion of care carried out in high cost, high tech hospitals - with in particular fewer emergency admissions, shorter lengths of stay, more use of remote monitoring and open-access to diagnostics. The size of the hospital sector will reduce.
- A concentration of some specialised services in fewer locations in order to deliver class-leading quality and outcomes.
- Community based services able to support early interventions to maintain health and wellbeing as well as to step up for short-term crisis care available consistently and on a 7 day, 24 hour basis as appropriate. The size of the community/primary care sector will increase. We will see people supported to die at home if they wish. We will see greater use of technology to support a reduction in the impact we have on patient/public own resources though reduced travel, multiple appointments etc.
- People with long-term conditions being supported through targeted and consistent individual case-management by joined up teams. There will be fewer emergency admissions for this population.

- Those who are high and frequent users of service or who are likely to become so will be identified and will receive targeted bespoke support. We will see a reduction in the proportion of overall resource utilised on the small number of highest users.
- Health and social care resources used with maximum flexibility, jointly to achieve better outcomes. We will see more pooled budgets and more on-the-ground joint working and shared processes.
- More consistent quality -assured primary care working to agreed pathways and protocols and supported to do so by their CCGs.

3 Principles of Working - We will

1. Seek authentic savings[1] to reinvest in improved services by tackling:
   - Any costs[2] resulting from unjustifiable variations in services across our patch that cause suboptimal outcomes.
   - Unnecessary duplication of services.
   - Poor coordination of services, plans or spending decisions.
   - "Rules" that get in the way of doing the right thing for the people we serve.
2. Share the financial risk of initiating agreed system-wide changes to services (as part of our work programme) and will seek to support demonstrably successful new ways of providing services through an open-book assessment of costs and benefits across all parties and future funding apportioned on that basis within the existing overall financial envelope.
3. Make shared decisions about which major whole-system innovations to roll-out at scale recognising that any innovation may not always favour all parties and that at times some sacrifice in the common good will be necessary.
4. Do everything reasonable to share appropriate information and records where that facilitates improved outcomes for the population we serve.
5. Take collective pride in moving the overall shape of services and outcomes for our population towards our shared strategic vision (section 2 above) and agree a shared set of "measures of success" that we will individually and collectively hold ourselves to account for.

[1] An "authentic saving" is one which reduces cost across the whole system of care and support whilst sustaining or improving quality of experience and outcome. An "inauthentic saving" is where one party reduces costs and obtains benefit simply by passing extra cost on elsewhere.

[2] "costs" in terms of negative quality impact on the population we serve and/or poor use of financial and human resources

6. Commit our organisations to a programme of collective work as agreed at the Birmingham & Solihull Chief Executive Forum and provide individual leadership to projects and programmes we will ensure senior participation in these projects as appropriate with people empowered to make decisions that we abide by. We will share in the overall governance of the work and the making of collective decisions that commit resource.

7. Share organisational plans and be transparent about budgets, costs, activity and utilisation data where that is required to enable the best joint decision making and also to allow us to agree 3 year financial strategies for each part of our health and care system and for the system overall.

8. Respect the right and need for individual organisations in our Cluster area to pursue their own objectives alongside our whole-system objectives. Working within relevant national frameworks, we respect the need for constructive competition in service provision to allow patient/service user choice or to achieve best value and, at times, this might mean that some information has to be retained for the sole use of one organisation. However, all efforts will be made to minimise the risks from this of major negative unintended consequences for other partners across the system and to avoid any major "surprises".

9. We will work closely with elected local Councillors and MPs to ensure they are well-briefed and understand and support, wherever possible, the need for major service and system changes, together with the consequences of these for the residents they serve. This will be carried out through established key mechanisms such as local authority-led overview and scrutiny, tried and tested communication and engagement routes, and other ad hoc discussion as necessary. With this in mind, it is accepted there could be exceptional occasions where political leaders may not wish to support particular major changes. Again, all efforts will be made to identify such views at the earliest possible juncture, and to assess the consequences of them.

4 The Programme of Joint Work

Shared leadership - we have brought together the leaders - clinical and managerial - of GP, community, hospital and Local Authority care services to make bold decisions about driving through new approaches to service provision at pace and scale. This shared leadership has already proven that it can break through barriers in rolling-out the new RAID service and it is the way in which we are taking forward work on our biggest priorities for change.

We will establish a rolling programme of work that we believe requires collaborative working to achieve the big outcomes and we all agree that shared commitment is necessary

for that work to succeed. Clearly how the work programme develops over time will depend on our experience of how successful we are in being partners.

The agreed joint work programme for 2012 and 2013 is as follows as at February 2012:

This will be added to over time, by agreement, to embrace other top priorities such as supporting aspects of children and families' services and, in particular, to ensure jointly vulnerable children are protected from harm.

1. **Frail elderly programme** comprising workstreams for dementia, end of life care, stroke, generic frailty and integration. Appendix 1 summarises the programme and the leadership and participation that we have jointly agreed. This incorporates the Accountable Care Partnership pilot in Solihull.

2. **Specialist hospital programme** comprising of a) strategic reviews of hospital paediatrics services and maternity services b) implementation of reconfiguration of major trauma services. In addition, the CEO Forum will maintain an overview of existing work to reshape vascular surgery services and will keep under consideration the need to establish a formal project under this programme. Appendix 2 summarises the programme and the leadership and participation we have jointly agreed.

3. **Roll out of RAID** across all of Birmingham and Solihull and, if successful, agreeing to a sustainable funding arrangement from within existing resources across the system. Appendix 3 summarises the programme and the leadership and participation we have jointly agreed.

4. **Establish one approach to deliver at pace shared records** and near real-time information on patient flows across Birmingham and Solihull on a basis of what is needed rather than comprehensive pursuit of perfection.

5. **Continuing System Leadership**. Time limited piece of work that looks at system leadership in the new commissioning architecture.

5 The Measures of Success

We have agreed that as part of furthering our commitment to joint working on transformation of the Birmingham& Solihull health system (underpinned by this "Compact") that we should identify a **short** list of measures that we can use to track our joint success . These measures must encompass quality and resource and be meaningful across all parties in the health and social care system. These will form the basis of a public commitment to action and also be the basis for regular reports to each constituent board - with a common report being used by us all to do that. We are agreed that the list is

sufficiently solid that it will carry on being relevant to new organisations as they emerge and can help to sustain partnership working.

The idea isn't to create comprehensive balanced scorecards for the economy or to use the full range of measures and dimensions that are available. Instead, we are looking at a few high level measures which are most impacted on by the interactions within a whole system (i.e. where we can only succeed together), urgent care and elderly care being the most obvious areas in the first instance, and which have good proxy power (i.e. doing well on this implies doing well on a range of other things that are dependent on partnership working).

The **criteria** for choosing the measures include:

a. They are well established, clearly defined and we can access historical trends and comparative data from elsewhere.

b. We can all agree that success is movement in one direction only.

c. They are relevant to the agreed transformation programme that we are working on together i.e. frail elderly specifically ,and the overall model in the strategic vision in section 2 above of moving services towards prevention; early identification of health issues; early intervention; intervention in lowest , most appropriate intensity setting; care in the right place at the right time (removing duplication or unnecessary steps and working to standards –based pathways consistently); supporting increased independence for patients/clients; supporting choice.

d. They make sense to commissioners, providers and partners.

e. They can be described to the public and to the workforce in positive, aspirational terms ...not just as "reductions"

A programme of quarterly reporting will be developed initially by the Birmingham and Solihull PCT Cluster to be migrated to a successor body agreed by us all. Additional measures may be added over time as agreed. Each element of our agreed work programme will also establish measures of success as part of an absolute commitment to thorough, high quality evaluation of all that we do together. We will also agree a way of measuring and reporting on whether we are developing our joint working as a system and how we compare in that to others.

The measures will be signed off by the CEO Forum by no later than April 2012 following consultation amongst all partners.

6 Keeping the Compact Alive

For the Partnership Compact to be a living force we need to be prepared to hold ourselves and each other to account for abiding by the principles and the specific commitments to the work programmes set out. We agree that where any party to the Birmingham and Solihull heath and care system believes that elements of this compact are not being honoured then

in the first instance the relevant chief executives should attempt to resolve the issue bilaterally, if necessary with the mediation of the CEO Forum Chair. However, in the exceptional circumstances where agreement cannot be reached the issue must be raised at the CEO Forum for consideration and resolution. We also agree that we will ask the Chairs of our organisations and also the two Health and Well Being Boards for Birmingham and Solihull to challenge us constructively to work to the principles we have set out herein.

The Partnership Compact will be governed by the CEO Forum. We all commit to maintain that Forum through the forthcoming changes to the NHS commissioning landscape and we will jointly agree whatever organising and leadership arrangements are appropriate to do that.

We also all recognise that our shared work programme requires resources to succeed. This will be a mix of first, financial resources to support the double-running cost of change; secondly, people resources that we commit from our organisations to work on projects; and thirdly some dedicated team resource to undertake coordination and programme/project management and support. We will agree jointly how to secure the necessary resource to support this third aspect of our joint commitment to strategic change by charging such support against future benefits.

Finally, we will establish a programme of development activities which include a clear role for NEDs/governors/members and regular sharing and testing of the strategies and plans of individual constituent organisations.

7 Signing Up

All parties have agreed to a process whereby the Compact is signed up to by Boards or equivalent.

Signing the Compact is agreed to signify the following:

- Support for the overall strategic vision as set out in section 2, recognition of the consequences of it (as set out in section 2 also) and acceptance that they will be incorporated in plans.
- Agreement to the principles by which we will work together (section 3)
- Agreement to the shared work programme and a commitment to provide the agreed leadership and participation from each organisation necessary to secure success (section 4)
- Agreement to employ a set of high level measures and to report them quarterly to public Boards using a shared single report (section 5)

Appendix 1

The Programme of Joint Work - Birmingham & Solihull Frail Elderly Programme

The Frail Elderly programme is the culmination of work undertaken within the Birmingham and Solihull Health and Social Care System whereby potential pressures have been identified in relation to an ageing population and the current systems ability to meet their desired outcomes whilst maintaining financial stability. Addressing this will not just about incremental modification of local systems it is about transformational change that will be:

- Necessarily radical, requiring change in the underlying assumptions held by those involved;
- Deliver a significantly different system in terms of structure, process, culture and strategy from the current state;
- Standardisation of process and service models/delivery across all of Birmingham and Solihull with any differences being deliberate as opposed to accidental/historic reasons;
- The emergent system will exhibit continuous learning, adaptation and improvement.

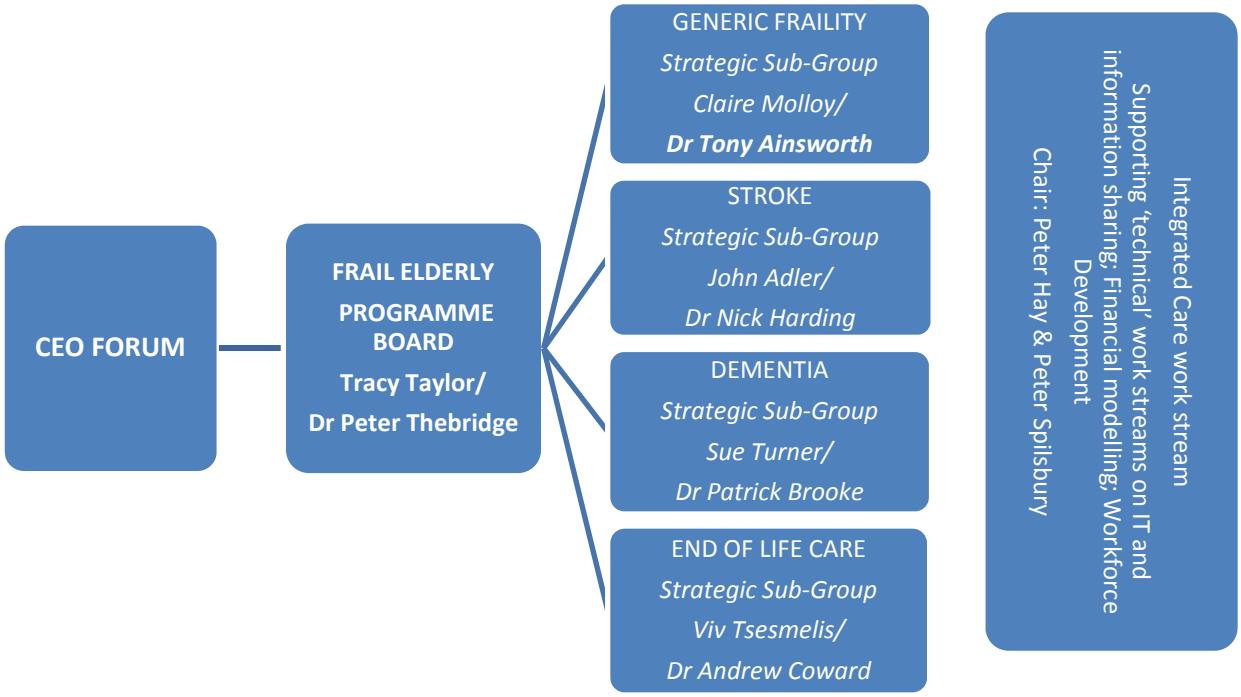
Consequently Chief Executives, of the key health and social care commissioning and provider organisations, and the GP leads of the emerging Clinical Commissioning Groups have agreed that collectively improving the quality and sustainability of the pathway for Frail Elderly is their number one priority.

Aim:
The Frail Elderly Programme is aimed at prevention, promoting support and maintaining independence for older people. To achieve this requires a whole system approach which will place the frail elderly person at the centre of planning and delivery.

Leadership & Participation:
The Frail Elderly Programme Board is chaired/co-chaired by Birmingham Community Healthcare NHS Trust and CCG's. Four work streams within the programme have been identified and work has begun to improve outcomes for the frail elderly and 'scale up' good practice and innovation. Each workstream is co-chaired by a member of the Frail Elderly Programme Board from a provider organisation and a CCG lead.

These workstreams a supported by a number of enabling groups focused on areas such as the operational delivery of integrated care, finance, workforce development, IT and intelligence.

Governance:



Duration:

Each of the Frail Elderly Programme Sub-groups are identifying early outcomes and benefits by establishing priority areas in terms of achievability, importance, financial impact and financial benefit. Any early improvements will be implemented in 2012/13 however the priority for the programme is to have service redesign plans in place by the summer of 2013 to enable any agreed contract change to commence in 2013/14.

Appendix 2

The Programme of Joint Work – Specialist Hospital Programme

Name: Designing High Quality Acute Paediatric Services Across The Birmingham & Solihull Health Economy.

Birmingham has three acute paediatric providers (BCH, City Hospital, HEFT (with three separate units at this one Trust)), plus children's and young peoples services within Birmingham Community Healthcare and multiple primary care providers. Research to date has provided limited evidence of effective, quality assured care pathways across this diverse provider landscape and there is little doubt that children and young people experience variations in quality depending on where they access the system.

Individual evidence based innovations have clearly taken place and show the potential for quality improvement and cost reduction however there is no systematic way of sharing best practice.

It is also clear that Birmingham & Solihull children and young people have a growing and large range of complex acute health needs that are increasing pressure on all providers during a time of resource constraint and costs will be difficult to control unless we do things differently.

Aim:
Develop system solution(s) that provide models of care to deliver high quality acute services for children and young people across Birmingham & Solihull, within the total resource envelope available whether in a hospital or community environment.
Improve the patient experience and quality of services through:

- Developing consistency and resilience in the delivery of children's acute services across Birmingham and Solihull.
- Identifying innovative, best in class, methods of delivering acute paediatric services in a safe and efficient manner across an entire care pathway.
- Identifying care pathways for high volume presentations that could reduce clinical variation in the treatment of common conditions across the health economy.
- Identifying factors that are either facilitators or barriers to the development, adoption and evaluation of care pathways and recommending how they can be overcome.
- Identifying potential areas of co-production with patient, families and carers that will enhance the patient experience.

Leadership & Participation:
The group will be chaired by the Chief Executive for Birmingham Children's Hospital NHS Foundation Trust, on behalf of all the partner organisations. The project group will consist of multi-disciplinary representatives from all acute sector providers, Birmingham Community Health, primary care and commissioners and the local authorities.

Governance:

Duration:
The project will be for 6 months; this will be reviewed in May on the basis of the group's initial report and recommendations.

Appendix 3

The Programme of Joint Work – Roll out of Raid

Name: Rapid Assessment Interface and Discharge (RAID) – PILOT

The Rapid Assessment Interface and Discharge (RAID) Mental Health Team brings together an integrated multidisciplinary team of mental health liaison practitioners specialising in general psychiatry, deliberate self harm, substance misuse and old age psychiatry so that all patients over the age of sixteen can be assessed and treated, signposted or referred appropriately. This group of multidisciplinary professionals will work closely with hospital clinicians and managers to ensure timely assessment is easily accessible to all patients presenting with mental health and substance misuse problems.

Aim:

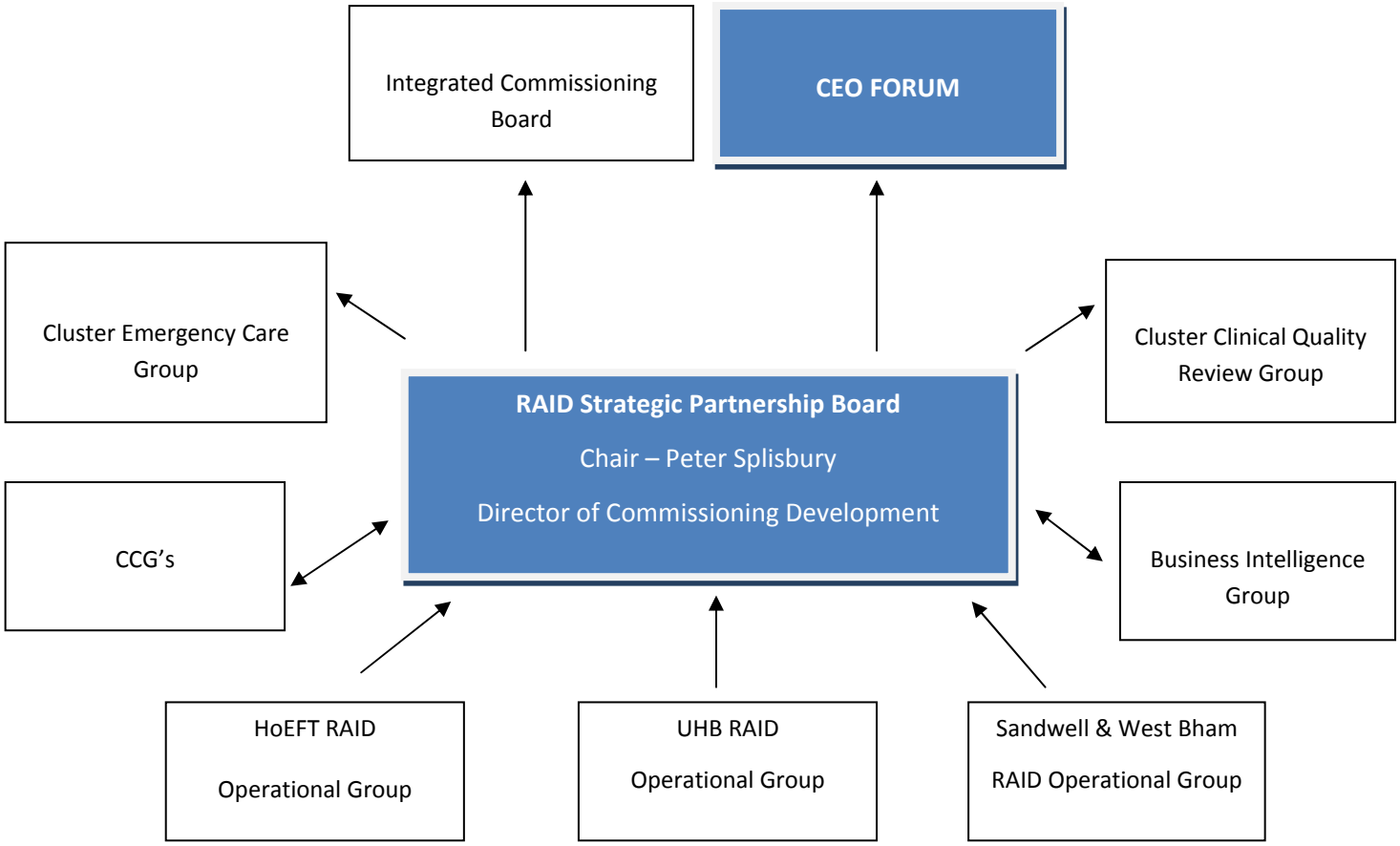
To oversee the development of a citywide rapid assessment interface and discharge (RAID) service within University Hospital Birmingham (UHB), Heart of England Foundation Trust (HoEFT), Sandwell West Birmingham Hospital and the continuity of the current service at City Hospital Birmingham.

- To develop and agree overarching strategic principles in the future commissioning of psychiatric liaison with partner organisations.
- To lead strategic planning, managing, overseeing and delivery of the programme.
- Ensure scoping of efficiencies and savings are clear and agreed.
- Ensure performance and contractual arrangements are clear and agreed.
- To seek assurance of implementation of RAID from partner organisations.
- Ensuring development of a sustainable model post re-enablement funding.
- Development of appropriate risk sharing agreements.
- To ensure the delivery and continuity of quality and safety assurance.
- Ensure business intelligence functions are aligned locally and cluster wide, including the development of overarching evaluation of the model.
- Ensure clear strategy for communication with stakeholders including a clear strategy for communication from local operational level to the Cluster Exec Board.
- Advise Cluster Exec Board and CEO Forum of future developments for the Service.

Leadership & Participation:

The group will be chaired by the Cluster Director of Commissioning Development and will consist of multi-disciplinary representatives from all acute sector providers, Mental Health Trust, primary care and commissioners.

Governance:


Integrated Commissioning Board
CEO FORUM
Cluster Emergency Care Group
Cluster Clinical Quality Review Group
RAID Strategic Partnership Board
Chair – Peter Splisbury
Director of Commissioning Development
CCG's
Business Intelligence Group
HoEFT RAID Operational Group
UHB RAID Operational Group
Sandwell & West Bham RAID Operational Group

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Foundation Trust Programme: Project Director's Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy & Organisational Development
AUTHOR:	Mike Sharon, Director of Strategy & Organisational Development
DATE OF MEETING:	29 March 2012

SUMMARY OF KEY POINTS:

The Project Director's report gives an update on:

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

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

FT Programme Board on 29 March 2012

FT Programme Director Report March 2012 – Overall status - Red

Activities this period

- Draft HDD1 action plan produced
- Three public engagement events held
- Draft outline timetable agreed with the SHA for revised TFA
- First meeting of reconstituted long term configuration working group
- Transport modelling to inform activity flow modelling commissioned
- Market research to inform activity flow modelling tendered
- First draft updated activity and capacity model produced
- Meeting held with OSC Chairs to discuss FT timeline

Activities next period

- Conclude engagement
- Agree case with SHA for renegotiation of TFA
- Reach agreement with PCTs on Activity and Capacity model
- Commence market research to inform activity flow modelling

Issues for resolution and risks in next period

- Conclude discussion on future strategy for IBP
- Process and resources required for twin track approach to be clarified

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 19 January 2012; 0900h – 1100h

Members Present		**In Attendance**
Prof D Alderson	[Chair]	Miss A Binns
Mr R Trotman		Mr S Parker
Dr S Sahota		Mrs H Mottishaw
Miss K Dhami		
Mr R White		**Secretariat**
Mr D O'Donoghue		Mrs E Quinn
Miss R Overfield		
Miss R Barlow	[Part]	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from John Adler and Simon Grainger-Payne.	
2 Minutes of the previous meeting	**SWBQS (11/11) 059**
The minutes of the Quality and Safety Committee meeting held on 17 November 2011 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (1111) 059 (a)**
The updated actions list was noted by the Committee. Miss Dhami specifically highlighted that the CIP quality and safety risk assessments would be presented at the next Committee meeting on 22 March 2012. For the benefit of the Committee, Mr White pointed out that 22 March was also the date for final submission of the financial plan to the Strategic Health Authority.	

PATIENT EXPERIENCE	
4 Complaints	
4.1 Complaints referred for independent review	**SWBQS (1/12) 012** **SWBQS (1/12) 012 (a)**
Mrs Mottishaw presented the list of complaints that had been referred for independent review by the Parliamentary Health Service Ombudsman (PHSO) as at 10 January 2012. The Committee was asked to note that of the 18 cases referred for independent review, 8 were to be or had been closed following the action requested of the PHSO. Of the 10 live cases, a decision was reported to be awaited on 6 of them. Of the remaining 4 cases, the Trust is undertaking/completing further local resolution/post PHSO report action.	
4.2 Action plan to the CQC regarding registration: Outcome 17	**SWBQS (1/12) 011** **SWBQS (1/12) 011 (a)**
Mrs Mottishaw presented the action plan and highlighted that the Trust had achieved considerable progress in respect of the delivery of the action plan. In summary all actions were now completed, with the exception of the changes that were to be made to the Trust's Complaints Policy and implementation thereof. Miss Dhami added that the information had been shared with the Care Quality Commission.	
4.3 Complaints trend analysis	**SWBQS (1/12) 014** **SWBQS (1/12) 014 (a)**
Mrs Mottishaw presented the complaints trend analysis data and reported that no clear trends or obvious cluster areas had been identified. The Committee noted that the number of complaints received concerning EAU and Lyndon 4 wards was escalating. Miss Overfield informed the Committee that it was planned to make a recommendation at the January Trust Board meeting that EAU ward be put into special measures. Miss Overfield also advised that she would re-visit the complaints received for these areas. Mrs Mottishaw agreed to send the details of the complaints received for Lyndon 4 and EAU wards to Miss Overfield.	
Action: Mrs Mottishaw to send the details of the complaints received for Lyndon 4 and EAU wards to Miss Overfield.	
5 CQC report into Privacy, Dignity & Nutrition and update on progress with action plans	**SWBQS (1/12) 010** **SWBQS (1/12) 010 (a)**
Miss Overfield presented the final report from the Care Quality Commission that detailed the findings of the visit made to Sandwell Hospital on 16 December 2011. The Committee was informed that the Trust had been found to be compliant with Outcomes 5 and 1 concerning privacy, dignity and nutrition. Miss Overfield stressed the importance of the Trust maintaining its compliance.	

CLINICAL EFFECTIVENESS	
6 Outcome of an audit and survey into the use of the WHO Surgical Safety Checklist	**SWBQS (1/12) 004** **SWBQS (1/12) 004 (a)**
Mr O'Donoghue presented the report on the outcome of the audit of compliance with the World Health Organisation (WHO) safer surgical checklist and highlighted that there was a greater issue with compliance than initially expected. Mr Parker informed the Committee of the methods used for undertaking the audit and concluded that, in the sample of cases audited, there appeared to be poor compliance with the use of the checklist in that it was not present in the records of over half of the cases audited. Some areas of the Trust had not regarded the use of the checklist as being appropriate for their area of work. This had arisen as some of the communications from the NPSA were subject to interpretation. Areas for development included the development of the Trust policy on the use of the checklist, which should provide detailed guidance on when and where the Trust expected the checklist to be used. In addition, there should be a requirement of the Directorates/specialty areas to conduct risk assessments if they consider its use was not appropriate, or where there was uncertainty. Mr O'Donoghue reported that a Taskforce had been developed, led by Dr Zoe Huish, to provide oversight on the delivery of an action plan aimed at gaining an improved level of compliance with the use of the checklist. The key deliverables of the action plan include the preparation of a policy, development of a monitoring process and preparation of a communications plan to ensure that all areas were aware of the need for compliance. Mr Trotman advised that he was extremely disturbed and dismayed at the audit results, as after three years of becoming a nationally mandated requirement to use the checklist, the Trust remained so far away from compliance. Mr Trotman also sought assurance from Mr O'Donoghue in terms of the timeline for delivery of the action plan. Mr O'Donoghue assured Mr Trotman that the Taskforce would give this their priority and that he accepted full responsibility. Professor Alderson felt that it was important to develop a detailed, high level action plan, to include what guidance was to be given to groups within the Trust. He also felt that assurance was needed that this matter was being handled as a priority and suggested that it should be discussed at the private session of the January 2012 Trust Board. As Acting Chair of the Trust Board, Mr Trotman fully endorsed this suggestion and agreed that this should be discussed. The Committee supported this decision. Mr Trotman suggested that compliance with the WHO checklist should feature on the Trust's risk register.	
ACTION: Mr O'Donoghue to prepare a detailed, high level action plan to improve compliance with the use of the WHO checklist. **ACTION: Mr O'Donoghue to arrange for the compliance with the**	

WHO Safer Surgery checklist to be discussed at the private session of the January meeting of the Trust Board.	
7 Update on the Haematology review action plan	**SWBQS (1/12) 006** **SWBQS (1/12) 006 (a)**
Mr O'Donoghue presented the update on the Haematology review action plan and informed the Committee that an interim review is planned to be undertaken on 19 March 2012. The Committee noted the progress with the delivery of actions.	
8 Clinical Audit forward plan: monitoring report	**SWBQS (1/12) 002** **SWBQS (1/12) 002 (a)**
Mr Parker presented the latest update on the delivery of the Clinical Audit forward plan, highlighting that a red status had been assigned to two audits. This was due to the change in the way that data is collected and submitted, resulting in a delay in meeting the data submission deadline. Miss Barlow asked Mr Parker to send her details of the next submission deadline in April so that she could ensure the deadline was met in future.	
ACTION: Mr Parker to send Miss Barlow details of the April submission deadline for clinical audit information	
9 PROMs update	**SWBQS (1/12) 003** **SWBQS (1/12) 003 (a)**
Mr Parker presented the PROMs update following the latest release of data in November 2011. The published data covers the period April 2010 to the end of March 2011. He highlighted that in terms of knee replacements, the Trust was an outlier. In view of this, within the last twelve months a lot of work had been undertaken or was planned, which should improve outcomes. A general discussion took place, following which, the Committee agreed that the Trauma and Orthopaedic directorate should conduct an audit to identify the reasons for being an outlier. The findings of this audit were to be presented to the Governance Board. Mr O'Donoghue was asked to to arrange for Mr Parekh, Clinical Director for the Trauma and Orthopaedics specilaity, to organise this audit.	
ACTION: Mr O'Donoghue to arrange for Mr Parekh to organise an audit of the Trauma and Orthopaedic Directorate to identify the reasons for being an outlier for knee replacements.	
10 CQC mortality alerts update	**Verbal**
Mr O'Donoghue informed the Committee that the alert in relation to Stroke was currently being tracked. A response had been sent to the Care Quality Commission in line with its deadline.	
11 Quality Account action plan update	**SWBQS (1/12) 009**

	SWBQS (1/12) 009 (a)
Mr O'Donoghue informed the Committee that the Quality Account action plan was due to be refreshed shortly. A fully updated action plan would be presented to the Governance Board in February 2012. An update would also be presented at the Trust Board meeting in February and at the next Quality and Safety Committee meeting in March 2012.	
PATIENT SAFETY	
12 NPSA safety alerts update	**SWBQS (1/12) 005** **SWBQS (1/12) 005 (a)**
Miss Binns presented the latest version of the NPSA safety alerts action plan. She advised that work to address the radiological imaging alert was ongoing to ensure that the alert could be signed off at the end of January 2012. An update on the progress with actions would be presented at the next meeting in March 2012.	
ACTION: Miss Binns to present an update on the progress with actions at the meeting of the Quality and Safety Committee planned for March 2012.	
13 Never Event update	**Verbal**
Miss Binns informed the Committee that following a recent Ophthalmology-related patient complaint, it had been discovered, as part of the investigation process, that there were a number of instruments reported to be missing from the Ophthalmology theatres. Although the missing instruments had been recorded on the surgical register, none of the missing instruments had been reported via an incident form. There was now a local action plan in place. Miss Dhami informed the Committee that this issue would be discussed at the next meeting of the Executive Team planned for the following week, to determine what further action is needed.	
14 NHSLA/CNST assessment preparations	**SWBQS (1/12) 013** **SWBQS (1/12) 013 (a)**
Miss Binns presented the NHSLA/CNST update and re-capped, for the benefit of the Committee, that the Maternity Directorate successfully achieved a Level 1 assessment of the NHSLA Maternity standards (CNST) in February 2010. Work had been ongoing for the past year, reviewing and revising guidelines and identifying any deficiencies in practice in preparation for a Level 2 assessment on 14 & 15 March 2012. Areas identified as hotspots prior to the interim visit in October 2011 were highlighted to have been around neonatal resuscitation, training needs analysis/training records and VTE assessment. The interim visit highlighted that documentation within the healthcare records was not as consistent as it could be and needed to be of a higher standard. With interventions, the directorate had seen a marked improvement in the record keeping standards within records.	

The directorate was reported to be recommending that in March 2012 that they undertook a Level 1 assessment and defer the Level 2 assessment until the latter part of 2012/13. This was approved by the Governance Board in January 2012 subject to a definitive date for Level 2 assessment being identified and an update provided at the next Governance Board meeting planned for February 2012. This was noted by the Committee.	
15.1 – 15.3 Minutes from Governance Board	**SWBGB (11/11) 178** **SWBGB (12/11) 193** **SWBGB (12/11) 193 (a)**
The Quality and Safety Committee received and noted the minutes from the Governance Board meeting held on 4 November and 2 December 2011. The Committee also noted the actions list that was discussed at the meeting held on 13 January 2012.	
16.1 & 16.2 Minutes from Clinical Quality Review Group	**SWBQS (1/12) 007** **SWBQS (1/12) 008**
The Quality and Safety Committee received and noted the minutes from the Clinical Quality Review Group meeting held on 2 November 2011 and 7 December 2011.	
17 Any other business	**Verbal**
There was none.	
18 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 22 March 2012 at 0900h in the Executive Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……