Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 25 November 2010; 1430h - 1700h

Members

Mrs S Davis	(SD)	[Chair]
Mr R Trotman	(RT)	
Dr S Sahota	(SS)	
Mrs G Hunjan	(GH)	
Prof D Alderson	(DA)	
Mr G Clarke	(GC)	
Mrs O Dutton	(OD)	
Mr J Adler	(JA)	
Mr D O'Donoghue	(DO'D)	
Mr R Kirby	(RK)	
Mr R White	(RW)	
Miss R Overfield	(RO)	
Mr M Sharon	(MS)	

In Attendance

Mr G Seager	(GS)	
Miss K Dhami	(KD)	
Mrs J Kinghorn	(JK)	
Mrs C Rickards	(CR)	

Guests

Mrs F Shorney	(FS)	[Item 9.1]
Dr B Oppenheim	(BAO)	[Item 9.2]

Secretariat

Mr S Grainger-Payne	(SGP)	[Secretariat]

Item	Title	Reference No.	Lead
1	**Apologies**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Chair's opening comments**	**Verbal**	**Chair**
4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 28 October 2010 as true and accurate records of discussions*	**SWBTB (10/10) 229**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (10/10) 229 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	MATTERS FOR APPROVAL		
7	**MRI scanning agreement with Lister in Health**	**SWBTB (11/10) 238** **SWBTB (11/10) 238 (a)**	**RK**
8	**Replacement of pre-analytics and main automated analysers in Clinical Biochemistry**	**SWBTB (11/10) 241** **SWBTB (11/10) 241 (a)**	**RK**
	MATTERS FOR INFORMATION/NOTING		
9	**Quality and Governance**		
9.1	Patient experience update - Nutrition	Presentation SWBTB (11/10) 244 SWBTB (11/10) 244 (a)	FS

9.2	Quarterly Infection Control update	SWBTB (11/10) 242 SWBTB (11/10) 242 (a)	BAO
9.3	Cleanliness and PEAT update	SWBTB (11/10) 232 SWBTB (11/10) 232 (a)	RO
9.4	Health and Wellbeing update	SWBTB (11/10) 236 SWBTB (11/10) 236 (a) SWBTB (11/10) 236 (b)	RO
9.5	Equal pay audit	SWBTB (11/10) 231 SWBTB (11/10) 231 (a)	RO
9.6	Quarterly Assurance Framework update	SWBTB (11/10) 239 SWBTB (11/10) 239 (a)	SGP
10	**Strategy and Development**		
10.1	'Right Care, Right Here' programme: progress report	SWBTB (11/10) 233 SWBTB (11/10) 233 (a)	MS
10.2	New acute hospital project: progress report	SWBTB (11/10) 234 SWBTB (11/10) 234 (a)	GS
11	**Performance Management**		
11.1	Monthly finance report	SWBTB (11/10) 237 SWBTB (11/10) 237 (a)	RW
11.2	Monthly performance monitoring report	SWBTB (11/10) 245 SWBTB (11/10) 245 (a)	RW
11.3	NHS Performance Framework monitoring report	SWBTB (11/10) 243 SWBTB (11/10) 243 (a)	RW
12	**Operational Management**		
12.1	Same Sex Accommodation update	Verbal	RK
13	**Update from the Board Committees**		
13.1	Finance and Performance Management Committee		
▶	Draft minutes from meeting held 18 November 2010	Hard copy paper	RT
13.2	Audit Committee		
▶	Draft minutes from meeting held 2 September 2010	SWBAC (9/10) 051	GH
13.3	Governance and Risk Management Committee		
▶	Draft minutes from meeting held 23 September 2010	SWBGR (9/10) 052	DA
13.4	Charitable Funds Committee		
▶	Draft minutes from meeting held 2 September 2010	SWBCF (9/10) 018	SS
14	**Any other business**	**Verbal**	**All**
15	**Details of next meeting** *The next public Trust Board will be held on 16 December 2010 at 1430h in the Churchvale/Hollyoak Rooms, Sandwell Hospital*	**Verbal**	**Chair**
16	**Exclusion of the press and public** *To resolve that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).*	**Verbal**	**Chair**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 28 October 2010

Present:

Mrs Sue Davis	(Chair)	Mrs Gianjeet Hunjan	Mr Richard Kirby
Mr Roger Trotman		Mr Gary Clarke	Mr Donal O'Donoghue
Dr Sarindar Sahota		Mr John Adler	Miss Rachel Overfield
Prof Derek Alderson		Mr Robert White	Mr Mike Sharon

In Attendance:

Miss Kam Dhami		Mr Graham Seager		Mrs Jessamy Kinghorn	
Dr Patrick Saunders	[Part]	Dr John Bleasdale	[Part]	Ms Kate Hall	[Part]
Mrs Debbie Talbot	[Part]	Mrs Chris Rickards			

Secretariat:

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mrs Olwen Dutton.	
2 Declaration of Interests	**Verbal**
There were no interests declared in connection with any agenda item.	
3 Chair's Opening Comments	**Verbal**
The Chair advised that the Board had been shortlisted for the Board of the Year award as part of the National Leadership awards. The Trust was nominated by the chair of the Strategic Health Authority. The Chair thanked all members for their hard work and achievements that had prompted this level of recognition.	
4 Minutes of the previous meeting	**SWBTB (9/10) 209**
The minutes of the previous meeting were presented for approval and were accepted as a true and accurate reflection of discussions held on 30	

September 2010.	
AGREEMENT: The Trust Board approved the minutes of the last meeting	
5 Update on actions arising from previous meetings	**SWBTB (9/10) 209 (a)**
The updated actions list was reviewed and it was noted that there were no outstanding actions requiring discussion or escalation.	
6 Questions from members of the public	**Verbal**
There were no members of the public in attendance at this meeting. Representatives from the Birmingham Mail and the Express and Star were noted to be present at the meeting.	
7 Public Health update – Sandwell PCT	**Presentation**
Dr Patrick Saunders, Associate Director of Public Health at Sandwell PCT joined the meeting to provide the Board with an overview of the PCT's Public Health annual report for 2009/2010, 'The Three Greens for Health'. The Chair asked what the Trust could do to assist with delivering the Public Health agenda. Dr Saunders advised that the Trust could assist most usefully by ensuring that the PCT had timely access to appropriate clinical data. Mr O'Donoghue advised that consultants had been given an overview of Public Health data at their recent annual conference and they had been very interested in the impact of the environment on Public Health and had expressed an interest in using their skills and influence to generate improvements in this field. Dr Sahota commented that a further significant issue that impacts on Public Health concerns skills and qualifications to allow people to move into better jobs and different environments. Thanks were extended to Dr Saunders for his useful and informative update and it was agreed that the Trust and PCT should maintain continual dialogue to ensure that the Public Heath work is progressed.	
8 Same Sex Accommodation plans	**SWBTB (10/10) 227** **SWBTB (10/10) 227 (a)** **SWBTB (10/10) 227 (b)**
Mr Kirby advised that work had been undertaken to review the Trust's position against the Department of Health's Same Sex Accommodation guidance. The Board was reminded that a compromise solution had been previously agreed for the Nightingale-style wards at City Hospital with the Department of Health, the Strategic Health Authority, the Trust's commissioners and the Board. Mr Kirby advised however, that since this agreement new emphasis has been placed on adherence to the guidance and the compromise	

solution had been highlighted to be non-compliant with the requirements. As such, a mandate had been issued asking for full compliance with the guidance by January 2011.

The consequences of continuing to pursue the existing approach were outlined, which included very significant fines by commissioners for admissions to wards non-compliant with Same Sex Accommodation regulations.

The Board was advised that as there was little scope to pursue alternative options, plans had been devised to implement single sex, mixed speciality wards, which covered all areas apart from Critical Care and Coronary Care.

Mr Kirby outlined the risks associated with implementing the single sex model, including the impact on clinical quality, patient flow and the difficulties with delivering such a significant change across a considerable areas of the Trust and involving so many staff. The Board was advised that the likely cost to the Trust was estimated to be £1.5m in revenue. In terms of the impact on capacity, it was highlighted that following the changes planned, there would be more beds open than planned, which would need to be considered in the context of the work to reduce Length of Stay and bed complement in line with the 'Right Care, Right Here' programme.

Summarising the position, Mr Kirby advised that there was little option other than to implement the plans and mitigate the associated risks and as such he asked for the Board's approval to do so.

Mr O'Donoghue highlighted that the Trust would be one of only a few organisations that would face these challenges and emphasised that the proposed changes were not ones that the Trust would have implemented had the Department of Health guidance not stipulated that they should be. The Board was advised that the clinical teams regarded the current compromise as a workable and practical solution to the Same Sex Accommodation requirements.

Miss Overfield pointed out that the impact of the plans would be felt more keenly by smaller specialities, such as ENT and Vascular. She also highlighted that there is a risk that due to the impact, good staff may choose to leave the Trust due to the changes and ward rounds could be logistically problematic.

Mrs Hunjan noted that some wards contain side rooms and asked to what extent the Trust would be deemed to have breached the regulations if side rooms are used to separate patients of the opposite sex. Mr Kirby advised that there is scope to negotiate with commissioners as to the circumstances under which a breach may be incurred without penalty as a result of clinical need. These discussions would include the use of side rooms for such purposes.

Returning to the issue of ward rounds, Mr Kirby was asked which wards undertake a ward round with the aim of ensuring prompt discharge. He advised that all wards undertake a ward round for this purpose to some degree, although the wards in the Sheldon Block at City Hospital are less likely to require a high number of ward rounds. The frequency of ward rounds in Respiratory Medicine needed to be increased. Mr O'Donoghue highlighted that the number of patients not needing to be assessed for discharge as part of a ward round is diminishing.

Mrs Hunjan asked whether an increased Length of Stay and an impact on patient experience would be observed as a result of implementing the plans. Mr Kirby advised that the current reduction in Length of Stay is likely to cease for a time and there is uncertainty as to when the position would recover.

Miss Overfield reported that the nursing staff will take time to adjust to the new environments and arrangements and some are likely to be unhappy with the changes. Mr Clarke asked what staff opinion was concerning the plans. Miss Overfield advised that staff had been widely consulted on the plans and the majority would not support them in any other circumstances. Mrs Rickards remarked that experience had shown that where services are integrated, staff are unhappy at losing the option of working in a specialist area, particularly if they had chosen to do so when recruited into post. The Chair agreed and added that many patients hope that staff have an in-depth knowledge of the condition for which they are being treated.

Mr Kirby advised that work had been undertaken with shadow FT members which had shown that their priorities centred on clinical soundness and the delivery of Same Sex Accommodation requirements. He highlighted that both could be honoured in the New Hospital accommodation.

Professor Alderson remarked that the plans were concerning however there appeared to be little option other to accept them. He asked how robust the existing measurement systems are to be able to detect any adverse impact of the reconfiguration on quality and safety. Mr O'Donoghue advised that there is a good level of assurance that such deterioration would be detected using the ward review process in particular.

Mr Adler drew the Board's attention to revised recommendations that were proposed in connection with the plans that had been issued, which reinforced that the current arrangements were seen by the Board as prererable.

The Chair commented that despite the implementation of the plans, members of the opposite sex in the form of visitors and clinicians will still be unavoidably in the proximity of patients. She acknowledged however, that there was little alternative, other than to implement the plans.

Mr Kirby reported that it had been proposed to the Strategic Health Authority that the plans be implemented in two phases, with the first to be delivered during January 2011 and the second to be completed by April 2011. The Chair asked whether this was likely to be acceptable. Mr Kirby advised that the Strategic Health Authority had agreed to support the proposal when presented to the Department of Health. The Trust Board was asked for and gave its approval to the plans for same sex wards at City Hospital, and agreed to their submission to the Strategic Health Authority. It was agreed that an update on the plans should be presented at the November meeting of the Trust Board.	
The Trust Board: **1. NOTED that the current approach to ward configuration taken by the Trust is felt to strike the right balance between clinical quality and privacy and dignity requirements;** **2. NOTED the reinforced national requirement to deliver same-sex accommodation against specific criteria (with which the current approach does not comply) and the consequences for the Trust if it does not;** **3. NOTED the significant risks associated with introducing same-sex wards at City Hospital;** **4. APPROVED the plan for same-sex wards at City Hospital for submission to the Strategic Health Authority;** **5. REQUESTED a further report from Mr Kirby at the November Trust Board in the light of more detailed planning and the Strategic Health Authority's response**	
9 Naming the New Hospital	**SWBTB (10/10) 228** **SWBTB (10/10) 228 (a)**
Mrs Kinghorn outlined the consultation process for the name of the new hospital and reminded the Board that the shortlist of names had been agreed in August. These names had been endorsed and championed by celebrities with a known connection to the area. Since the shortlist of names was agreed, the Board was advised that there had been significant engagement with patients, staff and the community and the process had been given good media coverage. The Board was advised that 952 votes had been received, of which the Birmingham and Black Country Hospital name had received very marginally more votes than the Midland Metropolitan Hospital and Grove Lane Hospital. James Brindley Hospital was noted to have received considerably fewer votes than the other names. The Board members were asked to vote on their preferred name for the new hospital. It was agreed that the vote should exclude James Brindley	

Hospital in recognition of its unpopularity with the patients, public and staff. Eight members voted for Midland Metropolitan Hospital; three voted for Birmingham and Black Country Hospital; and one voted for Grove Lane Hospital. It was agreed that the name of the new hospital should be The Midland Metropolitan Hospital.	
AGREEMENT: The Trust Board agreed that the name of the new hospital should be Midland Metropolitan Hospital	
10 Establishment of a Clinical Ethics Committee	**SWBTB (10/10) 219** **SWBTB (10/10) 219 (a)** **SWBTB (10/10) 219 (b)**
Dr John Bleasdale joined the meeting to present a proposal for the establishment of a Clinical Ethics Committee within the Trust. He advised that such committees started to be established from the beginning of the decade in the United Kingdom but had been established much earlier in the United States. The Board was advised that the plans to introduce a Clinical Ethics Committee had been considered earlier in the year when a 'flu pandemic was anticipated, where it was possible that difficult decisions would need to be made regarding the prioritisation of patients for treatment, for which ethical judgement would be beneficial. Dr Bleasdale advised that the plans for the establishment of the Committee had been discussed previously with and approved by the Governance Board. Mr Trotman remarked that he was surprised that the Trust did not already have a Clinical Ethics Committee established and asked what size the Committee was likely to be. Dr Bleasdale advised that the largest committee nationally was a membership of 27, with the smallest being six members. The committee to be established in the Trust is likely to be somewhere between these two extremes and will include members from a number of different specialities. Mr O'Donoghue advised that on three occasions, there had been a need to convene an ad-hoc group of staff to consider issues that would otherwise have been handled by the Clinical Ethics Committee, therefore the plans will formalise such a process to make it more robust. The Board was informed that the Clinical Ethics Committee is to be advisory and where Executive Directors have a professional responsibility, it is not the role of the Committee to replace this. Mrs Hunjan noted that it is the intention for an on-call service to be	

provided by the Committee and asked whether this service would be the remit of select members of the Committee rather than covering the entire team. Dr Bleasdale advised that only ethical specialists would be on call and would not have responsibility for making decisions, but would inform the thinking of other members of staff in these circumstances. Mr White asked what the view was as to how simple it was likely to be to attract the expertise of a specialist ethicist. Dr Bleasdale advised that he was confident that this expertise could be attracted into the Committee. Dr Sahota asked where the Committee was likely to report. He was advised that the Committee would report to the Governance Board on a periodic basis. The Chair asked with what frequency the Committee was likely to meet. Dr Bleasdale advised that efficient Clinical Ethics Committees meet monthly, with members being required to have an ongoing interest in ethics beyond this monthly commitment. The on-call element was highlighted as not likely to be a substantial element of the time commitment for the Committee. Dr Bleasdale advised that a screening process will be in place for members wishing to be members of the Committee. The Chair suggested that participation could be sought from the shadow FT members. The Board was asked for and gave its support to the decision made by the Governance Board to establish a Clinical Ethics Committee within the Trust.	
AGREEMENT: The Trust Board gave its support to the decision made by the Governance Board to establish a Clinical Ethics Committee within the Trust	
11 Quality and Governance	
11.1 Nursing update	**SWBTB (10/10) 226** **SWBTB (10/10) 226 (a) – SWBTB (10/10) 226 (d)**
Miss Overfield presented the biannual update on key developments and issues in nursing. Dr Sahota noted that it was encouraging to see less reliance on the use of bank and agency staff in nursing. Mr O'Donoghue asked how staff reacted to their wards being disclosed as a 'worry ward' within public Board papers. Miss Overfield advised that staff were not happy about the disclosure, however she highlighted that she regarded the inclusion of such issues within public reports as important to ensure transparency and as a means of encouraging better performance. Mrs Hunjan observed that plans were underway to phase out the use of drugs trolleys and asked whether patients are aware that they can bring in	

their own drugs. Miss Overfield advised that elective patients are discouraged from bringing their own medication into hospital, however for those patients for which it is appropriate do so, savings on Trust drug expenditure can be made. The Board was advised that the plans to remove drugs trolleys are also designed to improve safety around prescribing drugs in the hospital. The Productive Ward methodology was highlighted as being the principal means of assisting with phasing out the trolleys in areas in which it is appropriate to do so. Miss Overfield highlighted that the Same Sex Accommodation requirements complicate much of the progress achieved on wards and will hinder the work currently underway. Mr Sharon asked what comparative data could be used in future to benchmark the nursing work. Miss Overfield advised that initially pressure damage and falls information could be used, although it was pointed out that not all trusts are currently reporting against these metrics. In future, nutrition measures will be devised which will provide further comparators, such as weight loss during stay. Mr O'Donoghue advised that it was difficult to compare organisations on a like for like basis. Mr Kirby asked whether the general management team was behind the nursing work. Miss Overfield advised that there was an increasing interest in the work by General Managers, particularly as the costing impacts of the work may now be calculated in some areas.	
11.2 End of Life Care update	**SWBTB (10/10) 216** **SWBTB (10/10) 216 (a)**
Miss Overfield introduced Ms Kate Hall, Clinical Nurse Specialist for End of Life Care and reminded the Board that there is an intention to present genuine stories of patient experience to the Board on a themed approach. Ms Hall presented two patient stories, one of which highlighted good End of Life patient care and another where the care had been unsatisfactory. The Board was advised of the key themes and developments in End of Life care. In connection with the case of the patient who remained agitated towards the end of his life, Mr Trotman asked whether there were drugs available which could have assisted with this agitation. He was advised that drugs were available, however they had not been prescribed to the patient in this instance. The situation was reported to have prompted significant training on the ward in best practice for End of Life patients. Miss Overfield highlighted that the patient story illustrated that patients at the end of life stage are sometimes not clearly identified by the clinicians. The locum palliative care consultants now recruited specifically to treat such patients will assist with this issue however. Mr O'Donoghue suggested that further issues concerned the lack of clarity over the authority for clinicians to treat a patient palliatively and a reluctance in some instances for the family to accept that a palliative solution is best for the patient.	

Dr Sahota asked what relationship the Trust had with local hospices. He was advised that there is disparity regarding access to hospices between the Trust's two commissioners. At present the Board was advised that there is no hospice facility in Sandwell, however there is such provision in Heart of Birmingham, together with the developing 'Hospice at Home' service. Professor Alderson emphasised the need to ensuring that effort is given to reducing the number of patients that die within an acute setting. Mr Clarke noted that End of Life care was an emotive subject and asked whether a senior clinician will be identified to determine whether a patient should be treated palliatively. Mr O'Donoghue advised that this would be the case. Mr Sharon asked for further clarity as to what situation exists within the community in terms of End of Life care provision. He was advised that in Sandwell a good system of palliative liaison nurses is in place which can assess and implement an appropriate care package. Mr O'Donoghue highlighted that there is a cultural resistance in the area to dying at home and at present there is little infrastructure in place to support this facility. Some cancer patients for instance prefer to end their life in hospital given that they have the required technology and expertise to hand. Mr Clarke asked whether the Trust would consider becoming involved in hospice provision. Mr Kirby advised that there are plans to develop such a service for the Sandwell area in conjunction with St Mary's Hospice in Birmingham. Ms Hall was thanked for her interesting presentation.	
11.3 Annual Audit Letter	**SWBTB (10/10) 222** **SWBTB (10/10) 222 (a)**
Mr White presented the Annual Audit Letter issued by the Trust's external auditors, KPMG LLP, which he advised summarised the audit opinion for 2009/10. The Board was advised that the provisional Auditors' Local Evaluation (ALE) score of 3 had been confirmed in the Audit Letter. Recommendations following the annual audit were noted, implementation of which Mr White advised would be monitored by the Audit Committee. The Board was advised that the Annual Audit Letter would be published on the Trust's internet.	
12 Strategy and Development	

12.1 'Right Care, Right Here' programme: progress report	**SWBTB (10/10) 221** **SWBTB (10/10) 221 (a)**
Mr Sharon presented the latest 'Right Care, Right Here' programme progress report, which the Board received and noted. The Board was advised that overall level of urgent care activity had increased by 16%, although the level of this work handled by the Trust had reduced. Mr Sharon reported that a response to the Government's service reconfiguration tests had been completed, which had been agreed by the Partnership Board. Dr Sahota asked how may patients were being transferred from the Urgent Care Centres. Mr Kirby advised that very few patients are passed on from the facilities. Effort is being made to persuade patients presenting at the Accident and Emergency departments to be seen at the Urgent Care Centres where appropriate.	
12.2 New acute hospital project: progress report	**SWBTB (10/10) 211** **SWBTB (10/10) 211 (a)**
Mr Seager reported that the plan for the approval of the Outline Business Case was running as planned and work is underway to develop the design for the new hospital. The Board was advised that an exercise had been undertaken to encourage local companies to participate in the procurement process for elements of the new hospital. Mr Clarke, noting the earlier discussion about Public Health, asked whether the scheme included any green space. Mr Seager advised that green areas are likely to be incorporated within the wider redevelopment of the area around the new hospital, however within the scheme itself there are also plans to incorporate some open space. Dr Sahota confirmed that a Smethwick Delivery Board had been established which will take a hand in the regeneration of the area. Dr Sahota reported that there had been a successful launch of the art project for the new hospital.	
13 Performance Management	
13.1 Monthly finance report	**SWBTB (10/10) 214** **SWBTB (10/10) 214 (a)**
Mr White presented the finance report of the period April – September 2010, which was noted to have been discussed in detail at the Finance and Performance Management Committee at its meeting on 21 October 2010. It was noted that the draft minutes of the meeting were available within Board packs.	

It was reported that an in-month surplus of £61k had been achieved, resulting in a year to date surplus of £552k, £109k above the planned position. It was highlighted that some financial pressure remains, particularly in the Medicine and Emergency Care division as a result of the requirement to keep capacity open to handle unplanned demand, together with the marginal rate reimbursement for emergency activity. The Board was advised that there is likely to be some flexibility within the capital budget and proposals to handle this would be developed shortly. Mr White reported that both PCTs were expected to achieve compliance with their end of year financial targets.	
13.2 Monthly performance monitoring report	**SWBTB (10/10) 223** **SWBTB (10/10) 184 (a)**
Mr White presented the performance monitoring report and reminded the Trust Board that it had been reviewed in detail by the Finance and Performance Management Committee at its meeting on 21 October 2010. It was reported that cancelled operations had increased to 1% and Delayed Transfers of Care had risen. Performance against the stroke care target was reported to have plateaud however investigations were underway to determine the reasons behind the stalled improvement. The number of *C difficile* cases was reported to have fallen and no MRSA bacteraemia cases had been reported in month. The Trust remains within trajectory for both infection control targets. Overall sickness absence was highlighted to have declined and would be shown in future against a reducing quarterly target. Compliance with mandatory training was reported to have improved. The Board was advised that progress against the CQUIN targets had been discussed by the Finance and Performance Management Committee, with discussions focussing on particularly VTE assessment. Mr Kirby reported that the situation regarding the number of open beds had also been reviewed by the Finance and Performance Management Committee and it had been suggested that the Board be made aware that the planned closures may prompt operational pressures and challenges with meeting some of the national targets. Returning to VTE assessments, Mr O'Donoghue reported that a significant amount of work is being undertaken to improve the number of patients being assessed and achieve the 90% target required to qualify for the associated CQUIN funds.	

13.3 NHS Performance Framework update	**SWBTB (10/10) 224** **SWBTB (10/10) 224 (a)**
Mr White presented the NHS Performance Framework update for information. The Trust Board received the report and was pleased to note that the Trust remains classified as a 'performing' organisation.	
13.4 Corporate objectives progress report – Quarter 2	**SWBTB (10/10) 217** **SWBTB (10/10) 217 (a)**
Mr Sharon presented the updated progress against achievement of the Trust's corporate objectives. It was highlighted that progress against three of the objectives had been changed from green to amber to reflect some delay in delivery of the work. The objective associated with ensuring the right amount of wards, theatres and clinic capacity was noted to be at red status as a consequence of the current difficulties with closing medical beds in the face of higher than expected activity. Dr Sahota remarked that it was disappointing that progress with the objective to improve communication with GPs had changed from green to amber status. Mr Kirby advised that the change was reflective of the team's competing priorities with delivering Same Sex Accommodation plans and other operational pressures at present.	
14 Operational Management	
14.1 MRI scanner post implementation review	**SWBTB (10/10) 215** **SWBTB (10/10) 215 (a)**
Mr Kirby presented a post implementation review report which the Board had requested as part of the approval of the investment of the MRI scanner. The Board noted the benefits that had been delivered by the MRI scanner and Mr Kirby confirmed that overall a good performance had been achieved. Mr Trotman noted the increased productivity that had resulted by the commissioning of the new scanner and asked whether this in turn had resulted in less expenditure at the Sandwell Hospital site given that a greater number of scans are undertaken in City Hospital instead. Mr Kirby confirmed that this was the case.	
15 Update from the Board Committees	
15.1 Finance and Performance Management Committee	**Hard copy paper**
The Trust Board received and noted the minutes of the Finance and	

Performance Management Committee meeting held on 21 October 2010.	
16 Any Other Business	**Verbal**
There was none.	
17 Details of the next meeting	**Verbal**
The next public meeting of the Trust Board will be held on 25 November at 1430h in the Anne Gibson Boardrooms at City Hospital.	
18 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1 (2) Public Bodies (Admission to Meeting Act 1960).	

Signed: .....

Name: .....

Date: .....

Next Meeting: 25 November ber 2010, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

28 October 2010 - Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Mrs G Hunjan (GH), Mr G Clarke (GC), Dr S Sahota (SS), Professor D Alderson (DA), Mr J Adler (JA), Mr R White (RW), Mr R Kirby (RK), Miss R Overfield (RO), Mr M Sharon (MS), Mr D O'Donoghue (DO'D)

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

Apologies: Mrs O Dutton (OD)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 18 November 2010

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 123	Equality and Diversity update	SWBTB (4/10) 075 SWBTB (4/10) 075 (a) SWBTB (4/10) 075 (b)	29-Apr-10	Determine the source of the request to determine whether patients are asylum seekers or immigrants	RO	27-May-10	Under investigation and will provide update as part of next Equality and Diversity update in December	In hand - review next meeting	16-Dec-10
SWBTBACT. 124	Equality and Diversity update	SWBTB (4/10) 075 SWBTB (4/10) 075 (a) SWBTB (4/10) 075 (b)	29-Apr-10	Present the Trust's position regarding the requirements of the new Equality Bill at the next Trust Board seminar	RO	27-May-10	Presentation will be given to the E & D Steering Group by the Trust's Solicitors in October, which will then inform an update to the Trust Board as part of the E & D update in December 2010	In hand - review next meeting	16-Dec-10
SWBTBACT. 130	Staff Health and Wellbeing strategy	SWBTB (6/10) 133 SWBTB (6/10) 133 (a) SWBTB (6/10) 133 (b) SWBTB (6/10) 133 (c)	24-Jun-10	Present an update on the Boorman Review action plan at the December meeting of the Trust Board	RO	16-Dec-10	Included on the agenda of the November meeting	Completed Since Last Meeting	
SWBTBACT.134	Same Sex Accommodation plans	SWBTB (10/10) 227 SWBTB (10/10) 227 (a) SWBTB (10/10) 227 (b)	28-Oct-10	Present an update on the delivery of Same Sex Accommodation plans at the next meeting of the Trust Board	RK	25-Nov-10	Included on the agenda of the November meeting	Completed Since Last Meeting	

Next Meeting: 25 November ber 2010, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

28 October 2010 - Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Mrs G Hunjan (GH), Mr G Clarke (GC), Dr S Sahota (SS), Professor D Alderson (DA), Mr J Adler (JA), Mr R White (RW), Mr R Kirby (RK), Miss R Overfield (RO), Mr M Sharon (MS), Mr D O'Donoghue (DO'D)

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

Apologies: Mrs O Dutton (OD)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 18 November 2010

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.205	Minutes of the previous meeting	SWBTB (9/10) 209	28-Oct-10	The Trust Board approved the minutes of the previous meeting as a true and accurate records of discussions held.
SWBTBAGR.206	Same Sex Accommodation plans	SWBTB (10/10) 227 SWBTB (10/10) 227 (a) SWBTB (10/10) 227 (b)	28-Oct-10	The Trust Board approved the plan for same sex accommodation wards at City Hospital for submission to the Strategic Health Authority
SWBTBAGR.207	Name of the new hospital	SWBTB (10/10) 228 SWBTB (10/10) 228 (a)	28-Oct-10	The Trust Board agreed that the name of the new hospital should be Midland Metropolitan Hospital
SWBTBAGR.208	Establishment of a Clinical Ethics Committee	SWBTB (10/10) 219 SWBTB (10/10) 219 (a) SWBTB (10/10) 219 (b)	28-Oct-10	The Trust Board gave its support to the decision made by the Governance Board to establish a Clinical Ethics Committee within the Trust

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	MRI Scanning agreement between Lister in Health (previously Lister Bestcare) and Sandwell and West Birmingham Hospitals NHS Trust
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Jackie Morton, Tony Faulkner & Nicky Reid
DATE OF MEETING:	25 November 2010

SUMMARY OF KEY POINTS:

The Imaging Division / Trust have an existing scanning agreement for provision of a Managed MRI service at Sandwell General Hospital. The service includes supply of the MRI scanner (life span 7 – 8 years); all radiographers and administration and reception staff.

This was approved on 22nd January 2002 for a period of 7 years.

This agreement has been extended /interim agreement, until 30th December 2010 until completion of a detailed financial evaluation, pricing review, and submission of SIRG and Trust Board case for consideration and approval for agreement of a second term (7 year period January 2011 until December 2018).

The managed Magnetic Resonance Imaging service is provided in facilities on Sandwell Hospital site, owned by SWBH, and leased by Lister in Health, term 40 years (this includes all responsibility for maintenance and services).

The provision of a cost effective, high quality, efficient service is essential in maintaining reduced diagnostic waiting times, delivery of a full range of National targets (18 week RTT, 31/62 day cancer targets as well as supporting ED in delivering 4 hour target). There are also a number of national guidelines Stroke/Spinal/Cancer Reform Strategy) where the provision of an efficient MRI service is crucial to the patient clinical care pathway. This contract clearly defines service standards and monitoring process.

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

Approval	Receipt and Noting	Discussion

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Division recommends that:

- the Trust Board supports SIRG's and Finance & Performance Management Committee's decision to approve renewal of the contract with Lister in Health for a further 7 years (until December 2018)

ALIGNMENT TO INSPECTION CRITERIA AND OBJECTIVES:

Strategic objectives	The agreement is consistent with the Trusts strategy/partnership working with PCT's in terms of provision of MRI service on Sandwell site
Annual priorities	
NHS LA standards	
Core Standards	Renewal of contract ensures Division maintains KPI (MRI waiting times and complies with national guidelines
Auditors' Local Evaluation	

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

Financial		Financial evaluation supports renewal of contract
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		Legal advice obtained regarding contract
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		Included on the Trust Risk Register ref. 24

PREVIOUS CONSIDERATION:

SIRG approved renewal of the contract with Lister in Health for a further 7 years (until December 2018) at its meeting on 12th October 2010.

Finance and Performance Management Committee on 18 November 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Division of Imaging

MRI Scanning agreement between Lister in Health (previously Lister Bestcare) and Sandwell and West Birmingham Hospitals NHS Trust

1.0 Background

The Imaging Division / Trust have an existing scanning agreement for provision of a Managed MRI service at Sandwell General Hospital. The service includes supply of the MRI scanner (life span 7 – 8 years); all radiographers and administration and reception staff.

This was approved on 22nd January 2002 for a period of 7 years.

This agreement been extended /interim agreement, until 30th December 2010 until completion of a detailed financial evaluation/pricing review, and submission of SIRG/TB case for consideration/approval for agreement of a second term (7 year period January 2011 until December 2018).

The managed Magnetic Resonance Imaging service is provided in facilities on Sandwell Hospital site, owned by SWBH, and leased by Lister in Health, term 40 years (this includes all responsibility for maintenance and services.

The provision of a cost effective, high quality/efficient service is essential in maintaining reduced diagnostic waiting times, delivery of a full range of National targets (18 week RTT, 31/62 day cancer targets as well as supporting ED in delivering 4 hour target). There are also a number of national guidelines Stroke/Spinal/Cancer Reform Strategy) where the provision of an efficient MRI service is crucial to the patient clinical care pathway. This contract clearly defines service standards and monitoring process.

1.1 Details of current agreement

List of provider obligations (under the terms of the current agreement)

- Provide an MRI service in accordance with the terms and conditions of the agreement expeditiously and efficiently as possible with all reasonable care diligence and skill
- To obtain at it's own expense all licences which are or may become necessary in relation to the running of the Unit
- To ensue compliance with established medical practice or medical guidelines relating to MRI scanner use with particular reference to

i) Determining that an MRI scan and the procedures required in connection therewith are safe and suitable for the particular patient on the basis of the patient consent form interview
ii) Ensuring all patients of any risks and alternatives to an MRI scan in accordance with agreed protocols
iii) To ensure all patients have completed and signed a patient consent form prior to their MRI scan

iv) Not to do anything which might void any manufacturer's or supplier's warranty in respect of the system

v) To provide information to the Trust that would support the development of the unit and /or provision of the services

vi) To take full responsibility for all matters concerning MRI scans at the Unit to patients and to fully indemnify the Trust in respect of all costs, claims, damages and proceedings and liabilities arising out of services at the unit to any person who is not a Trust patient

1.2 Proposed changes to contract (new terms are as outlined below)

Outline of proposed amendments to the existing Scanning Agreement dated 22 January 2002

These changes are limited and could all be made with a 'deed of variation', extending the contract from 22 January 2011 (the end of the one year extension), for a further seven years, based on the following points

Clause 3.2 - this will include some amendment to incorporate the installation of the new scanner as further detailed in schedule 3
Clause 4.1a) – will include the projected NHS volumes of 6600, but that those volumes cannot be construed as a guarantee.
Schedule 2 – amend the current tiered price per person to a flat price per body part scanned of £75.00, with no tiered structure
Schedule 3 - include the specification of the new scanner
Schedule 1 – update the core hours with the opportunity to extend the hours as required and also include (to be agreed) KPIs, e.g. wait times for patient groups, uptime guarantee

With your agreement, we would also take the opportunity to amend the agreement from Lister Bestcare to InHealth Ltd, as well as correct any ambiguities in the agreement e.g. the role of Approved and Trust radiographers, which seems unclear. We would also take the opportunity to update the lease with regard to the named parties (as above)

The Division has obtained legal advice in terms of the contract changes and they are as follows;

This agreement been extended /interim agreement, until 30th December 2010 until completion of a detailed financial evaluation/pricing review, and submission of SIRG/TB case for consideration / approval for agreement of a second term (7 year January 2011 until January 2018).

The capital costs of replacing the MRI scanner, projected activity profile (7 year), and service specification (days of operation hours, performance eg maintaining a 2 week MRI waiting time) will inform the future pricing model. If there is a national guideline requiring provision of an out of hours/weekend MRI service (eg Stroke/TIA guidelines), then this will be reflected in the prices.

The financial evaluation will compare Lister in Health prices for MRI scans against national tariff /reference costs (MRI), costs of SWBH City service/ benchmarked against 6 other units (comparable).

As the contract is based on a per scan price, with risk of cost recovery lying with in Health, the contract should be classed as 'on balance sheet'.

There have been ongoing discussions with respect to transparency regarding all associated costs/existing recharge arrangements (Facilities) and consumables.

Provided the second term is approved, then Lister in Health shall upgrade/replace the system (MRI scanner) between the beginning of the ninth relevant year (2011) and the end of the 11th relevant year (2013). The Clinical Team will confirm the clinical specification for the MRI scanner to ensure it meets service requirements.

The Division has sought the expert advice of the Head of Procurement, Jenny Marshall and Trust legal team with respect to the renewal of the contract, have liaised with PCT leads, Head of Estates, Rob Banks and Angela Thomas, RCRH lead.

The legal teams have confirmed the contract is part B exempt, which means this does not undergo a full OJEU tendering process. Once SIRG/TB have approved a second 7 term then the next step is to advertise the contract award on the journal.

2. Strategic Context

As a support Division Imaging are required to provide a comprehensive inpatient/outpatient MRI service to all Clinical Divisions within SWBH, to support diagnosis and clinical management of patients. This service also ensures delivery of a full range of key performance indicators (18 week RTT target, cancer targets/NICE guidelines). MRI provides much greater contrast between different tissues of the body than CT making it especially useful in neurological (brain), musculoskeletal, cardiovascular and oncological scanning.

The agreement is consistent with the Trusts RCRH future strategy/partnership working with PCT's in terms of provision of MRI services on Sandwell site. The Capital Projects Team have given assurance that the Lister building and the MRI service will be fully considered as SWBH develops the feasibility of the retained estate solution.

Accessible and responsive care
Provision of a comprehensive MRI service (inpatient/out patient) for local population to support early diagnosis and clinical management of patients

Provision of a local, easily accessible and responsive MRI service

High Quality
Provision of a high quality MRI service (state of the art equipment), expert clinical team, according to agreed protocols, facilitating early diagnosis and treatment

Supports deliver of local, national targets/guidelines

Care Closer to Home
Ensures responsive MRI service available to local population

Good Use of Resources
Provision of a cost effective and timely MRI service, supports early discharge of patients, reduces length of stay and reduced costs to the organization

Imaging have arranged quarterly monitoring meetings (performance, financial, governance)

21st Century Facilities

Consistent with assumptions of RCRH model/maintains locally provided MRI service for local residents

The replacement of the MRI scanner at Sandwell ensures high standard service is maintained

An Effective NHS FT
Provision of a cost effective, efficient and timely MRI service if a key objective for SWBH/supports NHS Foundation Trust status

3. Anticipated Outcomes and Benefits

Benefits	Achieved by when	How will it be measured	Review date and Forum	Clinical Lead/Manager
Increased reliability	Contract stipulates equipment replacement between December 2010 and March 2011	Assessment of downtime	Lister in Health Contract meeting end March 11	Clinical Director/DGM
Supports service developments/increased range of examinations	Next 12 months	Provision of Cardiac MRI service Scope of exams (would be subject to separate business case)	Lister in Health Review mtg Sept 11	Clinical Director/DGM
Continued provision of high quality, VFM MRI service	Ongoing	Waiting time/Report turnaround times Finance reports	Quarterly Review mtgs	Clinical Director/DGM/SFM

4.Options

4.1 Consideration has been given to the options available for provision of the MRI service for Sandwell inpatients/outpatients requiring MRI examinations

Option	Description
1	Do nothing – not viable, implications with terms of lease contract, significant clinical governance risks
2	Renew contract with Lister in Health 2011 – 2018
3	Provision of in house MRI service at Sandwell

Option 1 – Do nothing

4.2 This option means termination of the contract and terms of the lease with Lister in Health

- The Trust would incur penalties from termination of the contract as outlined within the document
- There would be significant capital and revenue costs for establishing an in house service/implementing interim arrangement (mobile service)/using alternative provider
- There would be insufficient capacity on City site to accommodate Sandwell activity
- There would be a delay in progressing service developments and this would impact on patient care

Option 2 – Renew the contract with Lister in Health (January 2011 – January 2018)

4.3 **This option requires approval of SIRG/Trust board** in terms of approving investment over this 7 year period (January 2011) through to end of December 2018, subject to recommendation following full financial evaluation

4.4 The contract includes replacement of the existing MRI scanner with a Siemens Avanto 1.5T 18 Channel, with Diffusion (final specification to be agreed by the clinical team). The equipment replacement programme to be completed between December 2010 and March 2011).

- Budgeted cost £495K, build cost to remove existing scanner and install new scanner £200K (both exclusive of VAT)
- Full maintenance of the scanner £65K and chiller/other equipment £12K

The maintenance includes guaranteed uptime of over 98% against a set of agreed KPI's for response time.

The above will be incorporated into financial model, based on price per scan (not per patient rate). This will be a flat rate removing the current tiered system, which allows greater clarification for the Trust as part of financial planning

Lister in Health will also be responsible for providing contingency arrangements (on site mobile service during installation at no additional cost to the Trust).

4.5 The service will be operational 12 hours per day Monday to Friday and 8 hours on Saturday. It is important to note that patients are scheduled according to radiographic skill mix available with less complex cases being scheduled on lists when only 1 radiographer available

4.6 Lister in Health will be invoiced £34K per annum for energy costs /other Trust provided services

4.7 All staff costs will be borne by Lister in Health including holiday and sickness cover. The managed service includes all costs for the operation of the scanning service. The service includes booking and interface with patients; reception; as well as clinical duties associated with the service

4.8 The price per scan will be £75 per scan (see financial evaluation) and has been based on volume of 6600 scans per annum. Should there be a decrease in activity the risk is with Lister in Health who would need to secure additional activity from other sources to make good the loss.

Option 3 Provision of an in house MRI service at Sandwell (within existing facilities – subject to termination of lease agreement/other facilities)

4.9 This option would require significant capital investment in facilities and equipment as well as revenue investment to establish a local in house MRI service at Sandwell.

4.10 This would require SIRG approval for Capital Projects to undertake a feasibility of the Estate to agree a suitable location if it was not possible to use existing facilities, and work with Imaging to develop a Capital Project plan, including contingency arrangements to maintain service provision, whilst the new facilities were made fit for purpose/new scanner procured and installed within existing location.

The new facility would need to fit with RCRH model in terms of long term location and include waiting space, toilets, utilities, staff rooms, bed space (separation of male /female patients) and be fully compliant with the Infection Control Policy.

4.11 There would need to be SIRG approval for revenue investment for recruitment of appropriate staffing model to support in house MRI service, as well as investing in training.

4.12 There would need to be assurance that the costs of establishing an in house service were competitive with Lister in Health

4.13 Lister in health currently own the building in which they run the sand well service, if the trust was to develop its own in house service, the building would need to purchased / leased from Lister. The current net book value of the building is £600k.

5.0 Non Financial Evaluation

Benefit Description			
	Option 1	**Option 2**	**Option 3**
Increased reliability	0	5	5
Supports service developments/increased range of examinations	0	5	5
Continued provision of high quality, VFM MRI service	0	5	2
Total Score	**0**	**15**	**12**

Notes

The significant capital investment required within 10/11 and 11/12 to progress option 3 potentially makes this option unviable.

6.0 Financial Evaluation

6.1 Capital Expenditure

Under option 2, the capital expenditure would be incurred by Lister in-Health and charged back via the cost per scan mechanism. As this is provided by a managed contract it benefits from been VAT reclaimable. Lister bares the risks if the capital value used to calculate the cost per scan increases and whether activity reduces below that forecast.

Under option 3, the capital expenditure would be incurred by SWBH. Using the recent procurement of the City Scanner as a guide the Trust would have to find £1.2m of capital to procure the scanner. The figure Lister has quoted for purchase of the equipment is £600k.

The building is owned by Lister but the land leased from the Trust. If the Trust chose to terminate the contract the building would need to be procured from Lister. This currently has a net book value of £600k.

6.2 Income & Expenditure

Lister in Health have reviewed their current tiered pricing structure per patient with additional charges for multiple procedure's and "with contrast" scans and have replaced with a flat rate per scan.

The new price per scan advised by Lister in Health is £75. In 09/10 the average per scan price was £74.

The revised price of £75 per scan is subject to retail price indexation.

Based on Lister's projected activity forecast of 6,600 scans per annum this would equate to costs of £495k per annum.

Reporting of scans under both models is undertaken by SWBH Radiologists.

The Division has assessed what staffing would be required under option 3 to re-provide this service in house. Below is a cost comparison of options 2 and option 3.

Analysis of both options:

	LISTER		IN HOUSE	
Activity	6600		6600	
	WTE	£000	WTE	£000
Pay				
Consultant Radiologist reporting	2.25	(315)	2.25	(315)
Radiographer - band 7	-	-	1.00	(47)
Radiographer - band 6	-	-	3.00	(118)
Admin - band 2	-	-	1.00	(20)
IDA - band 2	-	-	2.00	(41)
Support services	-	-		(20)
TOTAL PAY	2.25	(315)	9.25	(561)
Non Pay				
Direct Expenditure MRI				(90)
Maintenance – MRI		-		(87)

Lister In -health contract		(495)		-
TOTAL NON PAY		(495)	-	(177)
Capital Charges				
MRI equipment – new		-		(157)
TOTAL CAPITAL CHARGES		0		(157)
Trust overheads @ 21%				(219)
Total expenditure	**10.15**	**(810)**	**10.15**	**(1,264)**
TOTAL Cost per scan		**£123**		**£192**
TOTAL Cost per scan - exc reporting		**£75**		**£144**

The total cost of the in house provision (excluding reporting) would be £144 per scan this is significantly higher than the Lister in Health cost of £123 per scan. The main factors in the price difference are shown below:

- As previously mentioned the Trust benefits from not paying VAT on this contract, saving c£100k per annum. The in-house service would not benefit from this. If the Lister service wasn't VAT reclaimable the cost per scan charge would rise from £75 to £90

- Trust overheads are currently running at 21%. Lister is passing across overheads of around 7%. If Lister charged SWBH 21% of their overheads this would increase their cost per scan charge to £101 (inc VAT).

- The other major factor is capital charges – these are calculated on the procurement price of the equipment. Lister's quote for the equipment is circa £600k, the SWBH quote is based on the recent City procurement (£1.2M). If SWBH could procure the same kit at the price Lister has quoted the in-house cost per scan would reduce to £99.

- If these contracts were truly like for like, ie both incur VAT and have similar capital equipment costs and overhead charges. The per scan price would be very close:
  - In-house provision £99
  - Lister £101

The non-mandatory tariff on average is £226 inclusive of reporting (£199 excluding the report). If a separate tariff for imaging was received the costs of undertaking the MRI service either in house or from Lister would be covered by the Income received.

A further option discussed would be for the Division to put out to tender the contract to see if another interested party would be able to offer a better deal than Lister. If this happened the Trust would need to buy the building that currently has a net book value of £600k. For this option to become the best value for money, the new provider would need to charge a per scan price of c£62 (18% reduction on the Lister proposed charge), which may not be viable for another provider to achieve.

6.5 Price comparison

Excluding the radiologist input, the table below shows a comparison of the revised SWBH price per test proposed by Lister compared to the charges Lister levy to other Trusts.

Price Comparison	Activity	Per scan price	Comments
Lister - SWBH charges	**6,600**	**£75**	
Lister - Trust A	7,500	£97	Renewal in past 12 months
Lister - Trust B	5,800	£92	
Lister - Trust C	7,350	£85	New contract won via competitive tender in past 12 months
Lister - Trust D	9,500	£95	Renewal in past 12 months
Lister - Trust E	7,200	£86	
Lister - Trust F	7,800	£79	

6.6 Summary of the key financials

The Lister/SWBH service models deliver similar service standards in terms of access within and outside of normal working hours (both offering extended and Saturday morning sessions), with diagnostic waiting times of less than 5 weeks. However, there are occasions when Lister are not able to support complex cases and there scheduling arrangements reflect this, whereas the SWBH deliver the same level of service for all sessions.

It is important to note that the significant differences in financial models are reflective of the fact that Lister (IS provider) are able to offer SWBH very competitive rates as they can charge private customers premium rates for their services. This is not part of the ethos of the NHS and so the in house financial model vs IS model is not a fair comparison. Lister in Health have also demonstrated significant purchasing power for capital procurement of MRI scanning equipment (significantly less than NHS Supply Chain)and do not have significant overhead charges (21% - reflected in the SWBH costs). The in house SWBH model however, would still be able to offer the service below tariff.

The current agreement with Lister in Health is in 2 parts; i) Scanning Agreement ii) Lease agreement (40 years). If Lister were not awarded the contract there would be significant financial and operational implications for the service. The penalty for termination of the lease agreement would be 600K and there would need to be a notice period. This would be a significant risk for the organization in terms of timeline for establishing an in house service with contingency arrangements in addition to the financial consequences.

If another IS provider were to be considered then they would also be required to address this matter, by covering 600K in scan prices, which would mean it would be highly unlikely they would be able to compete with the price offered by Lister in Health.

There has been expert advice (legal/Head of Procurement) with respect to the tendering process and the advice has confirmed the contract with Lister in Health is part B exempt, which means this does not undergo a full OJEU tendering process.

The Division has undertaken some research with respect to above and can advise that Lister in Health have recently been part of a competitive tendering exercise within another organization. The process included IS provider procuring a new MRI scanner as well as providing a scanning agreement and were awarded this contract, clearly demonstrating deliver of a value for money, high quality MRI service.

7.0 MRI Activity

7.1 CRIS Forecasts

MRI activity growth estimates (below) have been based on examination data extracted from the CRIS Radiology Information System. The rational for this approach is to avoid inconsistencies associated with earlier data collection systems (site specific RIS/exam codes pre CfH). It does, however, limit the number of years used to estimate future growth. The data set is also subject to variation due to increasing work patterns to cope with backlog and demand and these consequently impact on estimates.

The data has been adjusted to exclude 'City' referrals undertaken at Sandwell during installation of the new scanner and due to limitations of the old scanner. Therefore, any City referrals (request location City) have been deducted from Sandwell totals and added to City in an attempt to reflect a projection based on site specific activity growth.

Predicted growth based on CRIS data

YEAR		Sandwell	% growth		City	% growth		SWBH	% growth
2008/09		5635			6342			11977	
2009/10		6140	9		6578	4		12718	6
2010/11		6797	11		6852	4		13649	7
2011/12		7353	8		7101	4		14453	6
2012/13		7934	8		7356	4		15289	6
2013/14		8515	7		7611	3		16125	5
2014/15		9096	7		7866	3		16961	5
2015/16		9677	6		8121	3		17797	5
2016/17		10258	6		8376	3		18633	5
2017/18		10839	6		8631	3		19469	4
Overall growth 08-09 to 17/18		92			36			63	

7.2 RCRH forecast

At this stage activity projections indicate growth in excess of RCRH estimates. The rate of growth in the table above suggests that an additional scanner would be required in 2016 assuming that both scanners are at maximum capacity (9,000) exams per scanner per year). MRI and the activity of other modalities is monitored monthly and projections will be revised as more data becomes available.

Predicted growth based on RCRH Projections

Summary of MRI Scans	Scans 09/10	Scans 10/11	Scans 11/12	Scans 12/13	Scans 13/14	Scans 14/15	Scans 15/16	Scans 16/17	Scans 17/18	% Change 910 - 1718
A & E / Urgent Care Imaging Dept Growth @14%	57	61	66	71	76	82	89	96	104	68%
A & E / Urgent Care V5 Activity	223,313	226,231	229,281	232,512	236,037	239,758	245,253	249,815	254,525	12%
A & E / Urgent Care What If Growth assuming 09/10 sets the standard	57	58	59	60	60	62	63	64	65	13%
Total Difference in Scans between Options for A&E/ Ucare	-	3	7	11	16	20	26	32	38	
INPATIENTS Imaging Dept Growth @14%	1,584	1,545	1,581	1,615	1,703	1,776	1,850	1,915	2,061	21%
INPATIENTS V5 Activity	76,821	70,357	67,588	64,454	63,126	61,029	59,867	58,350	59,254	-24%
INPATIENTS What If Growth	1,584	1,459	1,410	1,360	1,355	1,334	1,312	1,283	1,303	-19%
Total Difference in Scans between Options for INPATIENTS	-	86	171	255	349	442	538	633	757	
OUTPATIENTS Imaging Dept Growth	9,466	9,662	9,822	9,644	9,471	9,585	10,395	10,954	11,688	16%
OUTPATIENTS V5 Activity	598,705	576,529	552,884	512,139	474,481	453,030	463,475	460,775	463,810	-23%
OUTPATIENTS What If Growth	9,466	9,124	8,759	8,122	7,532	7,199	7,372	7,336	7,392	-22%
Total Difference in Scans between Options for OUTPATIENTS	-	538	1,063	1,522	1,939	2,387	3,023	3,618	4,296	
Total Summary for MRI Scans	12,389	12,602	12,858	12,760	12,733	12,996	13,998	14,731	15,735	27%

By 2017/18 RCRH predicts a total of 15,735 MRI scans performed per annum compared to 19,469 under the CRIS predictions. The difference between the two forecasts by this time is 3,734 scans

7.3 Current Activity

The actual number of scans charged by Lister in 2009/10 was 6,518. This includes City activity referred to Sandwell during the construction period of the City scanner.

The forecast in 2010/11(based on M5 actuals) is 5,120, the reduction is referrals is due to the repatriation of City activity as required as part of CIP.

The current funding for Lister is £384k, based on an outturn of 5,120 scans. Whist the City scanner has capacity available to repatriate referrals away from Sandwell it will continue to do so. However, as and when new service developments are agreed the appropriate funding will be required to support additional referrals to Lister so that City capacity can be freed up to implement the new developments.

8.0 Risk Assessment and Management

This report has considered the risks associated with renewing the contract with Lister in Health for provision of a managed MRI service for a further 7 years, versus the provision of an in house MRI service on Sandwell site.

8.1 Some of the key risks for the Division and Trust are outlined below;

a) Significant financial implications of option 3 and restrictions on capital spend in 11/12 (consideration of New Hospital)
b) Impact on patient care as extended temporary arrangements would be required for option 3/with potential clinical governance risks

Risk	Option 2	Option 3	Mitigation

Risk	Option 2	Option 3	Mitigation
Ability to maintain high quality MRI service	1	1	Both options would deliver high quality clinical service
Impact on performance whilst MRI scanner replaced	2	4	Both options would need temporary mobile solution/support from City site, however the length of time required for option 3 would be for an extensive period
Financial evaluation	1	4	Conclusion of financial evaluation is option 2 is more cost effective
Impact on Capital Programme 11/12	0	5	There would be significant capital costs (equipment and building for option 3, this could be supported by using temporary mobile scanner/extending hours of existing facility at City (limited due to capacity constraints
Totals	**4**	**14**	

9.0 Preferred Option

Following a full and detailed financial evaluation and consideration of the options for providing a high quality MRI service on Sandwell site the Division recommend that option 2 be progressed and Lister in Health be advised that the contract has been renewed/awarded for a further 7 years (until December 2018)

10. Cashflow Phasing of Preferred Option

Preferred Option: Option2 – Lister in-health to continue to provide MRI service for a further 7 years

	Current Year () £000s	Year 2 (specify) £000s	Year 3 (specify) £000s	Year 4 (specify) £000s	Year 5 (specify) £000s	Subsequent years £000s
Capital Expenditure (-)	0					
Income– rent & utilities (+)	36.5	36.5	36.5	36.5	36.5	36.5
Income - derived(+)	372.9	1,491.6	1,491.6	1,491.6	1,491.6	1,491.6
Revenue Expenditure (-)	(202.5)	(810.0)	(810.0)	(810.0)	(810.0)	(810.0)
Net Cash Flow (+/-)	**206.9**	**718.10**	**718.10**	**718.10**	**718.10**	**718.10**

The income figure has been derived from the average non mandatory tariff. There is no separate tariff for imaging and is bundled within the inpatient / outpatient tariff the trust receives for an episode of care. The net cash flow is therefore a notional value.

11. Conclusion

The Division recommends that:

- the Trust Board supports SIRG's and Finance & Performance Management Committee's decision to approve renewal of the contract with Lister in Health for a further 7 years (until December 2018)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Replacement of Clinical Biochemistry Pre-Analytics and Main Analysers
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Dr Jonathan Berg, Pathology Director
DATE OF MEETING:	25 November 2010

SUMMARY OF KEY POINTS:

- The Biochemistry Department's pre-analytics and automated analysers are all out of contract in 2011. These analysers are based on reagent rental agreements, which is the intended route of replacement financing.

- After completion of a tendering process new equipment has now been identified that meets the future needs of the Trust. The successful company, Abbott Diagnostics, are, subject to Board approval, to be awarded the contract for supply of pre-analytical robotics and main clinical biochemistry analysers for a five year period from summer 2011. Contracts can be extended as required to fit with completion of the new hospital.

- New equipment will consolidate activities of the former Toxicology laboratory. Driving forward cross-departmental working will be much easier and the new equipment has greater emphasis on automation, enabling further changes in working practices and skill-mix.

- We will see a substantial cost benefit with analytical platforms and savings in reagent and more effective use of staff. Abbott Diagnostics are a new supplier to us, they have agreed to pay the full, and not insignificant costs, of modifications to the laboratory, removal of other manufacturer's equipment and installation of their own systems.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To agree to the replacement of the current pre-analytics and analysers with new ones from Abbott Diagnostics. This decision is based on the procurement and tendering process that has been ongoing since the initial report to SIRG in April 2010 and a final report in November 2010.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Accessible and responsive and high quality care making good use of modern resources in an effective organisation.
Annual priorities	Meeting turn round targets throughout our clinical activity with appropriate testing.
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**	Significant cost savings
Business and market share	**X**	
Clinical	**X**	New analysers should offer a more timely service
Workforce	**X**	Once installed the new analysers offer a number of potential savings. A vacancy freeze has been put in place in Clinical Biochemistry in part to ensure we can address these issues.
Environmental	**X**	There is a substantial saving in waste moving to a single supplier, from reduced deliveries through to less disposable plastics used on a reduced number of machines.
Legal & Policy	**X**	
Equality and Diversity	**X**	
Patient Experience	**X**	The new equipment should offer a more timely laboratory service which will impact positively on patient care.
Communications & Media	**X**	
Risks		The transition from the old to new analysers will need detailed project management.

PREVIOUS CONSIDERATION:

Strategic Investment Review Group (SIRG) on 9 November 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Clinical Biochemistry
Directorate of Pathology

Replacement of pre-analytics and main automated analysers in Clinical Biochemistry

Introduction

The Clinical Biochemistry laboratory offers a comprehensive service across the Trust. There has been an emphasis on updating the laboratory with equipment that can help in diagnosis and treatment in a timely and efficient manner.

Current analysers in the City and Sandwell Clinical Biochemistry Department are all out of contract in 2011. This includes analysers in the main automated laboratory at City Hospital, the Essential Laboratory at Sandwell and also the Toxicology Laboratory (which has been merged into the Clinical Biochemistry Department over the last 2 years). The equipment in its current form is of varying ages with some contracts having already been extended considerably so that it can all be replaced at the same time. Consequently the frequency of breakdowns is increasing and additional maintenance is required. This downtime impacts on the clinical service, especially to acute areas such as A&E. Currently two companies provide the analytical equipment for the main laboratories, Beckman (formerly Olympus) and Roche. All contracts are for reagent rental and this is generally the way that such analytical equipment is procured, though for a cash-rich organisation capital purchase may elicit significant discounts from tender prices.

Background and Strategic Context

Modern, relevant and cost-effective Pathology is central to the Right Care, Right Here approach. Replacement of the out of contract analysers at this time enables us to take forward major reconfiguration and rationalisation which fits very much with us being an effective organisation.

Introduction of new robotic analysers complies with the Annual Plan's emphasis on 21st Century facilities and helps us meet demand of current and future testing as well as facilitating the further development of changes in skill-mix both within and across pathology disciplines. In particular we will be able to work more closely with immunology offering much more automation for some key tests with savings in that department.

Simpler operation of the replacement analyser at Sandwell will help us to address skill mix during the day. At night this includes training the out-of-hours worker in Haematology to run the Biochemistry analyser. This will help drive forward skill-mix changes which are not possible while we have had to maintain two 24 hour services at our two acute hospital sites.

Environmental impact: We are reducing the number of analytical platforms and this has considerable potential to improve our environmental footprint. This includes less deliveries as we will now source from one major supplier as well as potentially less plastic and clinical waste in the laboratory processes.

Financial Appraisal
The revenue current and proposed revenue costs are as follows:

	Current Expenditure	Proposed Expenditure
Reagents	710,533	596,539
Service contracts	71,329	88,811
Capital charges	n/a	
IRFS - lease element	150,421	120,000
TOTAL	**932,283**	**805,350**

The analysis in the table shows that the regent rental is the cheapest option and would save circa £127k on current costs and much of this has to do with the removal of two platforms in the Toxicology laboratory.

The significant cost associated with the preparation of the laboratory for the installation of the new equipment will be fully met by Abbott Diagnostics as will be the moving and ultimately removal of the old equipment.

Expected Timeline

Expected Date of Commencement of Work: A tender will be accepted once agreed by the Trust Board. There will then be a period of laboratory preparation required including taking out some internal walls. Following on from this will be a phased implementation which includes validation work for all assays

Key Dates:

Final presentation to SIRG	9th November 2010
Trust Board Decision	25th November 2010
Notification to successful and unsuccessful companies	26th November 2010
Stand-down period for any appeal	10 days from 26th November
Contract details agreed	January 2011
Machines in for assessment work	April 2011
Installation in phased way	May – July 2011
Fully installed systems	August 2011

Change-over period: There is required to be a period of assessing the old and new equipment against each other. Samples have to be run on both machines for a period of time so that we can show any variation and also decide that the new methods are fit for purpose.

New Hospital: If the new hospital proceeds to time then it is likely that the current procurement will stay in place until the move into the new facility at Grove Lane and Sandwell. The analysers to be procured now will stay in their current locations until the end of their useful lives allowing us to have a new suite of analysers installed in the new laboratory

Tender Process

The process of tendering has been undertaken with the Supplies Department and a team of five staff from Clinical Biochemistry. Three final tender responses were received and two of these were short listed for full technical and financial evaluation. The tender process included:

Procurement Team

Dr Jonathan Berg	Head of Department
Dr Loretta Ford	Consultant Clinical Scientist
Simon Brown	Biochemistry Manager
Vanessa Lane	Biochemistry Deputy Manager
Leena Kaur	Sample Reception & Automation Manager

Our assessment has included:

1. Study of the Tender Responses - All members of the team have read the responses in detail.

2. Site visits - for the supply of main analysers after which two companies were short listed.

3. Financial assessment – undertaken by the Pathology finance lead, Nicola Reid and reported to SIRG.

4. Non-Financial Assessment – This was undertaken by the procurement team and the scoring sheets are enclosed. The scoring was based on the written tender replies, experience gained at site visits and also the written post tender clarification responses. A meeting was also held with other Departments within Pathology as is required by our Pathology Directorate to look at any Pathology wide implications of this procurement

It is the opinion of the Clinical Biochemistry Procurement Team and that **Abbott Diagnostics** tender response and post tender clarifications should be accepted by the Trust Board.

Summary

The analysers in Clinical Biochemistry are all at the end of their service life and we have had suitable tender responses from companies that would like to install and maintain a suitable suite of new analysers. The move to new analysers is being taken as a change facilitator in many areas of the laboratory's work. There are real cost savings in reducing the number of analyser platforms and it is hoped that there will also be more long term savings in terms of changing working practices.

The financial assessment clearly shows that both tender offers that have been fully explored deliver major financial savings, both in the direct cost of the reagents and contracts and also in the longer term by offering new approaches to analysis which will allow efficiencies in working practice. The Abbott Diagnostics tender is recommended to be accepted as it had the best technical and financial assessment.

Dr Jonathan Berg
5th November 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Nutrition Update
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Fiona Shorney, Assistant Director Therapies
DATE OF MEETING:	25 November 2010

SUMMARY OF KEY POINTS:

The attached report seeks to inform the Trust Board of work undertaken within Nutrition to identify and manage those patients at risk of malnutrition and dehydration.

It seeks to highlight to the Board areas of concern and to assure the board that systems are in place to address these challenges.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Safer Patient Care
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	CQC, HIA Keeping Nourished – Getting Better, NICE Nutrition Support for Adults CG32
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Not previously considered.

Report to:	**Trust Board**
Report by:	**Fiona Shorney, Assistant Director Therapies**
Report title:	**Nutritional Care Report**
Date:	**November 2010**

Introduction

The purpose of this report is to provide the Trust Board with an overview of nutritional care across Sandwell and West Birmingham Hospitals. The provision of good nutritional care is a matter of quality. Ensuring that malnourished or dehydrated patients admitted to our hospitals or those at risk of developing malnourishment or dehydration are identified and treated, clearly delivers against safety, effectiveness, equality and a positive patient experience. All organisations must now ensure high quality nutritional care if they are to meet the national standards set by the Care Quality Commission.

This report attempts to brief the Trust Board on our response to these challenges, our initiatives, how they are measured and the impact for our patients and the benefits to the Trust.

Background

Malnutrition is a cause and a consequence of disease leading to worse health and clinical outcomes in all social and NHS care settings. Having enough to eat and drink is a fundamental requirement for survival yet few of us appreciate how common malnutrition is in the UK so it frequently goes unrecognised and untreated. In August 2010 Age UK (formerly Age Concern) launched “Still Hungry to be Heard” their campaign to re-highlight the scandal of people later in life becoming malnourished in hospital. Their initial campaign 4 years ago has led to greater acknowledgement of the problem but there has, to date been insufficient action.

In 2009 NICE and the British Association of Enteral and Parenteral Nutrition (BAPEN) estimated that at least 25% of patients under 65 years old admitted to acute hospitals are either malnourished or at risk of malnourishment. This figure increases to 30% in the over 65s. They also estimate that a staggering 70% of malnutrition in acute hospitals is unrecognised and therefore untreated.

Common risks and consequences of malnutrition and dehydration include;

- Wounds heal more slowly

- Increased vulnerability to illness
- Increased risk of infection
- More medication required, for longer
- Loss of muscle strength, mobility reduced with loss of independence
- Impairment of cognition, depression and anxiety
- Longer stay in hospital – on average 1.4 days longer than well nourished patients.

The financial cost is clearly significant. BAPEN has estimated that, based on audits in 2007, public expenditure was in excess of £13 billion and recent guidance from NICE identified nutrition as the 4th largest potential source of cost saving to the NHS.

The cost of malnutrition and dehydration to our patients is very serious. No age group is immune but in 2009 Age UK reported that patients over the age of 80 are 5 times more likely to become malnourished than those under 50 years.

Developments

In December 2009 Nutrition and Hydration were identified as one of the High Impact Nursing Actions as "Keeping Nourished – Getting Better" with the focus that patients will not suffer malnutrition and dehydration whilst in hospital. As yet there is not a CQUIN target in this area. However national metrics have just been set for both malnutrition and dehydration towards a common benchmark for practice across the entire NHS regardless of the care setting. In the acute environment it requires robust action to ensure that patients are weighed on admission as part of a validated screening process to monitor Trust acquired malnutrition. With regard to dehydration the requirement is for all patients at risk to have their fluid intake recorded to ensure the recommended intake of at least 1500mls per day.

The Trust's multi-disciplinary Nutrition Steering Group and the High Impact Nutrition Group monitor compliance against the key clinical priorities and national standards. The Nutrition Steering Group has an action plan in place reporting to the Governance Board. The Assistant Director of Therapies reports monthly to the Patient Experience Professional Advisory Group (PEPAG).

Key Priorities

- Increase training initiatives particularly regarding MUST (Malnutrition Universal Screening Tool). MUST is a validated 5 step screening tool to identify adults who are malnourished or at risk of malnutrition or obese. The process requires the patient to be weighed and their height measured to acquire a BMI (Body Mass Index). Using a matrix the patient's risk status is scored 0 – 3. The step by step process offers guidance regarding an individualised care plan e.g. referral to a Dietician, implementation of a food diary, fluid chart, red tray.

- Ensure that nutrition and fluid balance status routinely forms part of the handover process and is acknowledged on the bed plan.

- Continue with protected meal times where all non-urgent activity ceases allowing patients to eat without interruption and receive assistance when required. Despite sustained effort on most wards the adherence to these times by other professional groups is variable requiring frequent reminders.

  In rehabilitation areas in particular therapists are, as agreed with patients, incorporating these periods as part of their rehab programme e.g. use of adapted cutlery and repositioning to facilitate their ability to self feed.

- Ensure we protect patient dignity by ensuring the environment at mealtimes is appropriate and that patients are prepared prior to receiving their meals.

- Have a greater awareness of dietary need. We should know what food our patients like or dislike, what food they find hard to eat and whether they have large or small appetites. This should involve family and carers where appropriate.

  Too often little help is offered to enable an informed choice to be made from the menu so patients are served something they don't like so they don't eat it. A missed meal can be just as important as missed medication.

  We must also ensure that patients are offered regular drinks. All patients should be offered 7 hot drinks a day including the option of our newly introduced hot milky drinks on the mid morning and the evening rounds. Vulnerable patients deemed at risk should be actively encouraged to drink with the appropriately monitoring.

- Ensure access to food out of hours. Ward staff need to be confident that they have access to food for their patients over a 24hour period.

Monitoring Methodology

- **MUST Audit** – Our current target is that 75% of patients have MUST completed within 48hrs of admission. In Q4 2009/10 MUST compliance was 31% across the Trust. At the end of Q2 2010/11 compliance has risen to 61%. In line with the new national metrics this target is likely to be amended.

- **Essence of Care standards** – These now include more robust nutritional data, first results due in early 2011.

- **Ward Review Tool** – Incorporates 5 nutrition related standards associated with nutrition. This will continue on a quarterly basis from 2011.

- **Comprehensive range of Meal Observation and Documentation Audits** – These indicate we particularly need to concentrate on how we prepare both patients and their immediate environment prior to receiving their meals.

Patient Feedback

The National Patient Survey results in relation to nutrition has highlighted that an area where the Trust performs poorly is around choice of meals. This is disappointing as our menu offers a comprehensive selection. We suspect however, that these results reflect the need for us to take time to assist those patients requiring assistance to make their choice of meals rather than make a selection on their behalf.

Within the Trust's own Inpatient Survey we ask 5 Food and Drink related questions. Up to the end of October it appears that patients do receive help at meal times when they require it, most get the food they ordered, most feel they have sufficient choice of meals and all have access to enough drinks. However, a significant number did not have any conversation with staff regarding their dietary needs.

We acknowledge however that this monthly data to date only represents a small cohort of our discharged patients and is unlikely to reflect the views of our most vulnerable. As this process is embedded as normal practice we anticipate more representative information.

Conclusions

The delivery and measurement of good nutritional care is challenging and complex and requires a collaborative, multidisciplinary approach, clinical engagement, pro-active leadership and robust educational initiatives. The Board should be assured that improving nutritional care is one of our quality priorities. We acknowledge that although we have made some significant progress we are not yet performing to an acceptable standard. Education, early identification of those patients most at risk and effective communication are at the centre of ensuring that we deliver good nutritional care to see an improvement in clinical outcomes and patient satisfaction whilst achieving significant reduction in costs.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Quarterly Report from Director of Infection Prevention and Control – July to September 2010
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Dr Beryl Oppenheim, Director of Infection Prevention and Control
DATE OF MEETING:	25 November 2010

SUMMARY OF KEY POINTS:

Organisational structures continue to work well both within our own organisation and across the wider healthcare economy.

Numbers of cases of MRSA and CDI remain within our national targets but maintaining these over the busy winter period will be challenging

We now have experience in undertaking surveillance on a range of other healthcare associated infections, some of which are likely to become mandatory in the future.

Antibiotic audits have shown a pleasing improvement in a number of key areas of antibiotic stewardship. Work which we are doing is also having an impact on antibiotic usage in primary care

An important challenge during this quarter has been the training of all junior doctors on a range of infection control related topics including ensuring competency in taking blood cultures

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

Approval	Receipt and Noting	Discussion
X		
To advise the Trust Board of the work undertaken by the Infection Control Service at Sandwell & West Birmingham Hospitals NHS Trust for the period July to September 2010.		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive and note the Quarterly Report for the period July to September 2010.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care
Annual priorities	2.1 – Continue to keep up high standards of infection control and cleanliness
NHS LA standards	2.4.9 - Infection control
CQC Essential Standards of Quality and Safety	Regulation 12; Outcome 8 – Cleanliness and infection control
Auditors' Local Evaluation	High Quality Care

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

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

PREVIOUS CONSIDERATION:

Routine quarterly update.

QUARTERLY INFECTION PREVENTION AND CONTROL REPORT
April – June 2010

Executive Summary

Organisational structures continue to work well both within our own organisation and across the wider healthcare economy.

Numbers of cases of MRSA and CDI remain within our national targets but maintaining these over the busy winter period will be challenging

We now have experience in undertaking surveillance on a range of other healthcare associated infections, some of which are likely to become mandatory in the future.

Antibiotic audits have shown a pleasing improvement in a number of key areas of antibiotic stewardship. Work which we are doing is also having an impact on antibiotic usage in primary care

An important challenge during this quarter has been the training of all junior doctors on a range of infection control related topics including ensuring competency in taking blood cultures

Management and Organisation

The Infection Control Operational Committee continues to work on reviewing and revising key policies, monitoring progress with the action plan and receiving reports on infection control initiatives across the Trust. Partnership working with colleagues in the community is progressing well, with a major recent initiative being a working group convened by Sandwell PCT considering approaches to minimising the impact of norovirus infection on the healthcare economy during the winter period.

MRSA

Mandatory reporting of MRSA bloodstream infections

There were 2 post 48 hour MRSA bacteraemias during the quarter July to September 2010 (Figure 1), bringing the total number of Trust attributable cases to 3 for the first half of the financial year. Both cases have been fully investigated.

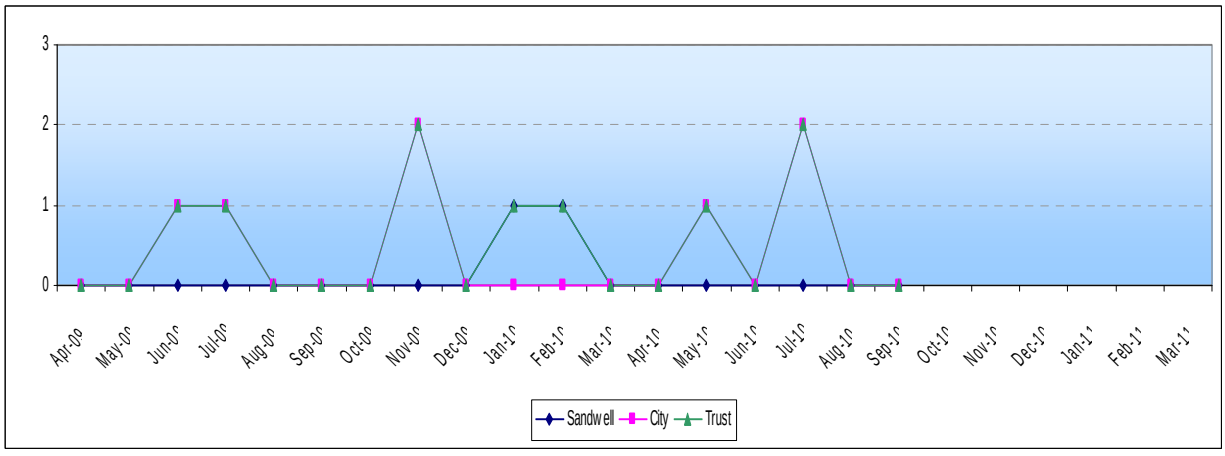


Figure 1. Number of MRSA bacteraemia cases

We continue to target all the major risk factors for MRSA bacteraemia. Avoiding contaminated blood cultures remains an important aim and we continue to monitor these, which have remained fairly low although there is still room for improvement (Figure 2). We are particularly gratified to see that contamination rates have remained low despite a major change over of junior doctors in August.

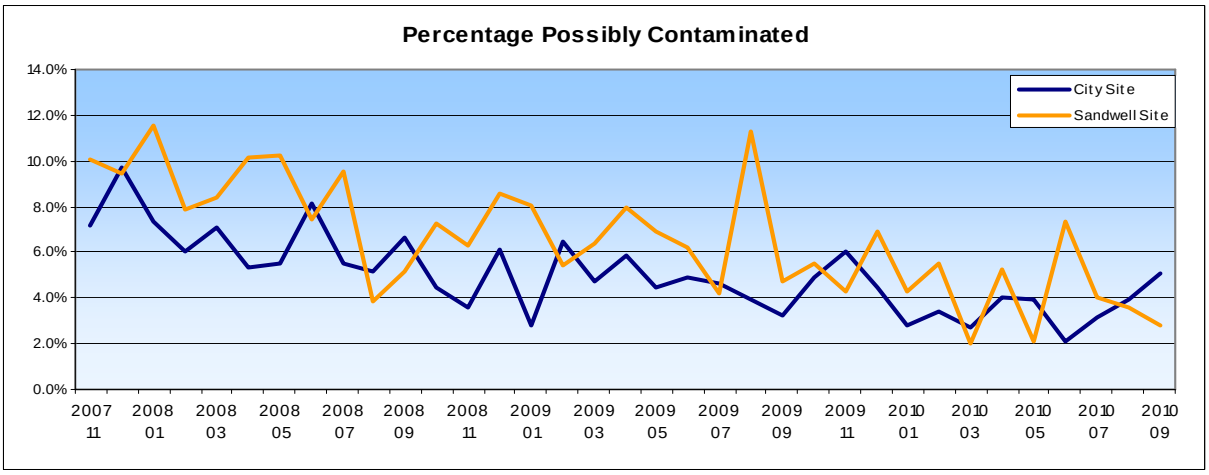
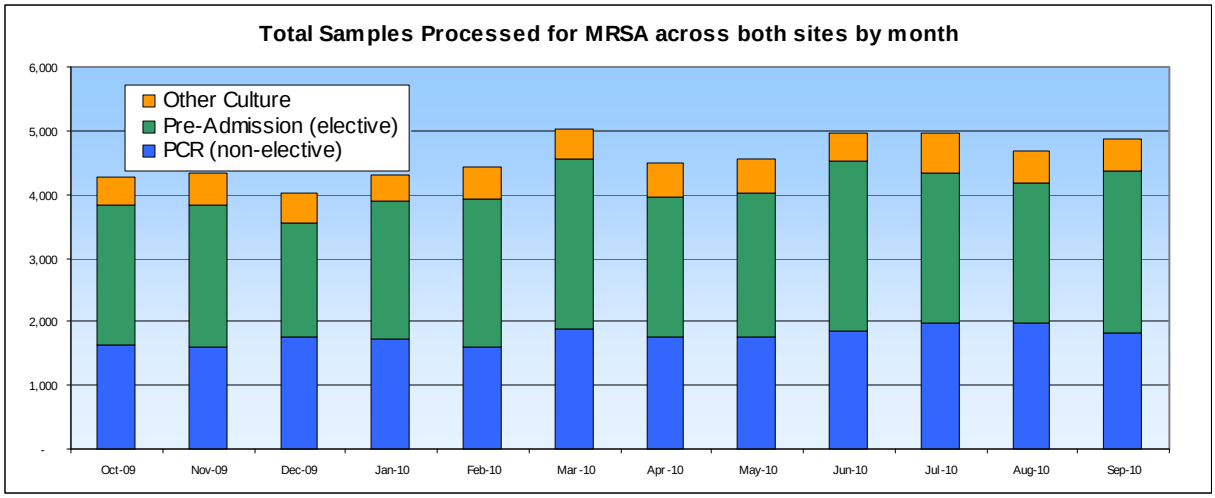


Figure 2. Percentage of possibly contaminated blood cultures

MRSA Screening and Decolonisation Therapy

MRSA screening remains another important tool to try to prevent MRSA infections. The number of patients screened remains similar each month with only a small fall during August possibly reflecting normal seasonal variation (Figure 3). However there does appear to be a genuine drop in positivity rates for emergency screening, while positivity rates for elective screening remain extremely low.



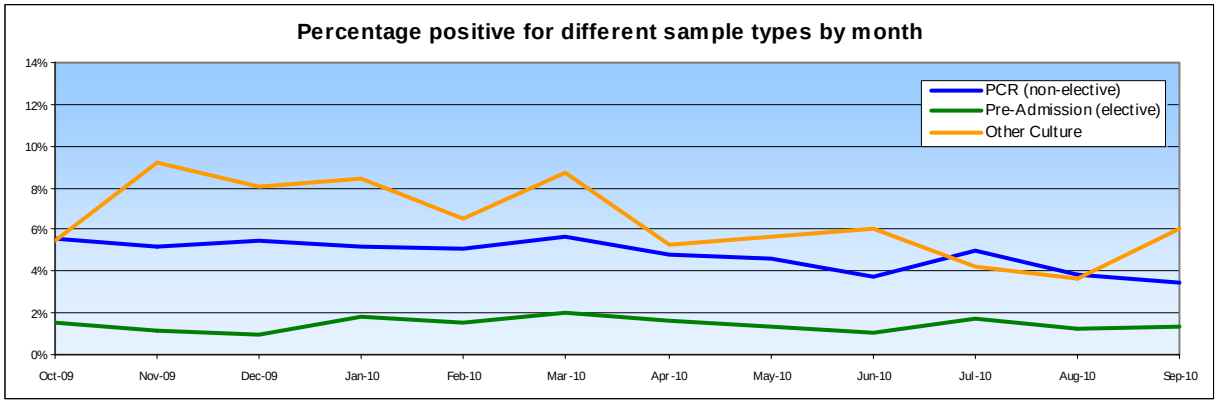


Figure 3. MRSA screening numbers and positivity rates

Clostridium difficile infections (CDI)

There were 40 cases of CDI occurring more than 48 hours after admission during the period July to September 2010 (Figure 4). While this is within our national target, this has put us above our local stretch target for 2010/11. This higher than expected number was mainly due to very high numbers of reported cases during August which is surprising. However a careful analysis of cases suggested that the explanation might be a high number of instances where samples were sent from patients who did not have relevant symptoms and where asymptomatic carriage rather than true infection was being noted. Much stricter criteria for submitting and testing have been put into place and this has been reflected in lower numbers of cases in September which we feel more accurately reflects the true burden of infection. However we do need to develop robust systems to ensure that clinicians continue to have a high index of suspicion for CDI in their patients and check that samples have been taken and results received.

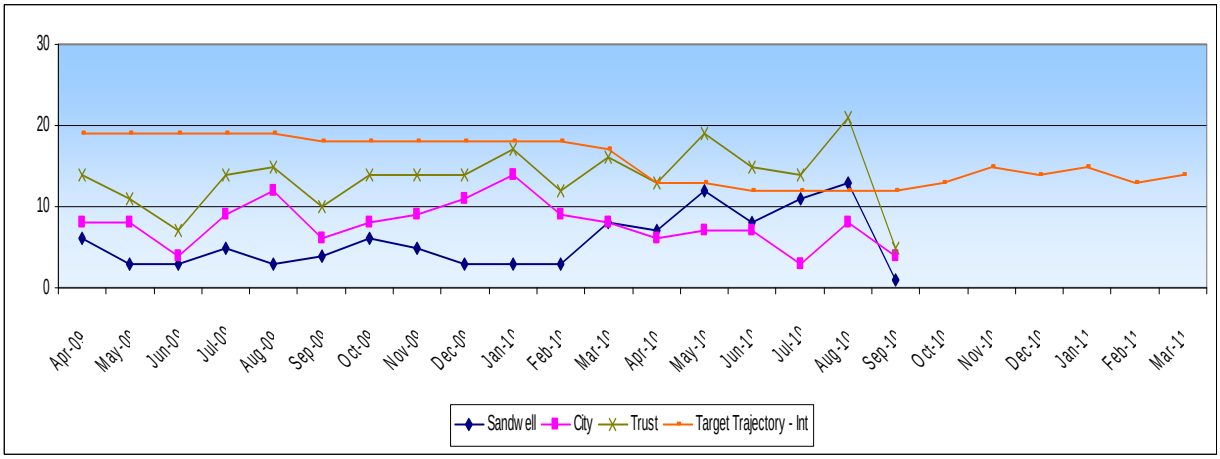


Figure 4. Numbers of post-48 hour cases of CDI

Surveillance of other healthcare associated infections

MSSA and E coli bacteraemias

We continue to monitor hospital acquired cases of methicillin sensitive *Staph. aureus* (*MSSA*) and *E. coli* bloodstream infections. Recent information suggests that this data collection will become mandatory from 2011 which would allow us to benchmark ourselves against similar organisations (Figures 5 and 6).However our own figures may change depending on definitions used nationally

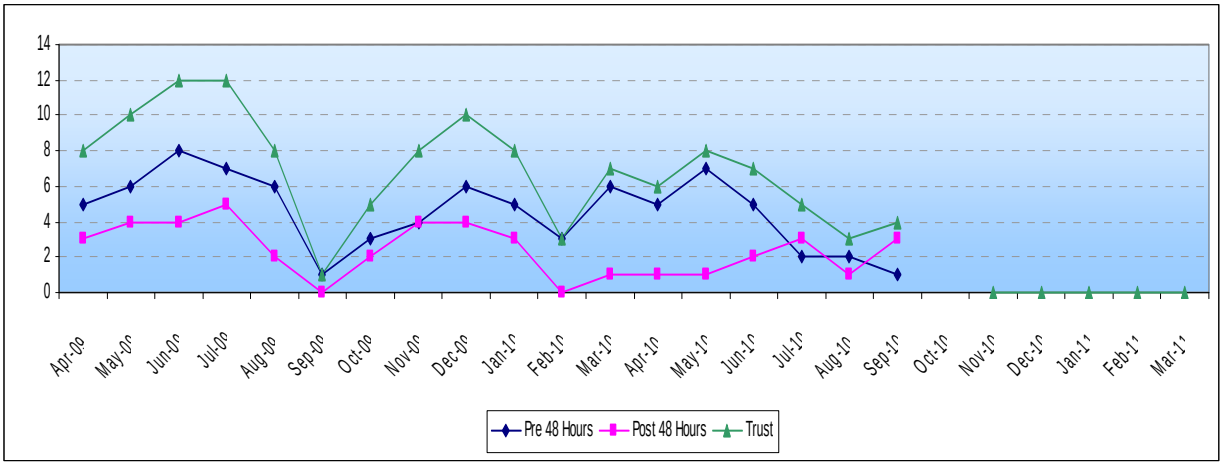


Figure 5. Numbers of MSSA bloodstream infections

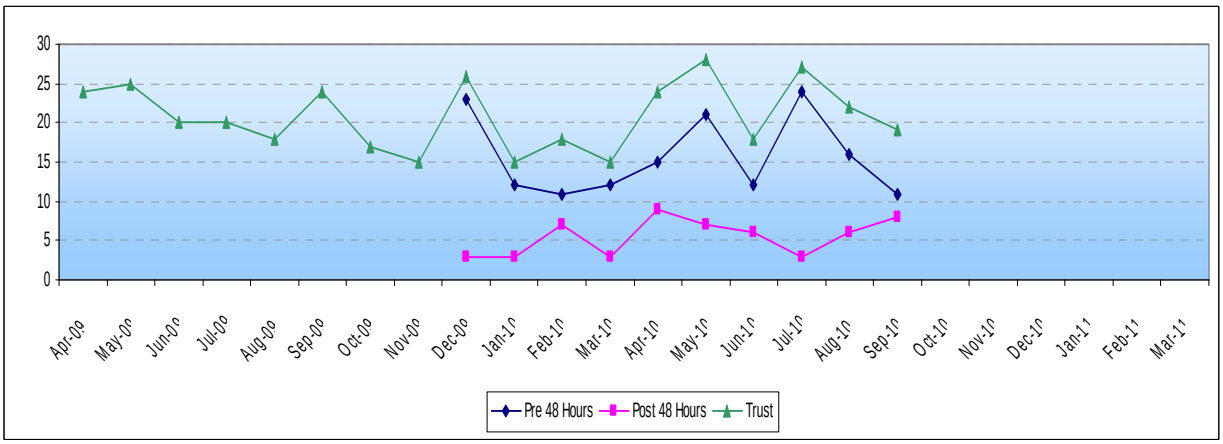
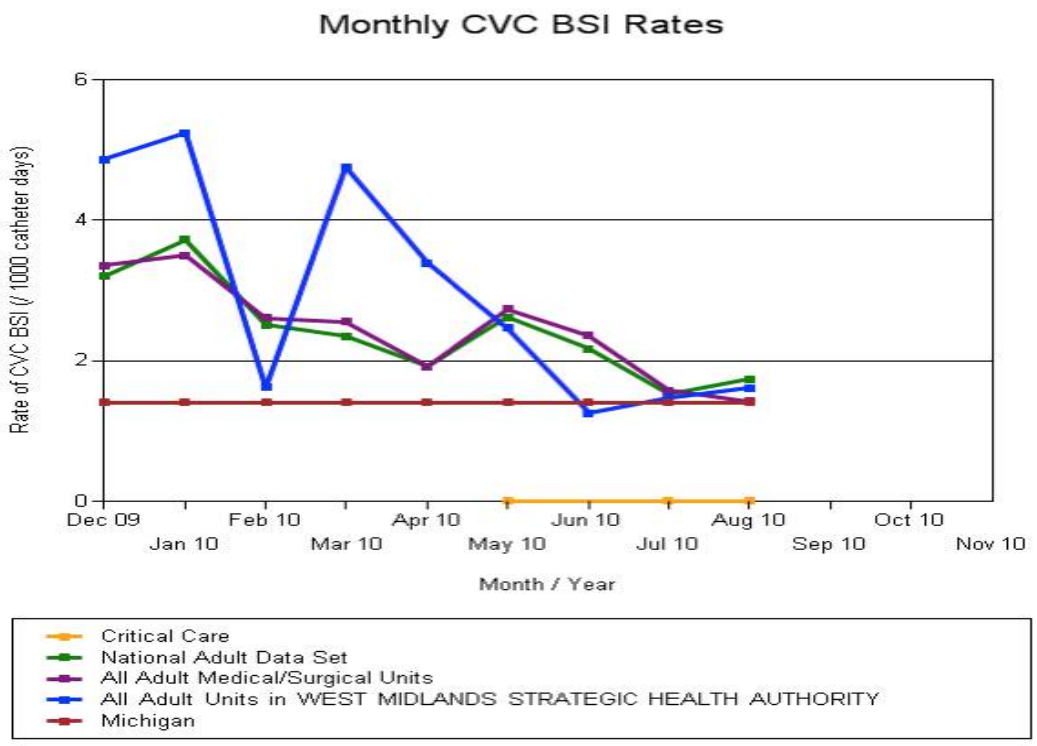


Figure 6. Numbers of E. coli bloodstream infections

Matching Michigan

Matching Michigan is a quality improvement project based on a model developed in the United States which, over 18 months, saved around 1,500 patient lives. It took place at Intensive Care Units (ICUs) in Michigan and introduced data definitions, technical interventions - changes in clinical practice - and non-technical interventions - linked to leadership, teamwork and culture change. When these interventions are applied together these have been shown to reduce Central Venous Catheter Bloodstream Infections (CVC-BSIs). Ninety seven per cent of acute trusts in England are participating in Matching Michigan. At SWBH data collection is carried out within the Critical Care Units and results for the first three months of data collection indicate a rate of 0 CVC-BSIs which is an outstanding result.



Antibiotic stewardship

We have continued to progress all aspects of our work on antibiotic stewardship. We continue to monitor antibiotic utilisation data and this provides a powerful tool to ensure that our policies are being followed and that any changes in policy are having the desired impact. For most of the commonly used antibiotics, our usage remains similar to the previous year (Figure 7).

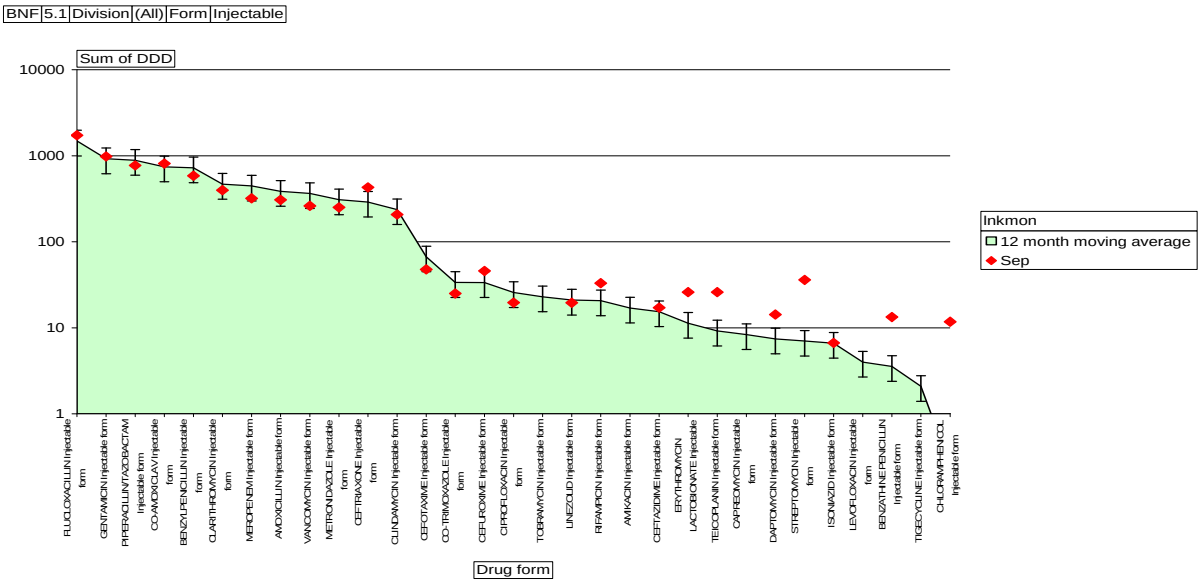


Figure 7.

Snapshot audits of practice also provide reassurance around policies to prevent excessive use of antibiotics and recent audits have shown small but pleasing improvements in a number of parameters such as duration of antibiotic prescriptions (Figure 8).

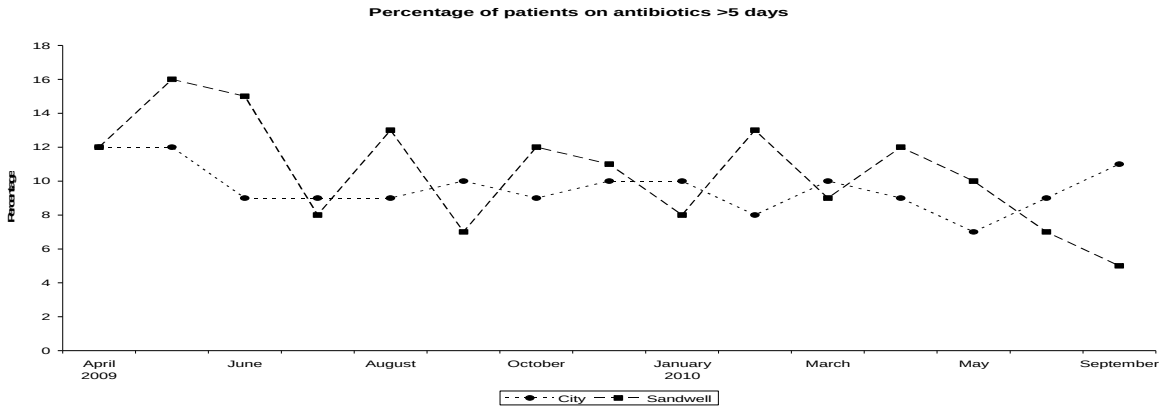
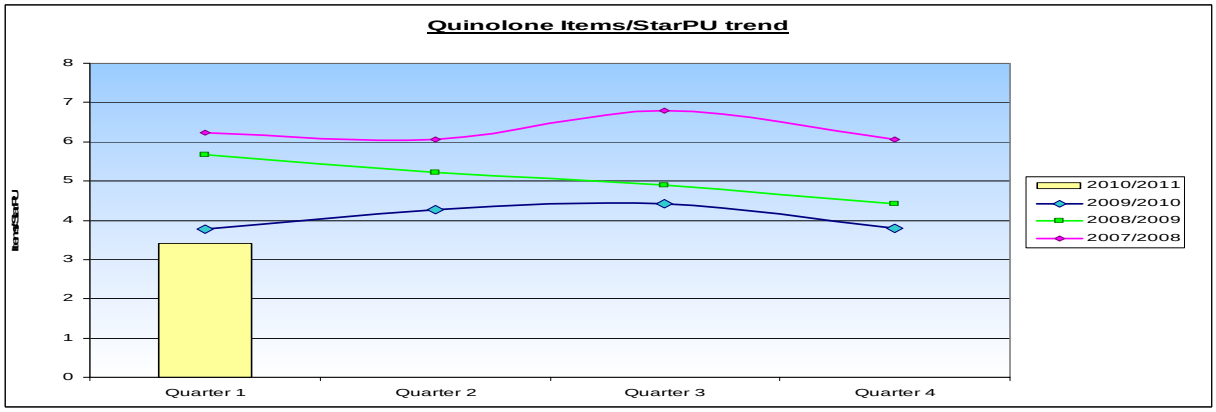


Figure 8.

We are also pleased that some of our joint working with community partners is showing major benefits for example in reductions of those antibiotics which are thought to predispose to antibiotic resistance and CDI (Figure 9).



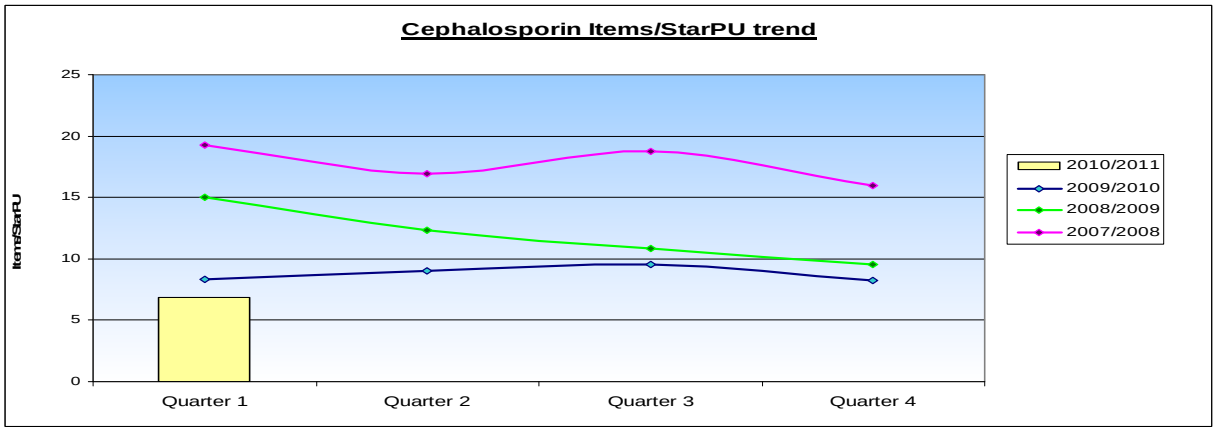


Figure 9

Training

The major project for this quarter involved ensuring that all new junior doctors starting at the Trust received both education on all infection control issues and practical hands on training on taking of blood cultures and hand hygiene. For the first time all new doctors were also given a leaflet containing guidance on all aspects of antibiotic prescribing. We are very grateful to all those who assisted in this extremely labour intensive process and feel that our infection surveillance data shows the benefits of this approach.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Cleanliness/PEAT Report
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Steve Clarke, Deputy Director - Facilities
DATE OF MEETING:	25 November 2010

SUMMARY OF KEY POINTS:

The report provides an update to the Board regarding the results from the National Standards of Cleanliness, PEAT audits and inspections for 2010.

The report provides and overview of the:

- National Standards of Cleanliness (NSoC) Guidelines
- Patient Environment Action Teams (PEAT) Assessments
- Environmental Issues

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to receive and note the report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to reduce hospital infection rates achieving national and local targets for MRSA and clostridium difficile including introducing MRSA screening in line with national guidance.
Annual priorities	
NHS LA standards	
CQC Essential Standards of Quality and Safety	To meet the National Standards of Cleanliness Guidelines.
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical	X	
Workforce		
Environmental	X	To help and assist in maintaining the patient environment.
Legal & Policy		
Equality and Diversity		
Patient Experience	X	To help and assist in maintaining the patient experience.
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Routine quarterly update.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD REPORT

CLEANLINESS & PEAT

25TH NOVEMBER 2010

The report provides an update to the Board regarding the results from the National Standards of Cleanliness, PEAT audits and inspections for April to September 2010.

NATIONAL STANDARDS OF CLEANLINESS AUDITS

The Trust has maintained its performance for the second quarter period for 2010/11 in the cleanliness of the critical areas designated as 'high' for general wards and departments and 'very high' for theatres, MAU etc.

	April 10		May 10		Jun-10		Jul-10		Aug-10		Sep-10	
	V High %	High %	V High %	High %	V High %	High %	V High %	High %	V High %	High %	V High %	High %
City	97	95	96	94	98	94	96	93	97	94	96	94
Sandwell	97	96	97	96	96	96	95	97	94	95	95	95
Rowley	N/A	98	N/A	98	N/A	97	N/A	99	N/A	99	N/A	99
BTC	98	96	97	96	97	97	97	97	98	97	96	96
Target	98	95	98	95	98	95	98	95	98	95	98	95
Overall Average	**97**	**96**	**97**	**96**	**97**	**96**	**96**	**97**	**96**	**96**	**96**	**96**

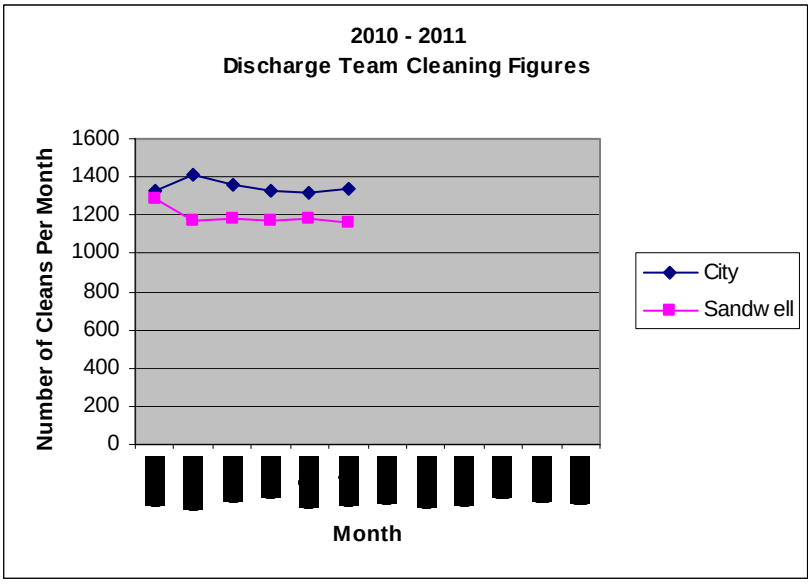
- **National Standards of Cleanliness – C4C**
  Although the above results are very good there have been questions raised resulting from the returns of the national and internal patient surveys regarding the cleanliness of wards, the survey indicates a 12% reduction in patients' perception of the ward being 'very clean'.

  A hand-held data capture system Credits 4 Cleaning (C4C) is now operational, the current room data and cleaning schedules have been transferred onto the system. Training has now been undertaken and the first review of the audits commenced the beginning of March 2010.

  There is a discrepancy between the NSoC scores and the audit results from C4C, the discrepancies are being investigated, however the majority are related to the individual's perception rather than a defined non-conformance. Further training is being undertaken with the Domestic Supervisors who are responsible for the NSoC audits.

  The next phase of the operation is to role out the C4C programme to the Supervisors who are co-coordinating the day-to-day audits.

- **Discharge Cleaning Teams – Performance**
  The discharge team is still providing a valuable service in terms of ensuring the bed space is cleaned on discharge and in terms of releasing valuable nursing time for patient care.



PEAT

- **Main PEAT Audits (External)**
  The new guidelines for the Patient Environment Action Team (PEAT) audits have been released. A range of additional policy information is now required regarding cleanliness, catering and hand hygiene.

  The PEAT inspections are planned for early February 2011 and the Facilities PPI Group members will be accompanying our in-house team on all audits.

- **PEAT Audits (Internal)**
  PEAT audits are ongoing, listed are some examples of the work undertaken this financial year:

  - Quiet rooms, ground and first floor complete (City).
  - D41 Kitchen complete.
  - D16 Linen room complete.
  - City exterior painting phase one complete, phase 2 in progress.
  - Internal ground floor main spine painting ongoing.
  - Antenatal Clinic Redecoration in progress.
  - OPD Entrance slabs complete and new roof complete. Underside of canopy refurbishment complete.
  - External fencing at City site wide regarding replacement / repair / redecoration ready to go.
  - Main spine fire panels protection rails and new frame work for text on order.
  - Flat screen TVs for City A&E.
  - OPD SGH, area fence and replacement doors complete.
  - EAU SGH, development of visitor waiting area.
  - A&E SGH, storage areas

- Dartmouth Clinic, new flooring.

- **PEAT Expenditure 2010/11**
  There are a number of major schemes currently being tendered and are due to commence asap, these include refurbishment of Sandwell ward kitchens, refurbishment of all linen rooms. A programme of redecoration for all the main hospitals buildings is also currently being undertaken.

	PEAT £000's	BED REPLACEMENT £000's	WARD EQUIPMENT £000's	TOTAL EXPENDITURE £000's
Budget	789	200	145	**1134**
Expenditure	462	68	162	**692**

ENVIRONMENTAL DEVELOPMENTS

- **Decontamination (Sandwell)**
  The bed store/wash down facility has been commissioned at Sandwell and is now part operational. The area is also the base for the porters following the rationalisation of Site Services (Porters and Security).

  The area is ideal for washing and storing mattresses but there are a number of problems with the separation of clean and dirty and storage of beds, there are also additional concerns regarding the storage of the bariatric beds. A plan and indicative costs are being put together for a phase-2 development.

- **Decontamination (City)**
  A similar facility for storage and a wash-down area is required at City and is a priority should a suitable area/ward become available on the acute spine.

- **Privacy & Dignity**

  - **Rowley Laundry**
    Plans are currently being reviewed for the upgrade of the laundry facilities to allow the Trust to process nightwear, the timescale for completion is March 2011.

  - **Nightwear**
    The specification for nightwear in terms of fire retardancy have been relaxed, (HSG 95/18) the new guidelines have opened up the market to allow for purchase of quality nightwear product from any supplier, and we are currently investigating all possibilities including working with a local/national branded name.

STEVE CLARKE
DEPUTY DIRECTOR - FACILITIES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Staff Health and Well-Being - Update
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse (Executive Lead for Workforce)
AUTHOR:	Gayna Deakin, Deputy Director of Workforce
DATE OF MEETING:	25 November 2010

SUMMARY OF KEY POINTS:

- The Trust's Staff Health and Well-Being Strategy and Action Plan was received and noted by Trust Board in June 2010.

- The Chief Nurse (Executive Lead for Workforce) was appointed by the Trust Board as Board Level Champion to drive the staff health and well-being agenda and lead the Trust's response to the NHS Health and Well-Being Review (Boorman).

- This paper provides a summary position for the Board. Attached is an update on performance against the Sickness Absence Management Plan and the action being taken to respond to the views of staff expressed at a recent LiA event. This event was held to finalise the staff health and well being action plan and to establish priorities for interventions. Progress can be summarised as follows:

    - The year to date overall average for sickness absence is 3.68% against this years internal target of 4%. The overall average for the same period in 2009 was 4.03%
    - Whilst overall sickness absence levels are improving, there are significant variations in divisional absence levels
    - Long-term absence levels have remained significantly higher than short term absence levels
    - A new service has been introduced to provide Indian head massages and shoulder and back massages as a means of relieving stress
    - Staff can now contact Physiotherapy directly
    - Advice and support on patient or load handling, ranges of equipment, hoists, slings, specialist seating etc is available from the Trust's Ergonomist
    - Weekly hypnotherapy services are being held to help with weight reduction, smoking cessation or phobias
    - BDMA Counselling Service offers a telephone support line (0800 919 765) from 7am until 11pm for staff who are experiencing difficulties or are worried about work or personal issues. Face to face counselling can be arranged if required
    - The Occupational Health Service will be introducing a programme of staying healthy topics starting from January 2011

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	An Effective Organisation
Annual priorities	Make improvements to the health and well-being of staff, including reducing sickness absence (6.11)
NHS LA standards	Sickness Absence (3.2)
CQC Essential Standards Quality and Safety	Regulation 22: Outcome 13 (Staffing) Regulation 23: Outcome 14 (Supporting Workers)
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical		
Workforce	**X**	Staff Health and Well-Being is a key element of the Trust's Workforce strategy and organisational development plans.
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Progress towards the implementation of the Staff Health and Well-Being Strategy and Action Plan is monitored by the Staff Health and Well-being Committee and reported to the Health, Safety and Welfare Committee and Governance Board.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

STAFF HEALTH AND WELL-BEING

Trust Board Update - November 2010

1. Introduction

The purpose of this paper is to inform the Trust Board of the actions taken and the progress made in implementing the Staff Health and Well-Being Strategy and Action Plan. It will give an overview of the work being undertaken with regards to reducing levels of sickness absence and improving staff health and well-being.

2. Background

The staff health and well-being agenda is an integral part of the Trust's workforce strategy, building a high quality workforce. It compliments and supports the Trust's wider organisation development plans and the Quality and Efficiency Programme (QuEP). It relies upon a more preventative approach to managing sickness absence with the aim of leading to further reduction in sickness absence levels and improved staff satisfaction.

The Staff Health and Well-Being Committee is responsible for overseeing the implementation and action plan and reports to the Trust Governance Board through the Trust's Health, Safety and Welfare Committee.

The Chief Nurse (Executive Lead for Workforce) is the Board level champion and the Trust Board has requested an update on progress with regards to improving staff health and well-being twice a year. This is the first of such reports and the second report will be provided in May.

3. Progress to date

A robust sickness absence management plan has been developed to achieve the reductions in sickness absence required. Progress against the plan is monitored by the workforce utilisation QuEP group. Regular progress reports are provided to the Trust Management Board. The following provides a summary position and a full update position is attached, for information, at Appendix 1:

- The year to date overall average for sickness absence is 3.68% against the Trust target of 4%. The overall average for the same period in 2009 was 4.03%
- Whilst overall sickness absence levels are improving, there are significant variations in divisional absence levels
- Long-term absence levels have remained significantly higher than short term absence levels
- A new service has been introduced to provide Indian head massages and shoulder and back massages as a means of relieving stress
- Staff can now contact physiotherapy services directly
- Advice and support on patient or load handling, ranges of equipment, hoists, slings, specialist seating etc is available from the Trust's Ergonomist
- Weekly hypnotherapy services are being held to help with weight reduction, smoking cessation or phobias
- BDMA Counselling Service offers a telephone support line (0800 919 765) from 7am until 11pm for staff who are experiencing difficulties or are worried about work or personal issues. Face to face counselling can be arranged if required.

A staff engagement event was held in August to involve staff in highlighting areas for improvement and to identify priorities for action. Staff identified priorities for improving workplace health as follows:

- Most staff (47%) ranked '**managing long-term sickness absence and incapacity for work'** first with 81% including this in their top 3 priorities.

- '**promoting physical activity in the workplace'** was next popular and selected as top priority by 21% of staff with 74% including this in their top 3 priorities.

- **'promoting mental well-being through productive and healthy working conditions'** follows marginally behind and was selected top priority by 19% of staff and in the top 3 priorities of 70%.

- **'Obesity'** was top priority for 11% of staff and appears in the top 3 priorities of 30%.

- **'Smoking cessation'** was only considered to be a top priority by 2% of staff and features in the top 3 priorities of 13%

A set of quick wins were agreed on the day and are set out as follows:

- Improving the provision of health eating options in staff restaurants/outlet
- Email Rules to help reduce the number of emails received
- Good Manners/Smile Audit
- Communicate staff support and benefits available
- Rules/messages re long hours culture/saying no
- Introduce 360 degree appraisal for Band 7 and above
- Consider meetings culture
- Develop communicating change template
- Redeployment bank to facilitate avoidance of sickness absence/earlier return to work
- Set out expectations at recruitment about importance of staff well being and good attendance

4. Key Actions and Issues

It has not been possible to secure additional or a dedicated resource to make speedy progress with the wider well-being agenda. Funding has just been identified to appoint a dedicated role for a four month period. Further funding avenues are being considered but have yet to prove successful.

The following 'quick wins' are currently being introduced:

- Implementation of revised Flexible Working Policy
- Email etiquette/tips for managing the 'inbox'
- Staff support and benefits catalogue
- Healthy eating plan to improve range of healthy eating options
- Communicating change briefing sheet for managers
- Expectations about staff attendance to be included in recruitment documentation/ Induction Programme/ Appraisals
- Redeployment bank to facilitate avoidance of sickness absence/earlier return to work

Plans to introduce the remaining 'quick wins' will be agreed at the Health and Well-Being Committee in December.

The Occupational Health Service will be introducing a programme of staying healthy topics starting from January 2011.

5. Conclusion

Good progress is being made against the Sickness Absence Management Plan and steady progress is being made in implementing the Staff Health and Well-Being Strategy. It is essential that the factors affecting staff attendance and well-being continue to maintain a high profile within the organisation and links continue to be made with plans for staff satisfaction (national staff survey findings and action plan), leadership development (leadership framework) and staff engagement (Listening into Action).

6. Recommendations

The Trust Board is asked to **receive** and **note** this update report.

Appendix 1

Sickness Absence Management – Update
October 2010

1.0 Introduction

The purpose of this paper is to update the Trust on regarding key findings and developments impacting upon sickness absence management.

2.0 Sickness Absence Rates - 2010

Apr – 10			May – 10			Jun – 10			Jul – 10		
ST	LT	Total	ST	LT	Total	ST	LT	Total	ST	LT	Total
0.95%	**3.01%**	**3.96%**	**0.87%**	**2.71%**	**3.58%**	**1.00%**	**2.68%**	**3.68%**	**0.87%**	**2.73%**	**3.60%**
Apr – 09			May – 09			Jun – 09			Jul – 09		
ST	LT	Total	ST	LT	Total	ST	LT	Total	ST	LT	Total
1.09%	**2.50%**	**3.59%**	**1.10%**	**2.58%**	**3.68%**	**1.26%**	**2.60%**	**3.86%**	**1.51%**	**3.16%**	**4.67%**

Aug – 10		
ST	LT	Total
0.87%	**2.73%**	**3.60%**
Aug – 09		
ST	LT	Total
1.17%	**3.19%**	**4.36%**

As demonstrated within the table above;

- Long term absence levels have remained significantly higher than short term absence levels
- Over the 5 month period Apr 10 – Aug 10, overall Trust sickness absence levels have remained below 4%.

The Trusts year to date overall average sickness absence level is 3.68%, which is an improvement compared to the average rate over the same period in 2009 which was 4.03%. Even though overall Trust sickness absence levels are improving, there are significant variations in terms of divisional absence levels.

3.0 Sickness Absence Audits

Sickness absence audits have been developed as a method for assessing compliance with the requirements of the Trusts Sickness Absence Policy and Guidance Notes. They form part of the evidence for NHSLA assessment.

During Jan - June 2010, 30 managers have been audited for short term sickness absence management and 30 for long term sickness absence management. The table below shows some of the main findings.

Short term sickness absence:

Positive findings	Areas that require improvement
Local departmental procedures for reporting and notification of sickness absence.	Completion of sickness absence statements for all episodes of absence. Completion of all required data fields.
Good overall knowledge of sickness certification rules.	Return to work interviews to be conducted following all episodes of absence.
Evidence of monitoring systems for sickness levels.	Communication during sickness reviews of the possible consequences of further absences.
Consideration and implementation of reasonable adjustments and rehabilitation programs.	Accurate recording of sickness data in ESR.
Formal sickness reviews are being held to address high levels of sickness absence.	Undertaking of PDR's as per Trust policy.

Long term sickness absence:

Positive findings	Areas that require improvement
Good overall referral rates to Occupational Health.	Pre-absence discussions in cases of pre-planned absence.
Consideration and implementation of reasonable adjustments & rehabilitation programs.	Ensuring employees PDR's and Mandatory training is up to date.
Good levels of communication with absent employees.	Accurate recording of sickness data in ESR.

Overall findings are positive in that managers are demonstrating knowledge of and implementation of policy requirements. There are however areas that need improvement to ensure both consistency in practice and effective management.

4.0 Analysis of long term sickness absence cases

The Human Resources Department utilise an in-house database for recording details of long term sickness absence cases. This serves as a useful tool for central recording of key actions taken during case management and enables analysis to be undertaken.

The following is a snapshot of analysis undertaken on cases that are classed as 'closed' (i.e. the individual is no longer absent) for the year Aug 2009 – July 2010.

4.1 Length of absence

A breakdown of the length of absence for each case of long term sickness absence during this period is shown below.

Length of Absence in Months	Number of Cases	Percentage
0-1	23	6.1%
1-2	135	35.6%
2-3	75	19.8%
3-4	55	14.5%
4-5	36	9.5%
5-6	23	6.1%
6-7	6	1.6%

7-8	5	1.3%
8-9	3	0.8%
9-10	4	1.1%
10-11	3	0.8%
11-12	3	0.8%
12+	8	2.1%
Total	**379**	**100.0%**

In the largest proportion of cases (35.6%) absence lasted for 1-2 months. In 34.3% of cases, absence lasted between 2 and 4 months. A minority of cases (8.5%) continued beyond 6 months absence.

4.2 Reasons for absence

Reasons for absence (as recorded on the case tracker) varied greatly, with the majority of absences (57.8%) being for the following reasons: Stress & Anxiety (19.5%), Surgery (16.4%), Musculo-skeletal other joint, lower limb (13.2%), Musculo-Skeletal Back (8.7%).

Support is available within the Trust for staff experiencing these types of conditions for example, BDMA counselling service, staff physiotherapy service, moving & handling risk assessments and pre-planned surgery Occupational Health referrals. The Trusts Stress Policy has also recently been updated to include an individual risk assessment to aid in the management of individual concerns.

These support mechanisms are communicated via the corporate sickness absence training sessions and via the Occupational Health service, however raising awareness of these support options, particularly with employees, may help to increase their utilisation and thus reduce the level of absence related to these conditions.

4.3 Referral time to Occupational Health

Of the 379 long term cases, the length of time taken for managers to refer to Occupational Health has not been reported in 98 cases (this is being addressed).

Of the 281 cases where this data is available, 61% of referrals to Occupational Health were made within 0-2 months of the employee's absence commencing and 40% were made after 2 months absence. It is concerning that a significant number of cases are not referred to Occupational Health until this late stage as this delays the receipt of medical advice which for most cases is instrumental to effective management.

It is positive that where referrals to Occupational Health were made before 4 weeks continuous absence, in 80.5% of these cases the reason for absence were musculo-skeletal, psychological or surgery. This is evidence that managers are demonstrating adherence to Trust Policy which stipulates that early referral should be made for these types of conditions.

4.4 Rehabilitation

Out of 379 cases of long term sickness absence, 174 cases (46%) have utilised a rehabilitation program to facilitate an earlier return to work. Only 8 of these were not successful.

The use of rehabilitation programs are positive for the Trust as they reduce the length of sickness absence periods and they are positive for employees, in that they enable a gradual return to normal duties/hours which can be difficult following periods of long term sickness absence. Long term sickness absence levels have fallen in part due to utilisation of rehabilitation programs which have facilitated an earlier return to work.

4.5 Redeployment

3 cases of long term sickness absence have necessitated a search for permanent redeployment. 1 case was successful in securing redeployment, where as 2 cases were not successful and resulted in termination of employment.

4.6 Workplace modifications

Workplace modifications were made in 43 cases in order to assist an employee return to and remain at work. The types of modifications made were varied, including (for example) provision of equipment, additional training and changes to working hours/pattern.

It is positive that managers are demonstrating such flexibility to assist employees.

4.7 Ill health dismissals

8 cases have resulted in ill health dismissal. The length of absence prior to dismissal ranges from 5 – 25 months. The average length being 8.4 months (excluding cases of 12 months plus). 3 cases have been 12 months plus.

5.0 Short term sickness absence

Levels of short term sickness absence are consistently significantly below that of long-term sickness absence.

Between Aug 2009 – July 2010, 15 cases of short term sickness absence have been formally investigated. 11 disciplinary hearings have been held, 8 of which have resulted in formal disciplinary sanctions being issued and 3 have resulted in dismissal. 3 cases are not yet concluded and 1 case has resulted in the employee resigning.

Although the numbers are quite low, this clearly indicates that action is being taken in a number of cases where levels of absence are below an acceptable level.

Further changes to the Trusts Sickness Absence Policy are currently being considered and consulted on, the most significant of which being changes to the Trust 'triggers for formal review' and 'targets' set, with the aim to allow for more effective management of short term sickness.

6.0 Sickness absence management action plan

Effective from June 2010 the Trust has developed a formal action plan for sickness absence management. This action plan is reviewed by the Workforce QuEP group, (chaired by Rachel Overfield) with one of this groups main objectives being to monitor and drive implementation of the action plan.

One of the actions currently of focus is improving the quality and accuracy of sickness absence data in ESR to allow for accurate reporting and development of appropriate and focused action plans.

To date, reasons for absence have not been robustly recorded in ESR. For illustration, over the period Apr – Sept 2010, there were 5346 episodes of sickness absence, yet reasons were not recorded in 38% of cases.

Communication is currently being disseminated regarding the importance of and requirement to report reasons for absence and the new requirement to complete return to work interview dates (for all episodes of absence) and Occupational Health Referral dates (as appropriate). Compliance with this will be monitored and areas targeted should improvements be required.

Other actions currently being considered include (for example); the introduction of 'Thank you' letters in recognition for good attendance; the issuing of a sickness absence leaflet at Trust Induction to highlight the Trusts expectations upon joining the Trust and including sickness absence as a standard area in Personal Development Reviews (PDR's).

As detailed in section 2 of this report, there are significant variations between divisions in terms of sickness absence levels. Those areas with high levels of sickness absence are being required to produce divisional action plans to address this.

7.0 Key Actions

- Continue review of the Trusts Sickness Absence policy, being mindful of potential implications that any revisions may have to the impending NHSLA assessment in February 2011.

- Review corporate sickness absence training program, particularly in light of the audit /case tracker analysis findings.

- Provide feedback to divisions of the findings from the sickness absence audits and case tracker analysis, focussing on common areas of good practice and areas for improvement.

- Raise the profile of the importance of accurate sickness absence reporting.

- Continue with sickness absence audits.

- Consider further actions required as per the Sickness Absence Management action plan and the Trust's Health and Well-Being Strategy.

8.0 Conclusion

Work is ongoing in relation to implementation of the corporate sickness absence management action plan with the various actions being "on track" for completion.

It is also positive that Divisions with high sickness absence levels are taking action to address this by developing their own Divisional action plans. It is essential that focus remains on progressing and implementation within the health and well being agenda.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

POLICY TITLE:	Equal Pay Audit
ACCOUNTABLE DIRECTOR:	Rachel Overfield, Chief Nurse
POLICY AUTHOR:	Gayna Deakin / Lesley Barnett, Deputy Director - Workforce
DATE OF MEETING:	25 November 2010

SUMMARY OF KEY POINTS:

An equal pay audit was carried out on all employees on Agenda for Change (AFC) Terms and Conditions / Medical and Dental Terms and Conditions, medical staff on local terms and conditions and employees on the Directors and Chief Executive Pay scale in post in January 2010. The audit findings were that there were no statistically significant variances in the analysis of basic pay of male and female staff on AFC terms and Conditions.

There were statistical variances in a number of pay-scales however further analysis indicated there was no evidence that pay inequality was due for gender or ethnicity in relation to employees on AFC terms and conditions. With regard to medical staffing post some anomalies have been highlighted and should be addressed by the movement of staff on old contracts to new Specialty Doctor and Associate Specialist payscales.

PURPOSE OF THE REPORT:

To assess whether there was inequity in pay due to gender, ethnicity or disability and to fulfil a statutory requirement to comply with the Gender Equality Duty Code of Practice and the Trust Single Equality Scheme.

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. The Trust Board is recommended to note the findings of the audit
2. Director of Governance to review criteria for appointments on trust terms and conditions
3. Director of Governance to continue to implementation process for movement to Specialty doctor and Associate Specialist contracts

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

This report was presented to the Equality and Diversity Steering Group on 15th February 2010

Report to	**Trust Board**
Report from	**Stephanie Cowin, Human Resources Manager**
Date	**6th February 2010**
Title	**Equal Pay Audit**

Introduction

The objective of an equal pay audit report is to assess whether there is inequity in pay due to gender, ethnicity or disability and to fulfil a statutory requirement to comply with the Gender Equality Duty Code of Practice and the Trust Single Equality Scheme.
There are 3 pay systems covering the majority of employees of SWBH as follows:

- 6,189 employees on Agenda for Change (AFC) pay system representing 87.6% of the workforce,
- 861 employees on Medical and Dental Terms and Conditions of Service representing 12.2% of the workforce,
- 10 employees on Directors and Chief Executive Pay scale representing 0.14% of the workforce

In addition there are 4 employees on protected senior manager local terms and conditions representing 0.06% of the workforce

Coverage

All employees on Agenda for Change Terms and Conditions / Medical and Dental Terms and Conditions, medical staff on local terms and conditions and employees on the Directors and Chief Executive Pay scale in post in January 2010 were covered by the audit. Employees on protected senior manager local terms and conditions following assimilation to AFC terms and have been excluded from this report.

Objectives

The Equal Pay audit provides information to the Equality and Diversity Steering Group on whether the application of the Trust pay systems are operating equitably, irrespective of gender and ethnicity; detail the nature of any inequalities; analyse the factors creating inequalities and diagnose the cause or causes; and identify what action is required to deal with any inequalities revealed

Audit Methodology

The Equal Pay Audit has three stages namely: pay gap analysis, pay gap diagnosis and identification of corrective action.

Pay Gap Analysis

In the first stage analyses have been carried out on relative rates of pay for male and female employees and on relative rates of pay for ethnic groups. The aim was to establish the degree to which inequality exists in the form a significant pay gap. The audit did not include a comparison of pay of employees on grounds of disability because only 3% of employees have declared a disability status which is too small to capture any meaningful data.

To establish a baseline, the approach used by the NHS Information Centre was adopted. The figures were calculated as follows

$$\text{Mean Salary} = \frac{\text{Total Basic Salary for pay band}}{\text{Total Head Count for pay band}}$$

Median Salary= The middle value of the ordered Salary data for the pay group. The median is less influenced by outliers/ extreme values compared to the mean salary.

Using the two measures together allows a deeper understanding of the gaps between 2 groups. The mean may show a gap however looking at the mean and the median allows a fuller appreciation of any gaps.

Pay Gap Analysis

In line with advice from the Information Centre, a variance of 5% or more for both the mean and median salary were taken to warrant further investigation to clarify the rationale for pay differentials

Conclusions

The audit findings were that there was no statistically significant variances in the analysis of basic pay of Male and female staff on AFC terms and Conditions.

There were statistical variances in a number of pay-scales however further analysis indicated there was no evidence that pay inequality was due for gender or ethnicity in relation to employees on AFC terms and conditions. With regard to medical staffing post some anomalies have been highlighted and should be addressed by the movement of staff on old contracts to new Specialty Doctor and Associate Specialist pay-scales.

Recommendations

1. The Trust Board is recommended to note the findings of the audit
2. Director of Governance to review criteria for appointments on trust terms and conditions
3. Director of Governance to continue to implementation process for movement to Specialty doctor and Associate Specialist contracts

Pay Gap Analysis Basic Pay of females compared to Males on AFC terms and Conditions		Pay Gap Diagnosis
There are no AFC pay bands in which there is a variation of 5% or more between the mean basic pay of female and male employees. The variances were as follows: AFC Band 1 (-0.56%) AFC Band 2 (+3.03%) AFC Band 3 (+1.61%) AFC Band 4 (+2.53%) AFC Band 5 (+0.25%) AFC Band 6 (+1.21%) AFC Band 7 (+2.20%) AFC Band 8A (-0.54%) AFC band 8B (-3.85%) AFC Band 8C (-1.09%) AFC Band 8D (-2.41%) AFC Band 9 (+0.22%)	There are no AFC pay bands in which there is a 5% or more variance when comparing the median pay rates of female employees as a percentage of the median pay rate for male employees as follows AFC Band 1 (0.00%) AFC Band 2 (0.00%) AFC Band 3 (0.00%) AFC Band 4 (+1.75%) AFC Band 5 (-0.70%) AFC Band 6 (0.00%) AFC Band 7 (0.00%) AFC Band 8A (+1.93%) AFC Band 8B (-2.72%) AFC Band 8C (-3.24%) AFC Band 8D (-4.75%) AFC Band 9 (2.12%)	Given that there are no significant consistent patterns in variances to pay in relation to median and mean pay for full time male and female employees on AFC terms and Conditions, no further analysis will be required.

Pay Gap Analysis Analysis of basic pay of females compared to males on Medical and Dental Terms and Conditions	Pay Gap Diagnosis
There are 6 pay bands in which there is a variation of 5% or more between the mean basic pay of female employees and male employees. These are as follows: Associate Specialist (-6.25%) Specialty Doctor (-7.67%) Specialty Registrar (-6.04%) Staff Grade (-7.48%) Trust Grade Doctor –Career Grade Level (93.32%) Trust Grade Doctor – Specialist Registrar Level (198.32%) There are 3 pay bands in which there is a 5% or more variance when comparing the median pay rates of female employees as a percentage of the median pay rate for male employees as follows: Specialty Doctor(-9.29%) Trust Grade Doctor - Career Grade Level (+93.32%) Trust Grade Doctor - Specialist Registrar Level (+111.31%)	Adopting the approach that where there is a variance of 5% or more in pay using both median and mean pay further analysis was carried out on these pay band as follows: **Specialty Doctors** There are 5 females and 11 males in post with spinal values of pay ranging from £36,443 to £67,959. Medical staffing have advised that doctors have been appointed on the pay scale in accordance with the Specialty Doctor Pay scale **Trust Grade Doctor - Career Grade Level** There is 1 female and 2 males in post with spinal values of pay ranging from £26,071 to £75,439. There is no pay-scale for this pay band and post holders are paid on locally determined spot rates. 2 post holders transferred onto this pay scale as a result of a TUPE transfer and 1 post holder was appointed to the pay-scale following his retirement as a consultant and subsequent as a part time consultant teacher. **Trust Grade Doctor - Specialist Registrar** When the audit was carried out there are 5 females and 4 males in post with spinal values of pay ranging from £22,500 to £104,286.. The post holders assigned to the lower pay rates £22,500 to £30,000 are fellows in ophthalmology and post holders on £104,286 are GP's with a special interest in dermatology. 3 post holders terminated their employment in February 2010.

<table>
<tr><th>Pay Gap Analysis

Analysis of basic pay of females compared to males on Directors and Chief Executive pay scale</th><th>Pay Gap Diagnosis</th></tr>
<tr><td>There are 9 employees in post with spinal value ranging from £98,455 to £162,000.
There is a variation of (-21.36%) between the mean basic pay of females compared to males and a variation of (-17.33%) between the median basic pay of females compared to males.</td><td>Remuneration for this group was formally reviewed in 2008 by independent consultants using a combination of job weight analysis and benchmarking data. The Remuneration Committee set salaries based on this review, effective 1-4-09</td></tr>
<tr><th colspan="2">Pay Gap Analysis

Analysis of basic pay of employees on AFC terms and Conditions by Ethnicity</th><th>Pay Gap Diagnosis</th></tr>
<tr><td>There are 7 instances in which there is a variation of 5% or more between the pay band mean in comparison with an ethnicity category as follows:

AFC Band 5 Mixed Heritage (-5.76%)
AFC Band 7 Mixed Heritage (-5.32%)
AFC Band 8A Mixed Heritage (+6.91%)
AFC Band 8B Black (-10.33%)
AFC Band 8C Asian (-6.89%)
Black (-13.23%)
Other Ethic Group (-6.89%)</td><td>There are 8 instances in which there is a variation of 5% or more between the pay band median in comparison with an ethnicity category as follows:

AFC Band 3 Other Ethnic Group (+6.19%)
AFC Band 8A Mixed Heritage (+11.61%)
Not stated (+8.33%)
AFC band 8B Asian (+5.58%)
Not stated (+11.17%)
Other Ethnic (+11.17%)
AFC Band 8C Black (-10.97%)
AFC Band 8D Not stated (+7.59%)</td><td>Adopting the approach that where there is a variance of 5% or more in pay using both mean and median pay further analysis may be carried out for the following employees. However given the low numbers of employees involved in the AFC Band 8A mixed Heritage category further analysis is not required

AFC Band 8A
Mixed Heritage 1 out of 172 employees
AFC Band 8C
Black 1 out of 29 employees

The 8C post holder was appointed to an acting 8C post in November 2009 and therefore was</td></tr>
</table>

		appointed in accordance to AFC terms and Conditions to the bottom of the pay scale.

Pay Gap Analysis Analysis of medical staff by Ethnicity		**Pay Gap Diagnosis**
There are 13 instances in which there is a variation of 5% or more between an ethnic group and the pay band mean: Associate Specialist Not Stated (+9.30%) Senior House Officer Black (-6.86%) White (-6.86%) Specialist Registrar Other Ethnic (-5.77%) Specialty Doctor Asian (-6.24%) Black (+6.90%) Mixed Heritage (+26.55%) Other Ethnic (+13.45%) Specialty Registrar Not Stated (+8.19%) Staff Grade Black (16.90%) Other Ethnic (-11.94%) Trust Grade Doctor- Specialist Registrar Level Other Ethnic (-63.68%) White (+24.33%)	There are 16 instances in which there is a variation of 5% or more between the pay band median in comparison with an ethnicity category as follows: Associate Specialist Not Stated (+8.19%) Hospital Practitioner Asian (+14.80%) Senior House Officer Black (-5.78%) White (-5.78%) Specialty Doctor Asian (-5.60%) Black (+9.88%) Mixed Heritage (+30.08%) Not Stated (+6.59%) Other Ethnic (+16.61%) White (-7.89%) Staff Grade Asian (+5.38%) Black (+26.89%) Not Stated (+16.13%) White (+13.44%) Trust Grade Doctor- Specialist Registrar Level Other Ethnic (-38.27%) White (+73.92%)	Adopting the approach that where there is a variance of 5% or more in pay using both mean and median pay further analysis was carried out for the following: **Associate Specialist** Not Stated 2 out of 25 employees **Senior House Officer** Black 1 out of 5 employees White 1 out of 5 employees **Specialty Doctor** Asian 9 out of 16 employees Black 1 out of 16 employees Mixed Heritage 1 out of 16 employees Other Ethnic 1 out of 16 employees **Staff Grade** Black 1 out of 20 employees **Trust Grade Doctor- Specialist Registrar Level** Other Ethnic 1 out of 9 employees White 3 out of 9 employees **Associate Specialist** There are 25 employees in post with spinal values ranging from £66,827 to £80,953. There are 2 pay scales an old pay scale ranging from £37,321 to £80,953 and a new pay scale ranging from £51,095 to £84,106. There are 2 employee on the new pay scale and 23 employees on the old pay scale with 17 post holders with discretionary points. The Head of Medical Staffing has advised that he is working with the relevant clinical directors to offer post holders on the old pay scale the opportunity to

		transfer to the new Associate Specialist pay scale. **Senior House Officer** There are 5 employees in post with spinal values ranging from £29,232 to £38,322. There are 3 employees on pay protection, 1 employee is a teaching fellow and 1 post holder is a SpR radiologist employee which SWBH acts as paymaster for and not employed by SWBH. **Specialty Doctor** There are 16 employees in post with spinal values ranging from £36,443 to £67,959. Medical staffing have advised that doctors have been appointed on the pay scale in accordance with the Specialty Doctor Pay scale **Staff Grade** There are 20 employees in post with spinal values ranging from £23,473 to £63,244. There are 2 pay scales with the old pay scale ranging from £33,762 to £52,523 and a new pay scale ranging from £33,762 to £63,244. There are 4 post holders on the new contract and the Head of Medical Staffing has advised that he about to commence the process with clinical directors of offering new contracts to remaining doctors on the old on the pay scale **Trust Grade Doctor- Specialist Registrar Level** When the audit was carried out there are 5 females and 4 males in post with spinal values of pay ranging from £22,500 to £104,286. The post holders assigned to the lower pay rates £22,500 to £30,000 are fellows in ophthalmology and post holders on £104,286 are GP's with a special interest in dermatology. 3 post holders terminated their employment in February 2010.

Pay Gap Analysis	**Pay Gap Diagnosis**
Analysis of basic pay of employees on Directors and Chief Executive pay scale by ethnicity	

There are 9 employees in post with spinal value ranging from £98,455 to £162,000. There are 2 instances in which there is a variation of 5% or more between an ethnic group and the pay band mean: Not Stated (-9.76%) Asian (-15.42%) There is 1 instance in which there is a variation of 5% or more between an ethnic group and the pay scale median Asian (-6.23%)	Remuneration for this group was formally reviewed in 2008 by independent consultants using a combination of job weight analysis and benchmarking data. The Remuneration Committee set salaries based on this review, effective 1-4-09

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Assurance Framework 2010/11 – Quarter 2 Update
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	25 November 2010

SUMMARY OF KEY POINTS:

This report is provided to update the Governance and Risk Management Committee on progress with actions undertaken to address the gaps in control and assurance against corporate objectives, which were identified in the Assurance Framework.

A summary of pre and post mitigation scores is below:

Pre mitigation		Post mitigation	
Risk Status	**Corporate Objectives**	**Risk Status**	**Corporate Objective**
RED	1.2, 2.1, 2.4, 2.6, 2.7, 2.8, 2.9, 2.10, 2.11, 3.2, 4.4, 6.1, 6.5, 6.6	**RED**	None
AMBER	1.1, 1.4, 1.5, 2.2, 2.3, 3.1, 4.1, 4.2, 5.2, 6.3, 6.4, 6.8, 6.10	**AMBER**	1.1, 1.4, 2.1, 2.3, 2.4, 2.6, 2.7, 2.9, 2.11, 3.1, 3.2, 4.1, 4.2, 4.4, 5.2, 6.1, 6.3, 6.5, 6.8,
YELLOW	1.3, 2.5, 4.3, 5.1, 5.3, 5.4, 6.2, 6.9, 6.11	**YELLOW**	1.2, 1.3, 1.5, 2.2, 2.5, 2.8, 2.10, 4.3, 5.1, 5.3, 5.4, 6.2, 6.4, 6.6, 6.9, 6.10, 6.11
GREEN	None	**GREEN**	None

Following the application of the proposed mitigating treatment, no risks remain at red status.

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 risks associated with the delivery of the Trust's corporate objectives and progress with actions to address the gaps in assurance and control.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Relevant to all strategic objectives
Annual priorities	Relevant to all annual priorities
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Supports the evidence required for the internal Control dimension

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:

Governance and Risk Management Committee on 18 November 2010.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ASSURANCE FRAMEWORK 2010-11 – QUARTER 2

The Assurance Framework provides the Trust with a simple and comprehensive method for the effective and focused management of the principal risks to meeting its corporate objectives. It also provides evidence to support the Statement on Internal Control.

The Framework identifies where action plans are needed to develop further controls and assurances to allow more effective management of the Trust's risks. These are reflected in the Trust Risk Register.

October 2010

Abbreviations:

CE	Chief Executive
CN	Chief Nurse
COO	Chief Operating Officer
DE / NHPD	Director of Estates/New Hospital Project Director
DFPM	Director of Finance and Performance Management
DG	Director of Governance
MD	Medical Director

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

ASSURANCE FRAMEWORK 2010/11

Principal risks				Controls			Assurances		Action plan to address gaps		Progress with the actions planned to address gaps			
	Pre-mitigation			Key controls	Assurances on controls	Gaps in controls	Positive assurances	Gaps in assurance				Post-mitigation		
What could or is preventing this objective from being achieved?	Probability	Severity	Risk score	*What controls / systems we have in place to assist in securing delivery of our objective*	*Where can we gain evidence that our 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 in making them effective?*	*We have evidence that we are reasonably managing our risks and objectives are being delivered*	*Where are we failing to gain evidence that our controls / systems, on which, we place reliance, are effective?*	*What needs to be done to address the identified gaps in control and assurance*	*Executive Lead and due date*	*Outline of progress to date on actions taken to minimise risk and/or progress with addressing the gaps in control and assurance*	Probability	Severity	Risk score
1. Accessible and Responsive care														
1.1 Continue to achieve national waiting time targets (including A&E, cancer targets and 18 weeks)														
High levels of demand for elective and/or emergency treatment mean that the Trust does not have capacity to hit targets.	4	3	**12**	Well established system for managing capacity.	Daily, weekly and monthly performance reports. Comparative performance with rest of SHA.	No significant gaps in control	The Trust systems have a track record of delivery.	No significant gaps in assurance.	No significant gaps.	COO	Revised action plan agreed in August for capacity changes and patient flow issues focussing on directorate by directorate activity.	4	3	**12**
Planned reductions to bed capacity take place without associated service changes resulting in insufficient capacity to hit targets.				Project team established chaired by Deputy COO.	Progress with capacity reductions reviewed at FMB and F&PC through CIP reports.	Currently have range of actions plans rather than single comprehens ive plan.	Regular reports to FMB and F&PC show progress.	No significant gaps in assurance.	Project team to pull together single action plan for all changes to capacity during 2010/11.		Winter plan arrangements now operational in order to provide capacity to cover the winter period.			

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
1. 2 Continue to improve the experiences of our patients by focusing on basic nursing care and standards of privacy and dignity														
a) Inadequate staffing levels	4	4	**16**	-Minimum staff policy -Establishment reviews -E-rostering -Bank and agency provision -Recruitment strategies	-Ward reviews -Quality audits -Incident reporting trends -Staff in post figures -Bank use		Board reports x 2 year. Incident and complaint reports. Bank reports.		Continue ward reviews. Implement e-rostering and activity measurement tools. Regular establishment reviews.	CN	No further update	4	2	**8**
b) Staff not focussed on delivery of high quality care.				-Training and competency assessment -Policies on basic care provision -Stated standards expected -Patient surveys -Carer surveys -Facilitators -Patient Experience Committee -Optimal Wards	-Ward Reviews -Quality audits -Survey results -Incident data -Patient feedback/ stories -Patient Experience Committee minutes.		Board reports. Complaint and incident reports. CQUIN targets. Patient survey reports.		Data collection. Increase frequency audits and observations of care. Reporting regularly. Appropriate equipment.					
1.3 Make communication with GPs about their patients quicker and more consistent														
Insufficient management capacity to make changes to communication as well as other changes.	4	2	**8**	Project team being established and key measures being identified.	Limited current assurances.	No system at present for measuring / reporting progress on this objective.		No system at present for reporting progress on this objective.	Establish clear project plan for improvement. Identify measures and introduce system for reporting progress.	COO (Sept)	Action plan being developed for this area of work but not yet finalised due to lack of operational capacity. Will seek to progress further in Q3 and Q4.	4	2	**8**
Limitations in the Trust's IT restrict the scale of change that can be delivered.				As above	As above.	As above.		As above,	As above.					

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
1.4 Improve our outpatient services, including the appointments system (QuEP)														
Insufficient management capacity to make changes to outpatient system on scale required.	3	4	**12**	Outpatient project board and project team established. Both chaired by COO. Project plan agreed.	Operational progress reviewed at project board and COO team meeting. Progress overseen by FMB and F&PC.	No system for reporting key measures by directorate.	FMB and F&PC oversight of progress with project.	No system for wider reporting of actions and progress to consultants / external stakeholders.	New trust dashboard to include key measures of success on this objective at directorate level. Monthly "public" report on progress and performance to be produced for wide dissemination.	COO (Jul) COO (Jul)	Good progress now being made with key actions to ensure improvement in outpatient systems. Monthly outpatient scorecard now reviewed by COO and operational team to measure progress.	3	4	**12**
Changes to the system for booking follow-up appointments and reducing cancellations to be piloted in autumn do not have expected effect.				Project plan agreed for BMEC pilot in autumn. Overseen by OP project board.	As above.	As above.	As above.	As above.	As above.					
Continued high levels of elective demand mean we remain reliant on high levels of premium rate activity.				System introduced for tracking PRW sessions. Plans being developed with directorates to address key concerns.	As above.	As above.	As above.	As above.	Monthly PRW reports to be shared from June onwards. Directorate-level plans to be agreed to reduce where necessary.	COO (Jul) COO (Sept)	Premium rate tracking systems now fully in place and plans agreed with directorates making heavy use. Overall levels of PRW have not reduced due to need to make further progress on waiting times before end of the year.			
1.5 Make improvements to staff attitude by ensuring our customer care promises become part of our day to day behaviour and are incorporated into the recruitment process														
Failure to effectively embed promises in day to day working of Trust	3	3	**9**	Implementation action plan developed, including recruitment aspects	Implementation plan monitored by LiA sponsor group	None identified	None available yet. Outcomes can be monitored via patient survey and complaint trends.	Sponsor Group has not yet reviewed progress with action plan.	Ensure that Sponsor Group reviews implementation of plan at regular intervals	CEO	Updated action plan reviewed by LiA Sponsor Group on 6 July – good progress has been made on most actions	2	3	**6**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
2. High Quality Care														
2.1 Continue to keep up high standards of infection control and cleanliness														
Infection control practices not adhered to by all staff all of the time.	4	4	**16**	- Training Standards set - Policies - Screening processes - IC team - DIPC - Action plans and assurance framework - Hygiene Code - Cleaning standards - PEAT processes	- Board reports - IC data and trends - Audit programme - Screening numbers - RAG rating action plan - IC Committee minutes.	None identified	Board reports. Data reports.	None identified	Not applicable	CN	Progress is reported via action plans and update reports to the Trust Board.	3	4	**12**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
2.2 Formalise our quality system to bring together all that we can do to maintain and improve our quality of care														
Complexity of the task of bringing together exiting data systems / process and organisational structures	3	3	**9**	Regular RAG rated reports covering: Performance, Quality, Nursing, Clinical Effectiveness, Patient Experience and Safety,	Monthly reporting on performance and quality indicators to the Trust Board, its sub-committees and Executive Committees.	None identified	External oversight by the SHA, PCTs and regulatory bodies.	None identified	Not applicable	DG	Development of the 'Service Quality System' continues. This will be presented at the November Board Seminar.	3	2	**6**
2.3 Improve the protection and care we provide to vulnerable children and adults														
Vulnerable adults and children are not identified and protected effectively.	3	4	**12**	- Committee structure - Dedicated experts - Policies - Training levels 1-3 - Action plans.	- Committee minutes - Board reports - Incident data - Ward reviews	None identified	Board reports. Incident and data reports.	None identified	Not applicable	CN	Action plans are progressing well.	3	4	**12**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
2.4 Demonstrate we have improved our management of risk by achieving NHS litigation Authority accreditation at Level 2 for both general and maternity standards														
The Trust may fail to achieve level 2 NHSLA risk management standards in February 2010 as a result of: ▪ Lack of awareness of and/or failure of staff to follow policy requirements, ▪ Inability to collect adequate evidence due to unavailability of evidence ▪ Interpretation of policies/ evidence by assessors at assessment The Trust may fail to achieve level 1 CNST maternity standards in Q4 2011/12 as a result of: ▪ Failure to evidence proper effective implementation of approved guidelines and processes.	4	4	**16**	Monthly project groups chaired by Director of Governance (NHSLA standards) and Clinical Director for Obstetrics (CNST maternity) Regularly reviewed action plans Executive and Operational Leads for specific standards/ criteria Work streams for identified "hot spot" standards Regular liaison with assessors. Dedicated NHSLA posts now funded	Regular updates to: Governance Board and Governance and Risk Management Committee	Band 7 newly created NHSLA post currently vacant	Successful Level 1 assessment in March 2010 at which 50 out of 50 policies were approved by the NHSLA assessor.	Lack of centralised evidence for some standards, resulting in difficulties in assessing status Compliance levels with some aspects of induction / mandatory training requirements Systems / processes to evidence implementation of policies need to be identified / developed for some policies.	▪ Fill vacant post ▪ Continue collection and assessment of evidence from leads / ward / service areas ▪ Continue targeted "hot spot" work streams (mandatory training, medical devices training, consent, blood ▪ Raise awareness across the organisations of the assessment process.	DG	Evidence is currently being collected from all corporate departments for this calendar year. Some evidence is being sent from individual departments, however requests for specific information will commence in October/November. Particular attention has been focussed on addressing the identified 'hot spot' areas. The Trust Policy Staff Handbook has been compiled and sent to the printers.	4	3	**12**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
2.5	**Successfully implement the outcome of the Maternity Review**													
Failure to open City Birthing Centre on schedule Failure to successfully implement obstetric reconfiguration Failure to adequately progress stand alone midwifery led unit in Sandwell (due to open Oct 2011)	2	4	**8**	Maternity Action Team acting as Project Board for scheme, chaired by CEO. Also overseen by Maternity Taskforce and Scrutiny Committee	Progress reports to MAT, MTF and Scrutiny	None Identified	Progress reports show all schemes progressing to timetable. City Birthing Centre open and operating well	None identified	No additional actions required	CEO	Not applicable	2	4	**8**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
2.6 Continue to improve our services for Stroke patients														
The Stroke Service is complex, cross-site and cross-divisional which makes it difficult to implement and embed operational change. Large number of new targets and standards set for 2010-11 – team may not have the capacity to deliver all. Data collection resources may not be adequate. Challenging targets may require fundamental review of emergency admission processes to resolve. Resistance from clinicians who may be adverse to change or perceived additional work	4	4	**16**	Stroke action team headed by Deputy Medical Director and Deputy Ops Director draws all the elements together. Objectives for 2010/11 prioritised in Integrated Stroke Action Plan Data collection clerk in post. Stroke implementation officers out to appointment Corporate oversight of information Stroke Action team Stroke Action Team - multidisciplinary - secures commitment from all stakeholders	Integrated stroke action plan Minutes of Stroke action team Monthly performance reports(not yet live)	Trust does not currently provide information on pathway basis across all elements of the service	Some elements of data corporately monitored – time to scan for all admitted patients and % of time on stroke unit. Evidence of re-engineering of pathways including protected beds Delivery of stroke action plan.	Operational Divisional teams currently not receiving stroke performance data Action plans not completed for all Workstreams PCTS not assured we are meeting contractual specifications. Data currently not accurate and incomplete	Deputy GM Medicine (Stroke) initiating overall comprehensive information package which will be reviewed by Elderly Care Directorate in short term. Trust to review reporting lines for cross cutting services including Stroke. Action Plans to be completed. Improve data.	MD 30/9/10 31/3/11 31/3/11 31/3/11		3	3	**9**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
2.7 Improve the quality of service and safety within our A&E departments														
Improvement requires a change in culture which takes time to embed. Difficulty recruiting quality staff – medical and nursing. Attempting service improvement in period of increasing activity. Clinician resistance to change in practice (eg cross-site working) or perceived increase in workload. IT infrastructure currently different on the two sites. Major adverse publicity due to unexpected event could overtake ED Action plan.	4	5	**20**	ED Action team meets fortnightly ED Risk Register Ongoing reporting of SUIs Ongoing monitoring of TTR action plans at AEC and EDAT External reviews- WMQRS , HEFT	ED action plan reported monthly to Trust Board Reports of external reviewers	Operational dashboard to be developed	Improvement in number of SUIs reported Improvement in staff survey results	No patient feedback	Complete actions on ED action plan Develop operational dashboard Plan program of patient surveys for 2011/12	MD 31/3/11 30/9/10 2011/12	Immediate actions on mitigation plan broadly complete and strategic development plan for the EDs in preparatory stages. Development efforts compromised somewhat by recruitment and retention problems at consultant level. Operational dashboard in prototype form as a monthly spot-check audit reported to the Board commenced in August 2010.	2	5	**10**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
2.8 Achieve the new Quality and Innovation targets agreed with our commissioners (CQUIN) for 2010/11														
IMT resource needed to design electronic data capture solutions for VTE, smoking, stroke and Think Glucose Do not yet have shared agreement and understanding of targets or priorities See Stroke (section 2.6 above) Targets are not achieved in relation to: Tissue Damage Falls Patient Survey	4	4	**16**	Smoking system already implemented Stroke systems under development as described in section 2.6 - Data collection - Training standards known - Internal surveys - Equipment in place - Relevant policies - Incident reporting - Optimal Wards	Regular reporting in performance report. Monthly reports Real time survey results Ward reviews Incident data	VTE and Think Glucose – similar risks to Stroke (see section 2.6). Systems under development.	Delivery of CQUIN targets Performance reports	n/a	Deliver stroke action plan Develop systems for think glucose and VTE	MD/ COO /CN 31/3/ 11 30/9/ 10	Satisfactory progress with systems development. 'Think Glucose' incorporated into bed management project as is VTE. Separate reports weekly for VTE performance.	2	3	**6**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
2.9 Improve our key patient pathways so that they improve patient experience and use of resources (QuEP)														
Operational pressures due to increased demand restrict our ability to deliver sustainable service improvement. Insufficient management capacity (either general mgmt or service improvement capacity) limits our ability to make changes.	4	4	**16**	Project teams and plan established for 4 key pathways. Specific measures of progress being identified.	Progress reported to COO Team and reviewed at F&PC monthly. Quarterly benchmarking information from BCBV provides external check.	Do not yet have specific set of measures of progress for each pathway.	Monthly reports to FMB, F&PC and TMB. Quarterly benchmarking information from BCBV.	No significant gaps in assurance.	Agree and begin to report specific measures for each of the 4 pathways.	COO (Aug)	Progress reports now in place for work on outpatients and elective surgery. Progress on discharges being managed through capacity reduction plan.	3	4	**12**
2.10 Deliver quality and efficient projects led by clinical directorates (QuEP)														
Not all directorates have proposed QUEP plans Need to co-ordinate and monitor proposed plans	5	3	**15**	Overall Directorate QUEP plan (under development) Monthly progress reporting from directorates Review through QMF process Monthly reports to FMB	Directorate QUEP plan Progress Reports Monthly reports to FMB	Lack of robust infrastructure for monitoring plans	Monthly monitoring and reporting to QUEP Workstreams at FMB.	n/a	Clinical fellow in medical leadership to be appointed and take overall project monitoring role.	MD 30/9/10	Plans now monitored quarterly through directorate review process. Monthly reporting needs to be improved.	3	2	**6**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
2.11 Implement the National Nursing High Impact Changes (QuEP)														
Staff do not adhere to plans for delivering high impact actions and patient care and experience does not improve.	4	4	**16**	- Action plans - Education and plans - ADN leads - Data collection - Nursing structure and appropriate staffing - Optimal Wards.	- Ward Review results. - Data reports.		Board reports. Incident reports. Patient survey results.		Reinstate and revitalise patient experience/ nursing quality group. Recruit Heads of Nursing posts. Electronic data capture. Regular reporting.	CN	Group is well established. Regular reports now available. Progress against key actions within target.	3	4	**12**
3. Care Closer to Home														
3.1 Make full use of the outpatient and diagnostic centre at Rowley Regis Hospital														
There is insufficient space at Rowley to increase outpatient activity. There is insufficient demand for services provided from Rowley.	4	3	**12**	Outline plan for future of Rowley produced. Needs to be developed into more detailed plans for 2010/11	Progress monitored through COO Team and RCRH Strategy Group.	Detailed plan for Rowley for 2010/11 still to be produced.	Plan will be presented to appropriate committee plus RCRH Strategy Group when prepared.	Arrangements for oversight to be agreed once plan produced.	Agree detailed plan for Rowley for 2010/11. Establish appropriate arrangements for sign-off of the plan and monitoring progress with delivery.	COO (Sep) COO (Sep)	Outline service development plan for Rowley agreed at RCRH Bd in September. Ophthalmology service now launched at Rowley. Progressing with developing detail of service development plan including LiA for Rowley staff.	3	3	**9**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
3.2 Make a full contribution to the Right Care Right Here programme, including three main projects – outpatient demand management, urgent care and intermediate care														
That the Trust has insufficient capacity (management and/or clinical) to contribute to these projects. That the projects are not able to deliver changes on the scale needed to support progress towards the RCRH model of care.	4	4	**16**	Trust has identified lead managers to support the projects. Progress is reported to RCRH Implement ation Board monthly (chaired by CEO).	RCRH Programme Director also produces monthly report on progress that is shared with Partnership Board and Trust Board.	Trust will need to keep level of resources committed to this work under review as it progresses.	RCRH Programme Director's report to Trust Board.	No significant gaps.	Keep level of project management support and input from Trust under review as projects develop.	COO (ong oing)	Trust playing full role in the delivery of the project to date	3	3	**9**
4. Good Use of Resources														
4.1 Deliver a planned surplus of £2.0m														
The risks that could materialise include an under-delivery of efficiency savings, unplanned costs arising especially where these are not offset by additional income for activity above targeted levels.	3	4	**12**	Performan ce Framework , F&PMC and TB. Qtrly reviews and Divisional scrutiny at F&PMC provides robust system of checks & corrective action.	Independent verification of strength of systems via IA plan, non-Exec chairing of committees and external audit opinion on Use of Resources.	The closing details of the modified contract for managing elective activity with SPCT and HoBtPCT must be finalised.	Risks identified and costed as part of the startpoint plan together with monitoring of that plan routinely at F&PMC and TB. Final drafts prepared for C&V elective element of overall contract.	None identified.	Director level resolution of final points of the elective agreement (overall contract value and volumes previously signed off). The outstanding element pertains to the monitoring of referral patterns and the consequent impact on income.	DFPM	Contract monitoring processes with commissioners now take account of referral behaviour for the purposes of measuring income variations	3	3	**9**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
4.2 Improve our expenditure by delivering a Cost Improvement Programme for £20m														
Potential risks include a delay in delivering savings targets leading to a financial shortfall that is not bridged via other new schemes. A further potential risks involves the replacement of recurrent schemes with non-recurrent savings leading to an underlying pressure in 11/12.	3	3	**9**	FMB monitoring and scrutiny of exception report together with discretion to agree replacement schemes.	Minutes of meeting, upward reporting to F&PMC.	None identified.	Line by line reporting at FMB, incorporated into Divisional Reviews, F&PMC review of Div position, minutes of meetings.	None identified.	None required. There are some challenges within the CIP but there are no weaknesses in the system for identifying these and implementing rectification plans.	DFPM	As some slippage exists, together with challenging schemes coming into place the post mitigation score reflects the startpoint and will be updated throughout the year.	3	3	**9**
4.3 Review corporate expenditure in key areas (QuEP)														
Non availability of comparative data or baseline analysis	2	3	**6**	Routine monitoring to FMB, F&PMC, availability of benchmarking data	Progress reports with achievement of deadlines together with ad hoc decision points on future strategy for certain corporate expenditure areas.	None identified.	Evidence gain from updates on project plan.	None identified	None required.	DFPM	Significant paper prepared on the future of procurement. Analysis has commenced of the central DH feedback from the back office benchmarking exercise.	2	2	**4**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
4.4 Ensure that we have the right amount of ward, operating theatre and clinic capacity for our needs (QuEP)														
That we are not able to deliver our bed reconfiguration plans for 2010/11 either due to increases in demand or difficulties in delivering service redesign.	4	4	**16**	Project team for medical bed changes established and being chaired by Dep COO. Progress reported to FMB and F&PC.	Reports to F&PC and FMB on progress with delivery of bed changes.	No significant gaps	Current delays to delivery due to increases in demand identified and plans being developed to respond to them.	No significant gaps in assurance.	Further development of bed reconfiguration project plan to respond to current levels of demand.	COO (Aug)	Bed reconfiguration plan has been updated in the light of performance to date, plans for winter and same-sex changes at City. Current plan on track.	3	4	**12**
That we are not able to improve theatre and outpatient efficiency in line with our plans.				Project plans in place for outpatient and theatre work. Progress reported to FMB and F&PC.	Progress reports to F&PC.	No significant gaps in control.	Progress being made and reported to F&PC.	No significant gaps in assurance.						
5. 21st Century Facilities														
5.1 Continue the process to buy the land for the new hospital														
CPO to be confirmed	2	4	**8**	Trust had professional advice and representation at Public Inquiry - now completed. Awaiting report form inspector followed by approval by SoS	Witness statements, Inquiry statements	None identified	Professional opinion of advisors, LAG meeting notes. Compliance with project timescales	None identified	None identified	DE/ NHPD	None required	2	4	**8**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
5.2 Start the formal procurement process for the construction of the new hospital														
Failure to achieve project plan, this could be due to:- Lack of resources, Change in requirements Technical difficulties, Failure of approval steps in timescales allowed, Failure of CPO	4	3	**12**	Agreed project plan and resource schedule in place	Acute hospital project board receive routine report and scrutinise process/ plans	None known	Board minutes and reports	Gateway Review planned	No further actions	DE/ NHPD	Not applicable	3	3	**9**
5.3 Ensure we are fully involved with our Primary Care Trusts in the design of major community facilities (i.e. City, Rowley and Sandwell)														
Insufficient resources to engage fully	2	3	**6**	Project teams for City and SGH established	Project team minutes and reporting Monthly report to Implementation Board	None identified	Projects progressing as planned	None identified	Secure sufficient resources to deliver projects	DE/ NHPD	None required at present.	2	3	**6**
5.4 Continue to improve current facilities, including a new CT scanner at Sandwell and a major redevelopment of the Medical Assessment Unit at City														
Insufficient resources to deliver programme	2	3	**6**	Project teams established	Project reported to SIRG (monthly)	None identified	SIRG project reports available	None identified	Not applicable	DE/ NHPD	None required at present.	2	3	**6**
6. An Effective NHS Foundation Trust														
6.1 Ensure that the Trust is registered with the Care Quality Commission and maintains its registration throughout 2010/11														
Failure to evidence compliance with essential quality and safety requirement for CQC registration which could lead to restrictions on service provision and/or financial penalty. Indicators 'flagged' on the Trust's Quality and Risk Profile of held by the CQC e.g. Staff and Patient survey results, response to NPSA safety alerts, NHSLA accreditation status etc.	4	4	**16**	Exec leads assigned to self-assess against CQC require-ments Assurance frameworks / action plans / perform-ance monitoring reports.	Regular updates to the GB and G&RMC Regular liaison with CQC Compliance Manager Internal Audit review (planned for Q4)	n/a	Application for Registration granted by the CQC wef 1st April 2010 with no conditions.	Outcome indicators need to be compiled and reviewed on a timely basis	System to provide monitoring of on-going compliance with CQC requirements to be developed. Electronic evidence repository to be developed.	DG	The Trust's Quality and Risk Profile has been produced by the CQC. An analysis of the lengthy document will be presented to the Board.	4	3	**12**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
6. 2 Embed Listening into Action as part of the way we do things in the Trust ensuring all areas of the Trust are involved and that the approach can be maintained														
Failure to maintain momentum and continuing spread of LiA Removal of resources supporting LiA	2	3	**6**	Monthly LiA Sponsor Group, chaired by CEO – reviews all projects on rolling basis Action Plan developed to ensure embeddin g	Notes of sponsor group meetings and progress reports on action and communicati ons plans. Cyclical reports to Trust Board. Results of staff survey	None identified	Evidence of continuing large scale organic spread of LiA. Improved scores in latest staff survey.	None identified	Not applicable	CEO	Not applicable	2	3	**6**
6. 3 Implement the next stages of our new clinical research strategy														
Maintenance of reliable income streams Failure of research governance Lack of clarity about the plan	3	4	**12**	Regular reporting of progress on R&D strategy to trust board/ governanc e board Reengineer ing of R&D finance at directorate level New governanc e reporting arrangeme nts in trust	Reports Budget reports Reports to R&D committee	None identified	Delivery of R&D strategy	None identified	Not applicable	MD	Not applicable	3	4	**12**
6. 4 Reduce our impact on the environment by continuing to implement our sustainability strategy														
Lack of resources to manage sustainability action plan	3	3	**9**	Routine group meeting and quarterly reporting to Trust	Reports to Trust Board	None identified	Progress against plan	None identified. Progress against plan could be verified by IA	Not applicable	DE/ NHPD	Not applicable	2	3	**6**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
				Board										
6. 5 Progress plans for a new organisational status and structure which will give staff and public a clear voice in the organisation in the future														
Uncertainty over options available (national policy) Inadequate resources to carry forward plans effectively Lack of ownership by staff, patients and public Failure to deliver Right Care Right Here derails organisational strategy	3	5	**15**	Monitoring of progress at Board Seminars. FT trajectory agreement with SHA	Limited evidence other than ad hoc updates	No formal project plan in place	Updates indicate good progress with ideas development	Lack of progress reports against plan (as plan does not exist as such) National policy not yet clear	Development of formal action plan, linked to FT application process Identification of Exec lead for project with adequate capacity Engagement process with internal and external stakeholders (using LiA)	CEO	Strategy and OD Director commenced in August 2010. Objectives include preparation of project plan. 'Owning the Future' launched at Leadership Conference, JCNC and LNCC. Also trailed in September Heartbeat. Further engagement event with patients/public scheduled for October 2010. White Paper published July 2010. Includes potential for this model. Discussion in progress with Department of Health. FT trajectory agreed with SHA. Actions related to RCRH (see secs 3 & 5)	2	5	**10**
6. 6 Embed clinical directorates and service line management into the Trust														
Insufficient CD time available Insufficient management resources available (finance , hr , general management) IMT resources not made	4	4	**16**	QMF QMF directorate review process Divisional	QMF documents produced quarterly for each directorate Minutes of	Some information not yet available to QMF Information	Service Line Implementation Steering Group monitors overall project plan for implementation of objective	No formal divisional review of directorates	Complete design and implementation of comprehensive quality and performance dashboards Engage with divisions to align formal	MD/ COO /DFP M 31/8/ 10	Satisfactory progress with QMF dashboard development. LiA event for CDs is scheduled for December 2010.	2	3	**6**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
available to enable information reporting by directorate Coding issues often make identification of data by directorate difficult Directorate teams do not have skills to fulfil roles Divisional reluctance to take ownership of common set of standards and processes in respect of performance management of directorates				Reviews Performance Management Dashboards	divisional reviews	in QMF does not add to division to trust yet Dashboard still under construction			directorate review by divisions with QMF	31/3/11				
6. 7 Implement our Leadership Development Framework														
To be picked up by Director of Strategy and Organisational Development when commences in post – update will be provided for Quarter 2														
6. 8 Refresh the Workforce Strategy and make progress with its implementation														
That Trust priorities and /or insufficient HR capacity may result in delay in/failure to deliver the work programme	4	3	**12**	HR work programme for 2010/11 Alignment of strategic HRM with Trust OD plans Repriority of HR service outputs and method of delivery	Regular review of progress against plan at Workforce DMT Regular reports to TMB Twice yearly reports to TB	HR work programme not yet finalised HR service priorities and method of delivery not finalised	Recent strategy review and update to TB Quarterly HR Dashboards Evidence of integrated approach to national staff survey, Boorman review, LiA, Leadership Framework etc.	No significant gaps in assurance	Finalise HR work programme Restructure HR service and set clear priorities and plans for deliverables HR Service Improvement LiA and Health and Well Being LiA events completed and action plans developed	CN	Progress to be monitored by reports to TMB	3	3	**9**
6. 9 Continue to develop our strategy for Information Management and Technology and improve the systems we use														
That we do not have the resources to develop our IM&T system as quickly as we would like.	4	2	**8**	List of IM&T projects for 2010/11 agreed at TMB.	In addition to our internal reporting to F&PC, there is external	Need to review the Trust's structure for engaging	Reports to F&PC and oversight of LHE Board provide assurance.	No significant gaps.	Review current structure for IM&T engagement and make changes as necessary.	COO (Sep)	Work in progress to review structure. Proposal for new structure will be developed for	3	2	**6**

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan to address gaps		Progress with the actions planned to address gaps			
That we are not able to secure sufficiently wide clinical engagement for our work on IM&T.				Progress reported in detail to SIRG, TMB and F&PC.	assurance from the reports of the LHE IM&T Board.	clinicians in IM&T.					November TMB.			
6. 10 Develop our strategy for medical education and training														
No one individual with overall operational responsibility for medical education and training Multiple external organisations have a view on our outputs eg UoB, deanery, SHA	4	3	**12**	Regular feedback on standards of training from deanery and medical school Internal self assessment by specialties Periodic external specialty reviews	Minutes of Gov Board Internal asst reports to Gov Board Reports from external bodies	Education and Training committee not live	None identified	None identified	Set up regular meetings of education and training committee Identify overall medical training lead Develop strategy	MD /DG 31/10 /10 31/10 /10 31/3/ 11	Head of Academy in place and co-ordinating with other medical educational leads. Training dashboard reported to the Board. Education and training strategy not yet developed.	2	2	**4**
6. 11 Make improvement to the Health and Well-being of staff, including reducing sickness absence														
Failure to reduce sickness absence as planned/in line with national target (3.39%) Failure to develop leaders and managers to improve organisational behaviours to create a healthy workplace	4	2	**8**	Staff Health and Well Being Strategy approved Action plans developed (H&WB + Sickness Absence)	Staff Health & Well-Being Committee chaired by Exec Lead for Workforce Regular progress reporting through LiA sponsor	Resource and funding stream to support implementation not yet identified	Staff H&WB strategy and action plan approved. Limited non-recurrent funding secured to kick start project areas during this financial year. Trust absence	Currently implementing changes to HR structure. Full benefit will not be delivered until later in the New Year.	Non-recurrent funding has been found to support the delivery of the Health and Wellbeing action plan. HR structure supporting delivery of sickness absence management has been reviewed and changes to improve directorate support to be	CN	Discussions with Sandwell PCT and other avenues being explored Will be considered as part of review of HR service delivery (LiA event on 8th July)	3	2	**6**

Principal risks				Controls			Assurances		Action plan to address gaps		Progress with the actions planned to address gaps			
				Key controls	Assurances on controls	Gaps in controls	Positive assurances	Gaps in assurance						
				H&WB Board level Champion identified Focus on sickness absence + H&WB through Divisional reviews Identify potential resource(s) available to support implement ation of H&WB strategy	group, H&WB Committee, H&S Committee. Specific reports to TMB and TB twice yearly		level currently at during 2010-11 to date has been consistently lower than achieved in 2009/10. Dedicated HR resource driving reduction in sickness absence		implemented w.e.f January 2011. An action plan has been developed following the HR Service Improvement LiA, implementation of which is ongoing.					

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	'Right Care, Right Here' Progress Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	25 November, 2010

SUMMARY OF KEY POINTS:

The paper provides a progress report on the work of the *Right Care Right Here* Programme as at the end of October 2010.

It covers:

- Progress of the Programme.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. NOTE the progress made with the Right Care Right Here Programme.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Care Closer to Home: Ensure full Trust participation in the delivery of Right Care, Right Here programme exemplars project
Annual priorities	
NHS LA standards	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Routine monthly progress report to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT NOVEMBER 2010

INTRODUCTION

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

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

PROJECT PERFORMANCE

Monitoring continues of the level of activity continuing to be provided in community settings for those services redesigned through former pilot projects. Overall the levels of community activity continue to be in excess of levels reported for the same period last year, with the exception of:

- Diabetes - 4% below owing to reduced service capacity within Sandwell Healthcare Community Services owing to staff absence and leaving to take up new posts.
- ENT - 28% below primarily owing to a delay in commissioning investment into the Ear Care Service.
- Gynaecology - 38% below primarily to difficulties in populating community clinics and withdrawal of clinics from some locations (e.g. Aston). Implementation of the new Community Gynaecology Service over the next 4-6 months will increase community activity.
- Intermediate Care at Rowley Regis Hospital – 6% below. The establishment of the new model of care in spring 2011 will increase this activity.
- Dermatology – 4% below.
- Ophthalmology - 3% below.

Monitoring of performance has also commenced for the three new service redesign workstreams within the RCRH Programme.

Emergency and Urgent Care - In relation to Emergency Department (ED) and Urgent Care activity for the first 5 months of the year the total SWBH ED attendances (including BMEC) was 2.2% lower than the same period last year. By contrast, the level of urgent care centre attendances has almost doubled, with a reported increase of 15,440 attendances (49%). This shows that the level of demand for urgent and emergency care combined has increased at month 4 compared tot eh same period last year by 16%. 32% of total A & E and urgent care activity was delivered through urgent care services for the period April-August 2010/11. Comparing the level of activity to the Activity and Capacity Model forecasts for 2010/11 at month 5, the actual urgent care activity delivered is twice the level forecast, with A&E activity being 11% higher than forecast. The work being undertaken through the Urgent & Emergency Network to encourage the public to use primary care and urgent care centres, and the proposed establishment of the Long Terms Conditions work stream, are key to reducing ED attendances to model trajectories.

Outpatient Work - The context report for Outpatient work stream is currently in development, and the comparison between 09/10 outpatient activity and this year will be available in the next couple of months. In summary performance at month 5, shows that whilst the level of activity in the community has increased the level of outpatients being delivered by SWBH in the hospital is 23% above the trajectory as a result of increases in outpatient referrals and follow ups.

ACUTE AND URGENT CARE CAPACITY REVIEW

Birmingham Review

The review has now formally concluded. The plan is to use the RCRH principles to inform the coming year's LDP negotiations with the same principles also being used in other parts of Birmingham.

Black Country Review

This group are beginning to reach some conclusions about 'challenged' specialties in the Black Country and are starting to develop recommendations.

OGC GATEWAY REVIEW

The Office of Government Commerce (OGC) will be undertaking a Gateway Review of the RCRH Programme at the end of November. The Review is likely to focus on how the Programme can develop further to ensure effective delivery of its objectives, taking account of emerging GP consortia and the changing role of local authorities in holding the responsibility for health and well being.

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
16th November 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	RCRH Acute Hospital Development: Project Director's Report
SPONSORING DIRECTOR:	Graham Seager, Director of Estates and New Hospital Project
AUTHOR:	Andrea Bigmore, New Hospital Project Manager Graham Seager, Director of Estates and New Hospital Project
DATE OF MEETING:	25 November 2010

SUMMARY OF KEY POINTS:

The Project Director's report gives an update on:

- The Outline Business Case (OBC) approvals process
- Naming the new hospital
- Commercial Documents
- Gateway Review
- Drop in sessions

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	21st Century Facilities
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Usual monthly update.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

right care right here

Report to:	**Trust Board**
Report of:	**Graham Seager / Andrea Bigmore**
Subject:	**Project Director's Report**
Date:	**November 2010**

1. Outline Business Case (OBC)

The Strategic Health Authority (SHA) Board approved the OBC on 19th October 2010, which has initiated the formal approval process with the Department of Health (DH).

The DH has made some comments and the team has responded to close all issues to facilitate approval. The Team continues to work very closely with DH to ensure that the approval process will run smoothly.

The DH will also need to seek approval from the Treasury before we are able to initiate the procurement process.

2. Naming the New Hospital

The Trust Board approved the name of the new hospital in October. It will now be known as the Midland Metropolitan Hospital.

3. Commercial Documents

Now that the OBC has been completed the team are focussing on the development of the procurement documents and will complete a major review with the Private Finance Unit in late November. This will support approval of these documents in parallel with the OBC to allow initiation of the procurement.

The team has been focussing particularly on how the procurement will be managed including:

- The procurement strategy;
- The deliverables we will require from bidding consortia;
- The evaluation process;
- Project structures; and
- Who will need to represent the Trust in the procurement process.

4. Gateway Review

A Gateway Review is planned for early December. Gateway Review is a peer review process designed to examine the progress and likelihood of successful delivery of the project. It

provides valuable additional perspective on the issues facing the project team and challenges the robustness of plans and processes. This particular review will focus on readiness for the procurement process.

Key project personnel and stakeholders will be interviewed and documents reviewed over three days culminating in a report which will be presented to the project's Senior Responsible Owner, (John Adler).

We hope to gain helpful feedback, which will help us plan for successful delivery of the project.

5. Drop in Sessions

The public and staff are still being encouraged to get involved in various ways. Drop in sessions have been arranged this month to help the public and staff to ask questions and find out more about the project.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – October 2010
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	25 November 2010

SUMMARY OF KEY POINTS:

The report provides an update on the financial performance of the Trust for the period April – October 2010.

For the period 1st April 2010 to 31st October 2010, the Trust achieved a "bottom line" surplus of £777,000 which is £129,000 better than the planned position (as measured against the DoH performance target).

Capital expenditure for the year to date is £8,437,000 and the cash balance at 31st October was £4.8m above the revised plan.

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

Approval	Receipt and Noting	Discussion
X	**X**	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

NOTE the contents of the report; and
ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

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:

Financial Management Board and Trust Management Board on 16 November 2010 and Finance and Performance Management Committee on 18 November 2010.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2010

EXECUTIVE SUMMARY

• For the period 1st April 2010 to 31st October 2010, the Trust achieved a "bottom line" surplus of £777,000 which is £129,000 better than the planned position (as measured against the DoH performance target).

• A prudent view continues to be taken of LDP over performance (based on priced activity up to 30th September) and this is reflected in the reported financial position.

• At month end, WTE's (whole time equivalents) were approximately 39 above plan which is 14 higher than the position reported for September. The flow of emergency work and, in particular, the cover required in certain medical rotas has led to ongoing high use of agency staff and this is very similar to the level used in September. Total pay expenditure for the month, inclusive of agency costs, was £231,000 above plan which brings the year to date position to £511,000 above plan.

• The month-end cash balance is approximately £4.8m above the revised plan, approximately £1m higher than the September position. This includes receipt of Department of Health acute project enabling funds.

• Capital expenditure is higher than plan for both October and the year to date but this continues to relate to phasing does not represent a real pressure on budgets.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	18	129	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	304	388	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	(231)	(511)	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	186	(895)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	(39)	(11)	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	4,752	4,752	>= Plan	> = 95% of plan	< 95% of plan
CIP Actual v Plan £000	(45)	(86)	>= 97½% of Plan	> = 92½% of plan	< 92½% of plan

Note: positive variances are favourable, negative variances unfavourable

Performance Against Key Financial Targets

Target	Year to Date Plan £000	Year to Date Actual £000
Income and Expenditure	648	777
Capital Resource Limit	4,643	8,437
External Financing Limit	---	4,752
Return on Assets Employed	3.50%	3.53%

2010/2011 Summary Income & Expenditure Performance at October 2010	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	341,501	28,048	28,022	(26)	199,367	200,501	1,134	344,131
Other Income	40,422	3,314	3,689	375	23,163	23,823	660	40,922
Operating Expenses	(358,189)	(29,349)	(29,394)	(45)	(209,246)	(210,652)	(1,406)	(360,819)
EBITDA	23,734	2,013	2,317	304	13,284	13,672	388	24,234
Interest Receivable	25	2	7	5	15	48	33	75
Depreciation & Amortisation	(18,724)	(3,515)	(3,806)	(291)	(10,051)	(10,343)	(292)	(19,274)
PDC Dividend	(5,855)	(488)	(488)	0	(3,415)	(3,415)	0	(5,855)
Interest Payable	(2,417)	(201)	(201)	0	(1,410)	(1,410)	0	(2,417)
Net Surplus/(Deficit)	**(3,237)**	**(2,189)**	**(2,171)**	**18**	**(1,577)**	**(1,448)**	**129**	**(3,237)**
IFRS/Impairment Related Adjustments	5,275	2,394	2,394	0	2,225	2,225	0	5,275
SURPLUS/(DEFICIT) FOR DOH TARGET	**2,038**	**205**	**223**	**18**	**648**	**777**	**129**	**2,038**

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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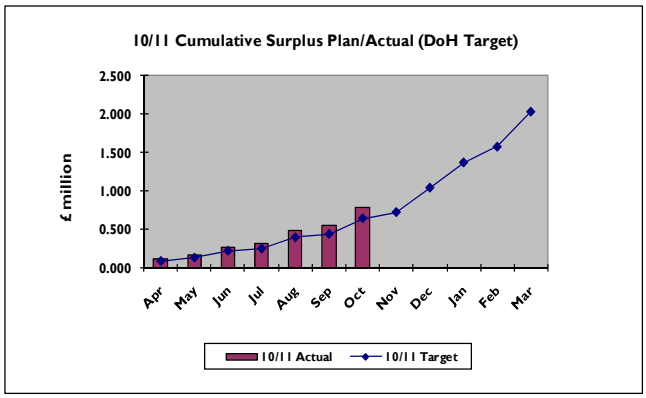
Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph with current performance continuing to be slightly ahead of plan.



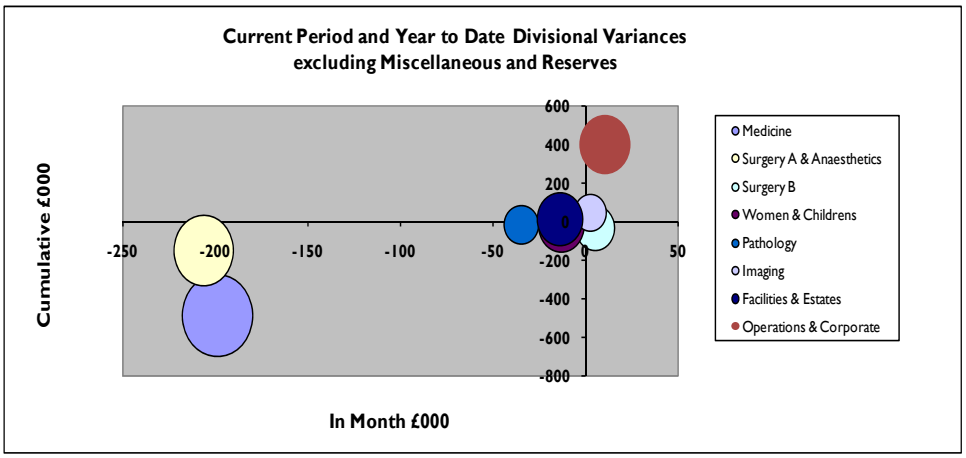
Divisional Performance

• In October, the performance of the majority of divisions was broadly in line with plan with the only significant variances being the adverse performances of Medicine and Surgery A, Anaesthetic & Critical Care balanced by better than planned performance in Miscellaneous and Reserves.

• For the year to date, Medicine and , to a significantly lesser extent, Surgery A, Anaesthetic & Critical Care are the only divisions with material "bottom line" deficits against plan.

• For both Medicine and Surgery A, much of the adverse performance is being generated through higher than planned staffing levels, mainly through bank, agency or additional sessions. In the case of Medicine, this is the result of a combination of maintaining additional ward capacity and covering vacancies and other shortages in key areas, notably Emergency Services while the primary driver in Surgery A relates to coverage of vacancies in Critical Care and Theatres as well as the use of waiting list sessions to maintain activity levels and control the level of the waiting lists themselves.

• Particularly in the light of the difficult financial outlook, it is essential that all divisions are successful in containing costs, delivering cost improvement programme savings and achieving bottom line financial targets while still dealing with ongoing operational pressures. This applies both to the remainder of the current financial year and, to an even greater extent, to 2011/12 and beyond.

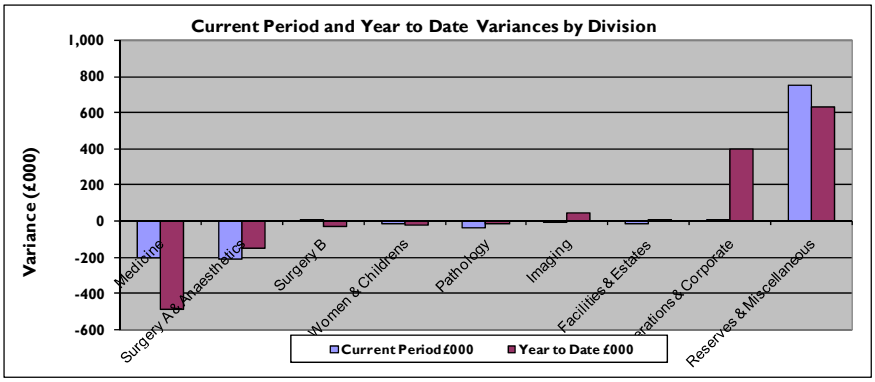


The tables adjacent and overleaf shows generally favourable performance in month with only Medicine having a significant year to date adverse performance.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

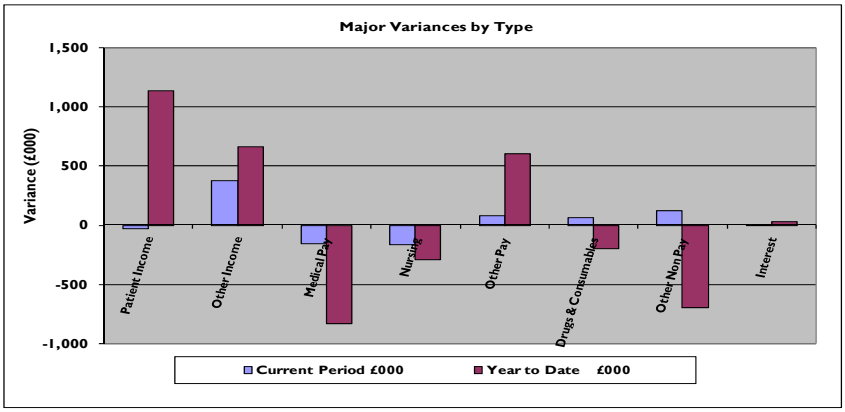
Financial Performance Report – October 2010

Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine	-199	-484
Surgery A & Anaesthetics	-206	-148
Surgery B	5	-31
Women & Childrens	-13	-22
Pathology	-35	-16
Imaging	3	46
Facilities & Estates	-14	11
Operations & Corporate	10	399
Reserves & Miscellaneous	751	630



For the year to date, the table and graph below illustrate that overall, income is performing significantly better than plan but offset by higher levels of expenditure required to maintain additional capacity and deliver higher activity levels.

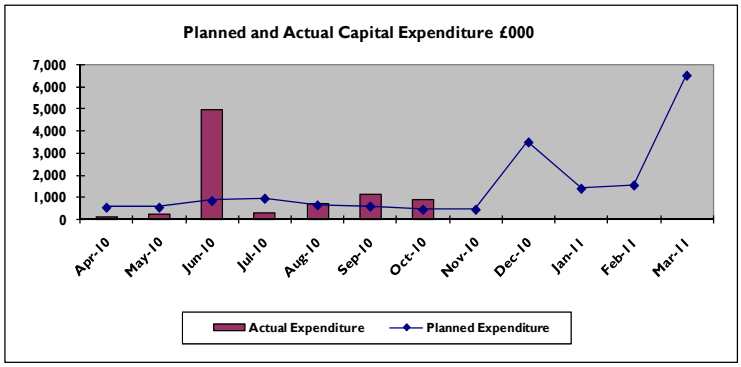
Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	-26	1,134
Other Income	375	660
Medical Pay	-152	-830
Nursing	-162	-288
Other Pay	83	607
Drugs & Consumables	66	-196
Other Non Pay	120	-699
Interest	5	33



Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Higher than planned expenditure was again incurred in month, primarily in respect of maternity services, digital mammography and statutory standards. At the same time, an adjustment in respect of VAT on the purchase of land has been made.

•Expectations of slippage on the programme, particularly in respect of the remaining purchase of land, will mean that some schemes can be brought forward from 2011/12 as pressure is increased in that year with further acquisition of land.



Sandwell and West Birmingham Hospitals NHS
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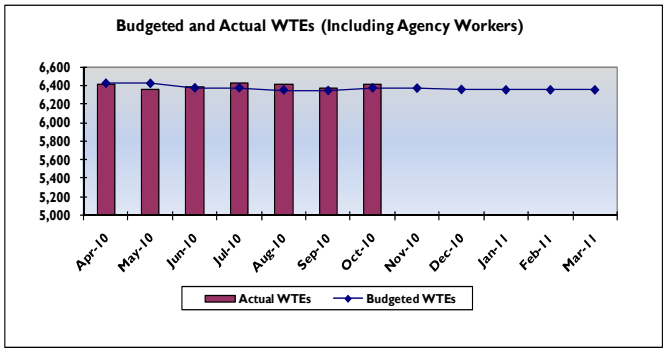
Financial Performance Report – October 2010

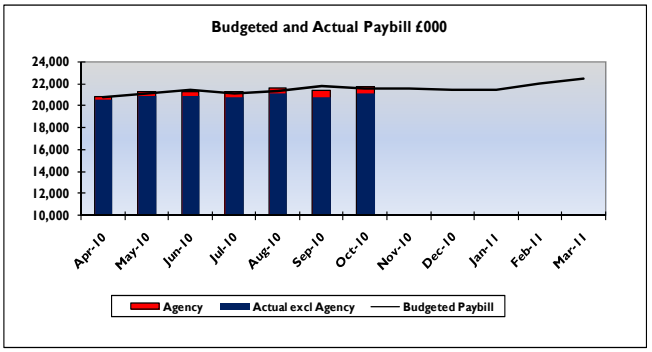
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 39 wtes above plan for October, an increase of 14 compared with September with an increase of 44 actual wtes in month. However, this does need to be considered in the context of relatively high levels of bank and agency spend which account for around 411 wtes or 6½% of the Trust's workforce and which can be very variable from one month to another.

• Total pay costs (including agency workers) are £231,000 above budgeted levels for the month and £511,000 above for the year to date. The main areas where expenditure remains in excess of plan continue to be medical staffing, healthcare assistants and nursing offset to some degree by lower than planned expenditure among other pay groups.

• Expenditure for agency staff in October was £605,000 compared with £594,000 for September. Almost half of this expenditure, whether for October or the year to date, relates to medical staff with a significant proportion of medical agency cover residing within the Medicine Division.





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 October					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	43,783	42,947		1,666	44,613	(830)
Management	7,911	7,427		0	7,427	484
Administration & Estates	16,954	16,397	3	589	16,989	(35)
Healthcare Assistants & Support Staff	16,007	14,904	783	609	16,296	(289)
Nursing and Midwifery	43,547	41,927	1,481	427	43,835	(288)
Scientific, Therapeutic & Technical	20,820	20,137		313	20,450	370
Other Pay	77	0			0	77
Total Pay Costs	149,099	143,740	2,267	3,604	149,610	(511)

NOTE: Minor variations may occur as a result of roundings

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – October 2010

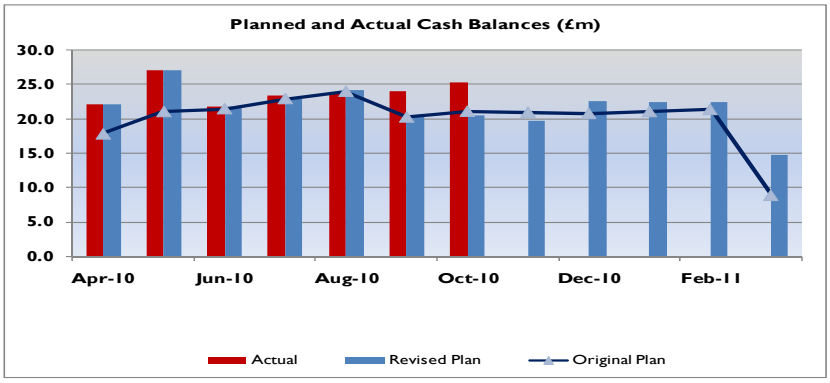
Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the statutory accounts for the year ended 31st March 2010.

• Cash balances at 31st October are approximately £4.8m higher than the revised plan, an increase of around £1m mainly the result of the receipt of £1.4m from HoB PCT in respect of RCRH project funding.

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at March 2010 £000	Balance as at October 2010 £000	Forecast at March 2011 £000
Non Current Assets	Intangible Assets	426	375	400
	Tangible Assets	220,296	219,367	219,976
	Investments	0	0	0
	Receivables	1,158	1,275	1,350
Current Assets	Inventories	3,439	3,606	3,450
	Receivables and Accrued Income	19,289	19,632	19,500
	Investments	0	0	0
	Cash	15,867	25,325	17,861
Current Liabilities	Payables and Accrued Expenditure	(31,962)	(45,446)	(40,127)
	Loans	0	0	0
	Borrowings	(1,698)	(1,665)	(1,690)
	Provisions	(5,338)	(2,202)	(5,000)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	0	0	0
	Borrowings	(32,476)	(31,486)	(30,786)
	Provisions	(2,175)	(3,044)	(2,150)
		186,826	185,738	182,784
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,231
	Revaluation Reserve	36,545	37,140	36,250
	Donated Asset Reserve	2,148	1,940	1,698
	Government Grant Reserve	1,103	1,076	1,043
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	(22,259)	(23,707)	(25,496)
		186,826	185,738	182,784



Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – October 2010

Cash Flow

• The table below shows cash receipts and payments for October 2010 and a forecast of expected flows for the following 12 months.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT October 2010

ACTUAL/FORECAST	Oct-10 £000s	Nov-10 £000s	Dec-10 £000s	Jan-11 £000s	Feb-11 £000s	Mar-11 £000s	Apr-11 £000s	May-11 £000s	Jun-11 £000s	Jul-11 £000s	Aug-11 £000s	Sep-11 £000s	Oct-11 £000s
Receipts													
SLAs: Sandwell PCT	**13,452**	13,586	13,586	13,586	13,586	13,586	13,236	13,236	13,236	13,236	13,236	13,236	13,236
HoB PCT	**7,114**	7,163	7,163	7,163	7,163	7,163	7,022	7,022	7,022	7,022	7,022	7,022	7,022
Associated PCTs	**4,907**	4,786	4,786	4,786	4,786	4,786	4,765	4,765	4,765	4,765	4,765	4,765	4,765
Pan Birmingham LSCG	**1,379**	1,399	1,399	1,399	1,399	1,399	1,371	1,371	1,371	1,371	1,371	1,371	1,371
Other SLAs	**532**	819	819	819	819	819	820	820	820	820	820	820	820
Over Performance Payments	**0**	0	500	0	0	0	0	750	750	750	750	750	750
Education & Training	**1,302**	1,506	1,506	1,506	1,506	1,506	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Loans	**0**	0	0	0	0	0				0	0	0	0
Interest	**7**	6	6	6	6	6	6	6	6	6	6	6	6
Other Receipts	**4,346**	2,004	2,004	2,004	2,004	2,004	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Total Receipts	**33,039**	31,270	31,770	31,270	31,270	31,270	30,719	31,469	31,469	31,469	31,469	31,469	31,469
Payments													
Payroll	**12,313**	12,553	12,402	12,495	12,495	12,546	12,450	12,450	12,450	12,450	12,450	12,450	12,450
Tax, NI and Pensions	**8,383**	8,936	8,829	8,895	8,895	8,931	8,900	8,900	8,900	8,900	8,900	8,900	8,900
Non Pay - NHS	**1,847**	2,319	1,555	2,076	2,076	2,366	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Non Pay - Trade	**7,654**	6,957	4,666	6,227	6,227	8,418	6,500	6,500	6,500	6,500	6,500	6,500	6,500
Non Pay - Capital	**935**	595	595	940	940	4,808	750	750	750	750	750	751	751
PDC Dividend	**0**	0	0	0	0	2,746						2,750	
Repayment of PDC	**0**	0	0	0	0	0							
Repayment of Loans	**0**	0	0	0	0	0							
Interest	**0**	0	0	0	0	0							
BTC Unitary Charge	**370**	365	365	365	365	365	374	374	374	374	374	374	374
Other Payments	**312**	400	400	400	400	400	250	250	250	250	250	251	251
Total Payments	**31,814**	32,125	28,813	31,398	31,398	40,579	31,224	31,224	31,224	31,224	31,224	33,976	31,226
Cash Brought Forward	**24,100**	25,325	24,470	27,427	27,299	27,171	17,861	17,357	17,602	17,847	18,092	18,338	15,831
Net Receipts/(Payments)	**1,225**	(855)	2,957	(128)	(128)	(9,309)	(505)	245	245	245	245	(2,507)	243
Cash Carried Forward	**25,325**	24,470	27,427	27,299	27,171	17,861	17,357	17,602	17,847	18,092	18,338	15,831	16,074

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

Risk Ratings

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	6.5%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	102.9%	5
Return on Assets	Surplus before dividends over average assets employed	1.6%	2
I&E Surplus Margin	I&E Surplus as % of total income	-0.6%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	-0.5	1
Overall Rating			**2.3**

Risk Ratings

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

•In addition to the normal low score in respect of liquidity, other measures have also deteriorated as a result of the inclusion of impairment charges which are scored against Monitor targets but which are offset when measuring performance against DoH objectives and in a normalised Monitor assessment.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2010

External Focus

• Key PCTs continue to report a financial position and a projected outturn which is manageable within contingency reserves. Heart of Birmingham PCT, in particular, has reported a slowdown in the growth in acute activity levels experienced during the first half of the year which is consistent with internal performance monitoring by the Trust. However, there is some recognition that the underlying higher activity levels will increase the pressure on PCT budgets in future years as baseline LDP levels are uplifted.

•The Comprehensive Spending Review (CSR) was announced on 20th October, although more detail of the full impact of the settlement is required in order to provide a clearer picture of the financial prospects for 2011/12. Further details will be available with the publication of the NHS Operating Framework which is expected around mid December. The CSR headline indicated a small real terms increase of 0.1% pa for the NHS, although the expectation remains that a "flat cash" scenario is still the most realistic outcome when other budget movements have been taken into account. The tariff deflator which sets out the efficiency savings required of providers will be set somewhere between -2% to -4% with an overall efficiency assumption of 4%, any balance being generated through reductions to specific tariff prices.

• The SHA have set up a performance incentive scheme for the winter based on A&E waits, ambulance turnarounds and delayed discharges which is worth around £170k a month to the Trust from November to March (approximately £1m in total) split between the Trust and the PCTs with over £0.5m due to the Trust if targets are met. This potential source of income reflects some of the increased pressures being faced by the Trust (and other acute hospitals) with regard to emergency admissions.

Conclusions

• The Trust's performance against its Department of Health control total (i.e. the bottom line budget position it must meet) shows a surplus of £777,000 for the first seven months of the financial year. Performance against the statutory accounts position (which includes one-off charges for changes in asset values) shows a deficit of £1,448,000 as this includes non cash adjustments for revised asset values.

• The corresponding results for the month of October show a DH control total surplus of £223,000 and a statutory accounts deficit of £2,171,000.

• Capital expenditure in October was £933,000, primarily related to maternity services, digital mammography and statutory standards.

•At 31st October, cash balances are approximately £4.8m higher than the revised cash plan.

• Adverse performance continues to be generated by some clinical divisions, particularly Medicine and, to a lesser extent Surgery A, Anaesthetics and Critical Care with further deficits being generated in month. Favourable performance within Corporate Divisions and on Miscellaneous and Reserves continues to make a significant contribution to the overall favourable position of the Trust.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2010

Conclusions (cont)

•A prudent approach in terms of potential data challenges and non divisional expenditure items continues to be maintained.

• Activity related cost pressures remain a major issue for the Trust and for individual divisions. For the Trust to achieve its financial targets, it is imperative that these pressures are successfully managed especially as additional pressures will be felt as the Trust approaches the winter period.

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:	25 November 2010

SUMMARY OF KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – October 2010.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Financial Management Board and Trust Management Board on 16 November 2010 and Finance and Performance Management Committee on 18 November 2010.

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - OCTOBER 2010

EXECUTIVE SUMMARY

Note	Comments
An additional column has been added to the report which is intended to indicate the magnitude of improvement required to deliver the various National & Local Priority and CQUIN targets. The assessment is based upon recent performance, performance to date and end target.	
a	**Cancelled Operations** across the Trust decreased both numerically and as a percentage during the month of October. Cancellations at Sandwell increased significantly, whilst those at City decreased significantly, when compared with the previous month.
b	**Delayed Transfers of Care** decreased overall to 4.10%, influenced by a reduction to 2.5% at Sandwell.
c	**Stroke Care** - provisional data for the month of October indicates the percentage of patients who spent at least 90% of their hospital stay on a Stroke Unit was 68.4%. Following validation performance during September improved to 73.5%.
d	The overall number of cases of **C Diff** reported across the Trust during the month of October was 9, with a similar distribution between sites. There was 1 case of **MRSA Bacteraemia** reported during the month, at Sandwell. The total number of C Diff cases for the year to date is well within the External (DoH) trajectory for the period and marginally in excess of the Trust's internal trajectory. The total number of cases of MRSA Bacteraemia (4) reported year to date is identical to the trajectory for the period.
e	**Referral to Treatment Time** - the range of indicators within the report has been revised and now includes data on the admitted and non-admitted patient backlog, as well as the number of specialties which have failed to meet the respective targets within month.
f	**Sickness Absence** - overall sickness absence for the month of October is 4.51%, this is compared against the performance trajectory for the third quarter of the year. The trajectory reduces each quarter to the Trust target set by the SHA of less than 3.40% by 2013. The forward projection assessment is based upon the need for further, on-going improvement to meet this target.
g	Overall compliance with **Mandatory Training** modules is now in excess of 80%, although there is variation by Training Module and by Division. Provisional **PDR** data for the month of October indicates a reduction in the number undertaken. Performance for the year to date represents 83% of PDRs expected to have been undertaken during this period.
h	**CQUIN:**
	Overall scheme financial values are included within the main body of the report.
	VTE (Venous Thromboembolism) Risk Assessment - Performance for October improved significantly to 54.9%. Improvement of a similar magnitude will be required to meet the target of 90% of patients risk assessed for VTE, during Quarter 4, 2010 / 2011.
	Breast Feeding - Breastfeeding status at time of Guthrie Test (usually day 6 or 7) (*or discharge from midwifery care*). Q1 Baseline data 62.3%, was used to set the target of 72.3% (baseline plus 10%). Final assessment is an audit of Q4 performance. Performance during Q2 is reported as 62.0%.
	Tissue Viability (Pressure Ulcers) - Comprises 3 components; Assessment on admission, Decrease in number of acute hospital acquired grade 2, 3 and 4 ulcerations and Table Top Reviews on all ulcerations of grade 3 or 4. • The Q2 audit indicated 83% of patients were assessed on admission (target 75%). • The number of Hospital Acquired Pressure Sores (Grades 2, 3 and 4) for the first 6 months is 27.5% less than the baseline (Q4 target 10% less). • Table Top Reviews for Grade 3 and 4 Pressure Sores are all up to date for Quarters 1 and 2.
	Inpatient Falls - the target comprises 3 components. An assessment of risk for in-patients, with a target of 75%, a 10% reduction in the number of inpatient falls and Table Top Reviews on all falls with fracture. • The Q1 audit indicated 83.6% of patients were assessed (target 75%). Q2 data awaited. • The number of inpatient falls reported for the first 5 months of the year is 8.2% less than the baseline (Q4 target 10% less). • Table Top Reviews on falls with fracture are all up to date for Quarters 1 and 2.
	Brain Imaging for Emergency Stroke Admissions (within 24 hours admission) - provisional data for October indicates performance of 85.7%.
	Hip Fracture Operations within 24-hours of admission - provisional data for the percentage of patients receiving an operation with 24 hours of admission during October is 90.0%, well ahead of the trajectory for the period.
	Smoking (Brief Intervention in Outpatients) - a total of 1171 referrals are recorded during the first 7 months of the year, in line with the trajectory for the period.
	Safer Prescribing of Warfarin - Number of patients prescribed warfarin with INR (International Normalised Ratio) within the target range. The baseline audit at 2 months identified 65.13% compliance, compared with a final target of 65% by March 2011. Performance at 6 months indicated a level of 70.3% compliance.
	Patient Experience - Composite of response to 5 inpatient survey questions. Goal to improve responsiveness to personal needs of patients. Survey to be conducted between October and January, for patients who had an inpatient episode between July and August. Target is an improvement (increase) of 2 percentage points on 2009 / 10 baseline.
	Think Glucose - target relates to Inpatients with a secondary diagnosis of Diabetes. Final indicator value is evidence of participation in NHS Institute Think Glucose Programme. A number of outcome measures to evidence participation have been identified, with data capture and reporting systems being established.
	Parent's Consultation with Senior Clinician - parents able to discuss care of their baby with senior clinician within 24 hours of admission onto neonatal unit. A target of 81% for Q4 has been set by the Specialised Commissioners. The most recent quarterly performance is 72% (Q2), although this fell to 69.0% during October.
	Neonates Offered Breast Milk - to maximise the number of babies admitted to the neonatal unit who will be offered some breast milk (from mother) during the inpatient episode. A target of 79% for Q4 has been set by the Specialised Commissioners. The most recent quarterly performance is 90% (Q2), although this fell to 71.0% during October.
	Herceptin Home Delivery - the original target, set by the Specialised Commissioners, has been revised from 90%, with Trust's now required to aim for 50% in Q2. This was met by the Trust during the month of September, and has increased to 55% during October. The Trust awaits confirmation of any further revisions.

Note | **Comments**

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

j **Activity** (trust-wide) to date is compared with the contracted activity plan for **2010 / 2011** - Month and Year to Date.

	Month				Year to Date			
	Actual	Plan	Variance	%	Actual	Plan	Variance	%
IP Elective	1022	1163	-141	-12.1	6958	7496	-538	-7.2
Day case	4486	4209	277	6.6	31510	27128	4382	16.2
IPE plus DC	5508	5372	136	2.5	38468	34624	3844	11.1
IP Non-Elective	5022	5475	-453	-8.3	35686	36582	-896	-2.4
OP New	13723	14333	-610	-4.3	96104	92385	3719	4.0
OP Review	35815	36544	-729	-2.0	259956	235547	24409	10.4
OP Review:New	2.61	2.55	0.06	2.4	2.70	2.55	0.15	5.9
AE Type I	14997	16499	-1502	-9.1	108516	117217	-8701	-7.4
AE Type II	3238	3021	217	7.2	22079	21466	613	2.9

Activity to date is compared with **2009 / 10** for the corresponding period

	2009 / 10	2010 / 11	Variance	%
IP Elective	8073	6958	-1115	-13.8
Day case	30454	31510	1056	3.5
IPE plus DC	38527	38468	-59	-0.2
IP Non-Elective	37554	35686	-1868	-5.0
OP New	97832	96104	-1728	-1.8
OP Review	243684	259956	16272	6.7
OP Review:New	2.49	2.70	0.21	8.4
AE Type I	115844	108516	-7328	-6.3
AE Type II	21093	22079	986	4.7

Overall Elective activity for the month and period to date exceeds the plan for the respective periods. Year to date Non-Elective activity is 2.4% less than plan, and 5% less than the corresponding period last year. Overperformance against plan, year to date, for Outpatient Review activity remains disproportionally greater than that for Outpatient New activity and continues to adversely impact upon the Follow-Up to New ratio.

k The **Non-Admitted Care** range of Key Performance Indicators has been expanded within the report, and forms a sub-set of those contained within the Outpatient Improvement Plan.

l **Bank and Agency Use** - the overall number of Nurse Bank and Nurse Agency shifts, and costs during the month of October increased, although year to date both remain within the trajectory set for the period. Overall expenditure on Medical Agency and Medical Locum staff reduced by c.£60K during October. Overall Agency Spend, expressed as a percentage of Total Pay Spend for the year to date is 2.4%.

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - OCTOBER 2010

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS			June	July	August	September			October			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			10 / 11 Forward Projection	08/09 Outturn	09/10 Outturn
				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	10/11							
RW	Net Income & Expenditure (Surplus / Deficit (-))		£000s	105 ▼	44 ▲	176 ▲	→		61 ▲	→		223 ▼	777	648	2038		0%	0 - 1%	>1%	●	2535	2279
RK	Cancer	2 weeks	%	94.3 ▼	93.8 ▼	94.3 ▲	→		94.3 ■	→			94.2	=>93	=>93		No variation		Any variation	●	98.6	93.9
		2 weeks (Breast Symptomatic)	%	93.3 ▲	93.0 ▼	93.3 ▲	→		95.6 ▲	→			93.7	=>93	=>93		No variation		Any variation	●	n/a	93.6 (Q4 only)
		31 Days	%	100 ■	100 ■	100 ■	→		99.4 ▼	→			99.9	=>96	=>96		No variation		Any variation	●	100	99.7
		62 Days	%	89.4 ▲	84.4 ■	85.5 ■	→		87.8 ▲	→			87.2	=>85	=>85		No variation		Any variation	●	98.6	89.1
RK	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	1.0 ■	1.0 ■	0.6 ■	0.4 ▲	1.3 ■	0.9 ■	0.9 ■	0.5 ■	0.7 ■	0.9	<0.8	<0.8	a	<0.8	0.8 - 1.0	>1.0	●	1.0	0.8
		28 day breaches	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	1	0	0		3 or less	4 - 6	>6	●	0	0
	Delayed Transfers of Care	Total	%	5.1 ■	4.8 ▲	4.0 ■	4.4 ■	5.7 ▼	5.0 ■	2.5 ■	5.8 ▼	4.1 ▲	4.4	<3.0	<3.0	b	<3.0	3.0 - 4.0	>4.0	● ● ●	3.1	3.0
	Cardiology	Primary Angioplasty (<150 mins)		80 ▼	87.5 ▲	75 ■	100 ▲	100 ■	100 ▲				90.3	=>80	=>80		=>80	75-79	<75	●	83.6	86.2
		Rapid Access Chest Pain	%	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■				100	=>98	=>98		>99	98 - 99	<98	●	100.0	99.7
		Thrombolysis (60 minutes)	%	no pts	no pts	no pts	→		no pts	→			no pts	80	80		>80	75-80	<75		0	no pts
DO'D	Stroke Care	>90% stay - EXTERNAL (DH) TARGET	%	78.9 ▲	61.4 ▼	70.0 ▲	→		73.5 ▲	→		68.4 ▼	70.4	60	60	c	=>60	31-59	=<30	●	36.5	62.0
		>90% stay - INTERNAL TARGET	%	78.9 ▲	61.4 ■	70.0 ■	→		73.5 ■	→		68.4 ■	70.4	72	80		No Variation	0 - 2% Variation	>2% Variation	● ●	36.5	62.0
		TIA High Risk Pts. Treatment <24 hours	%												60							
RK	A/E 4 Hour Waits		%	97.8 ▼	97.6 ▼	98.5 ▲	99.0 ▼	96.5 ▼	97.4 ▼	98.1 ▼	95.3 ■	96.3 ▼	97.63	98	98		=>96	95 - 96	<95	●	98.16	98.55
	GUM 48 Hours	Patients seen within 48 hours	%	87.5 ▲	80.8 ▼	88.4 ▲	→		87.5 ▼	→		88.6 ▲	86.0	=>90	=>90		=>90	80-89	<80	●	81.0	86.8
		Patients offered app't within 48 hrs	%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	=>98	=>98		=>98	95-98	<95	●	98.3	99.8
R0	Infection Control	C. Diff - EXTERNAL (DH) TARGET	No.	15 ▲	14 ▲	21 ■	1 ■	4 ▲	5 ■	4 ▼	5 ▼	9 ▼	96	143	243	d	No variation		Any variation	●	163	158
		C. Diff - INTERNAL TARGET	No.	15 ▲	14 ▲	21 ▼	1 ■	4 ■	5 ■	4 ▼	5 ▼	9 ▼	96	87	158		No variation		Any variation	●	163	158
		MRSA - EXTERNAL (DH) TARGET	No.	0 ■	2 ■	0 ■	0 ■	0 ■	0 ■	1 ■	0 ■	1 ■	4	4	6		No variation		Any variation	●	15	14
RK	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	93 ▼	94 ▲	94 ■	→		95 ▲	→			94.0	90	90		>/=90	89.0-89.9	<89	●	87.0	95.5
		Maternity HES	%	7.3 ▼	7.3 ■	5.3 ▲	→		5.3 ■	→		5.3 ■	6.0	<15	<15		=<15	16-30	>30	●	n/a	5.8
RO	Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	99.4 ▲	→	→	→		99.5 ▲	→		→	99.47	=>98.0	=>98.0		=>98	95-98	<95	●	99.9	99.3
		Breast Feeding Status Data Complete	%	99.9 ▲	→	→	→		100 ▲	→		→	99.9	=>98.0	=>98.0		=>98	95-98	<95	●	97.8	99.3
		Maternal Smoking Rates	%	12.5 ■	→	→	→		12.3 ▲	→		→	12.4	<11.5	<11.5		<11.5	11.5 - 12.5	>12.5		12.6	11.6
		Breast Feeding Initiation Rates	%	63.8 ▼	→	→	→		64.6 ▲	→		→	64.2	>63.0	>63.0		>63.0	61-63	<61.0	●	54.2	63.1
RK	RTT Milestones	Admitted Care (RTT <18 weeks)	%	93.9 ▼	94.4 ▲	93.7 ▼	→		92.5 ▼	→			92.5*	=>90.0	=>90.0	e	=>90.0	85-90	<85.0	●	98.6	93.4
		Admitted Care RTT -Specialties <90%	No.	1 ■	2 ▼	1 ▲			2 ▼				2*	0	0		0		>0	● ●		
		Admitted Care RTT -Backlog	No.	357	529	576			689				689*	No. Only	No. Only							
		Non-Admitted Care (RTT <18 weeks)	%	98.1 ▲	98.5 ▲	97.3 ▼	→		97.6 ▲	→			97.6*	=>95.0	=>95.0		=>95.0	90 - 95	=<90.0	●	98.8	97.6
		Non-Admitted Care RTT -Specialties <90%	No.	0 ■	0 ■	0 ■			1 ■				1*	0	0		0		>0	●		
		Non-Admitted Care RTT -Backlog	No.	56	84	116			158				158*	No. Only	No. Only							
		Audiology Direct Access Waits (<18 wks)	%	100 ■	100 ■	100 ■	→		100 ■	→			100*	=>95	=>95		=>95.0	90 - 95	=<90.0	●	99.0	100.0
DO'D	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	83.3 Mar '10	77.9 Apr'10	112.3 May'10	→		95.5 Jun'10	→		88.2 Jul'10	96.0	< Lower Confidence Limit			< Lower Confidence Limit		>Upper Confidence Limit		105.1	93.0
		Peer (SHA) HSMR	HSMR	87.7	84.3	95.9	→		92.2	→		92.6	95.4								103.9	93.5
RK	Readmission Rates within 28 days of discharge	Readmission to any specialty	%	8.7	9.3	9.7	10.1	8.6	9.3				9.5	No. Only	No. Only						11.6	11.4
		Readmission to same specialty	%	3.6	4.8	4.2	6.0	3.4	4.6				4.5	No. Only	No. Only						4.6	5.7
	Readmission Rates within 14 days of discharge	Readmission to any specialty	%	6.4	7.1	7.5	7.8	6.4	7.1				7.2	No. Only	No. Only						7.3	8.8
		Readmission to same specialty	%	2.8	3.7	3.4	4.7	2.7	3.7				3.5	No. Only	No. Only						3.4	4.6
RO	Sickness Absence	Long Term	%	2.68 ▲	2.73 ▼	2.73 ■	→		3.27 ■	→		3.32 ■	3.22 (M7)	<2.90	<2.90	f	<2.90	2.90-3.20	>3.20	●	3.16	3.10
		Short Term	%	1.00 ▼	0.87 ▲	0.87 ■	→		1.04 ▼	→		1.19 ▼	1.19 (M7)	<1.20	<1.20		<1.20	1.20-1.35	>1.35	●	1.22	1.31
		Total	%	3.68 ▼	3.60 ▲	3.60 ■	→		4.31 ■	→		4.51 ▼	4.51 (M7)	<4.10	<4.10		<4.10	4.10-4.55	>4.55	●	4.38	4.41
	Learning & Development	PDRs (includes Junior Med staff)	No.	351 ■	607 ■	547 ▼	→		400 ▼	→		205 ■	2598	3116	5341	g	0-15% variation	15 - 25% variation	>25% variation	●	4518	4748
		Mandatory Training Compliance	%	71.5 ▲	75.7 ▲	77.0 ▲	→		77.3 ▲	→		81.9 ■	81.9	100	100		=>80	50 - 79	<50	●	4044 (No.)	71.1

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS (Cont'd)		Value £000s		June Trust	July Trust	August Trust	September S'well	September City	September Trust	October S'well	October City	October Trust	To Date (*=most recent month)	TARGET YTD	TARGET 10/11	Exec Summary Note	THRESHOLDS			10 / 11 Forward Projection	08/09 Outturn	09/10 Outturn
DO'D	CQUIN	VTE Risk Assessment (Adult IP)	454	%	16.5 ▲	16.8 ▲	21.0 ▲	→		27.2 ▲	→		54.9 ▲	54.9*	70	90		=>90		<90	● ● ●	n/a	n/a
RO		Breast Feeding (At D'charge from M'wife)	420	%	62.3 (Q1)	→	→	→		62.0 ■	→			62.0 (Q2)	66	72.3		No variation		Any variation	● ● ●	n/a	n/a
RO		Tissue Viability - assessment <12hrs	210	%	86.0 ■	→	→	→		83.0 ▼	→			83.0 (Q2)	75	75		=>75		<75	●	n/a	n/a
RO		Tissue Viability - Hosp Acq'd Grade 2/3/4	84	%	-7.3 ■	→	→	→		-47.6 ▲	→			-27.5	-5.00%	Base - 10%		=>-2.5%		<-2.5%	●	n/a	n/a
RO		Tissue Viability - TTR of Grade 3/4	126	%	100 ■	→	→	→		100 ■	→			100	100	100		100		<100	●	n/a	n/a
RO		Inpatient Falls Assessment		%	83.6 ■	→	→	→			→			83.6 (Q1)	75	75					●	n/a	n/a
RO		Inpatient Falls reduction	420	%	-5.6% ▼	+7.4 ■	-11.2 ■	→			→			-8.2%	-5.00%	Base - 10%		=>-2.5%		<-2.5%	●	n/a	n/a
RO		Inpatient Falls - TTR of all Fractures		%	100.0 ■	→	→	→		100.0 ■	→			100	100	100		100		<100	●	n/a	n/a
DO'D		Brain Imaging for Em. Stroke Admissions	420	%	87.9 ▲	73.2 ■	96.0 ■	→		89.3 ▼	→		85.7 ■	85.7*	86.0	90.0	h	No Variation	0 - 2% Variation	>2% Variation	●	72.0	81.8
RK		Hip Fracture Op's <24 hours of admission	420	%	44.4 ▲	73.5 ■	50.0 ■			47.8 ▼			90.0 ■	90.0*	62.0	70.0		No Variation	0 - 2% Variation	>2% Variation	●	n/a	55.0
DO'D		Smoking - Brief Intervention in OP	420	No.	185 ▼	165 ■	180 ■	→		113 ■	→		170 ■	1171	1167	2000		=>167	per month	<167	●	7	1164
RK		Safer Prescribing of Warfarin	420	%	→	→	→	→		70.3 ▲	→		→	70.3(M6)	65.0	65.0		=>65		<65	●	n/a	n/a
RO		Patient Experience	454	%	→	→	→	Composite of 5 Qs - Survey October			Composite of 5 Qs - Survey October						09/10 +2%						n/a	n/a
DO'D		Think Glucose	420		→	→	→	Participation in Think Glucose Programme			Participation in Think Glucose Programme												n/a	n/a
RK	CQUIN (Specialised Commissioners)	Parent's consultation with senior clinician	51	%	73 ▲	72 ▼	86 ■	→		72 ▼	→		69 ■	69.0*	75	81		No variation		Any variation	●	n/a	n/a
		Neonates Offered Breast Milk	51	%	69 ■	81 ▲	100 ▲	→		90 ▲	→		71 ■	71.0*	75	79		No variation		Any variation	●	n/a	n/a
		Herceptin Home Delivery	85	%	Service Live	10	31	→		50 ■	→		55 ▲	55.0*	50.0	50.0		=>50		<50	●	n/a	n/a
CLINICAL QUALITY																							
R0	Infection Control	Savings Lives Compliance		%	100 ▲	100 ■	100 ■	→		100 ■	→		100 ■	100*	>95	>95		< YTD target		> YTD target		99.0	99.0
		MRSA Screening (Elective)		No.	2824 ▼	2360 ▼	2716 ▲	→		3060 ▼	→		2878 ▼	18503	17790	30000		0-15%	16-30%	>30%		6495	24710
		MRSA Screening (Non-Elective)		No.	2544 ▲	2607 ▼	1965 ▼	→		1815 ■	→		1758 ■	15694	17640	30000		0-15%	16-30%	>30%		n/a	18571
DO'D	Obstetrics	Post Partum Haemorrhage (>2000 ml)		No.	2 ▼	0 ▲	0 ■	1 ▼	2 ▼	3 ▼	0 ▲	0 ▲	0 ▲	5	28	48		=<2	3 - 4	>4			10
		Admissions to Neonatal ICU		%	4.5 ▲	4.7 ▼	3.5 ▲							4.6	=<10	=<10		=<10	10.0-12.0	>12.0			5.5
		Adjusted Perinatal Mortality Rate		/1000	7.5 ▼	15.0 ■	7.3 ■	4.4 ▲	9.1 ▲	7.2 ▲				7.3*	<8.0	<8.0		<8	8.1 - 10.0	>10			10.9
		Caesarean Section Rate		%	22.5 ▼	26.4 ■	23.9 ■	24.3 ▲	25.3 ■	24.9 ▼	22.7 ▲	22.9 ■	22.8 ▲	23.8	<25.0	<25.0		=<25.0	25-28	>28.0		27.0	23.3
FINANCE & FINANCIAL EFFICIENCY																							
RW	Gross Margin			£000s	2164 ▼	719 ▲	1987 ▲	→		1873 ▼	→		2317 ▲	13672	13284	26711		0%	0 - 1%	>1%		26436	30436
	CIP			£000s	1580 ■	1666 ▲	1740 ▼	→		1704 ■	→		1725 ▼	20907	21250	20840		0 - 2.5%	2.5 - 7.5%	>7.5%		11084	15075
	In Year Monthly Run Rate			%	16.67 ▼	57.14 ▲	19.73 ▼	→		38.64 ▲	→		8.78 ▼	19.91	0	0		NO or a + variation	0 - 5% variation	>5% variation		1.4	0.44
RK	Income / WTE			£s	5090 ■	5127 ■	5147 ▲	→		5135 ▼	→		5061 ■	5110	5127	5127		No variation	0 - 5% variation	>5% variation		5014	5058
	Income / Open Bed			£s	34732 ▲	35240 ▲	37846 ▲	→		35539 ▼	→		33952 ▼	34828	32697	32697		No variation	0 - 5% variation	>5% variation		30498	32697
	Income per Spell	Total Income		£s	2884 ■	2914 ■	3229 ▲	→		3009 ▼	→		3011 ▲	3025	2908	2908		No Variation	0 - 4% Variation	>4% Variation		2701	2908
		Clinical Income		£s	2573 ■	2609 ■	2878 ▲	→		2697 ▼	→		2661 ▼	2704	2580	2580		No Variation	0 - 4% Variation	>4% Variation		2400	2580
		Non-Clinical Income		£s	311 ■	305 ▼	351 ■	→		312 ■	→		350 ■	321	328	328	i	No Variation	0 - 4% Variation	>4% Variation		301	328
	Cost per Spell	Total Cost		£s	2882 ■	2907 ■	3207 ■	→		3000 ■	→		3218 ■	3045	2891	2891		No Variation	0 - 4% Variation	>4% Variation		2682	2891
		Total Pay Cost		£s	1923 ■	1922 ▼	2154 ▼	→		2015 ▲	→		2064 ▼	2018	1909	1909		No Variation	0 - 4% Variation	>4% Variation		1785	1909
		Medical Pay Cost		£s	541 ■	548 ▼	635 ■	→		577 ■	→		600 ■	593	555	555		No Variation	0 - 4% Variation	>4% Variation		532	555
		Nursing Pay Cost (including Bank)		£s	585 ▲	578 ▲	630 ▼	→		596 ▲	→		614 ▼	602	660	660		No Variation	0 - 4% Variation	>4% Variation		625	660
		Non-Pay Cost		£s	960 ■	984 ■	1053 ■	→		985 ■	→		1153 ■	1027	982	982		No Variation	0 - 4% Variation	>4% Variation		897	982
		Mean Drug Cost / IP Spell		£s	121 ■	136 ■	133 ▲	→		132 ▲	→		126 ■	131	124	124		No Variation	0 - 4% Variation	>4% Variation		120	124
		Mean Drug Cost / Occupied Bed Day		£s	52 ■	55 ▼	52 ▲	→		55 ▼	→		50 ■	53	49	49		No Variation	0 - 4% Variation	>4% Variation		47	49

Exec Lead	PATIENT EXPERIENCE			June	July	August	September			October			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			08/09 Outturn	09/10 Outturn
				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	10/11						
RK	Same Sex Accommodation Breaches	Number of Breaches	No.	897 ■	786 ▼	879 ▼	→		999 ▼	→		1164 ▼	6587	3500	6000		<500 pcm	501 -800 pcm	>800 pcm	n/a	3711 (Nov - Mar)
		Percentage of overall admissions	%	6.83 ■	6.83 ■	8.21 ▼	→		9.54 ▼	→		9.25 ▲	8.44	<3%	<3%		<3%	3 - 6%	>6%	n/a	6.47 (Nov - Mar)
KD	Complaints	Number Received	No.	221	→	→	→			→		→	221	No. Only	No. Only					789	875
		Response within initial negotiated date	%	n/a	→	→	→			→		→	n/a	85	85		80%+	70 - 79%	<70%	81.1	70.6
	Thank You Letters		No.	n/a	→	→	→			→		→	n/a	No. Only	No. Only					2912	2286
RK	Elective Access Contact Centre	Number of Calls Received	No.	13550	11847	11367	→		11523	→		11346	83772	No. Only	No. Only					190434	
		Average Length of Queue	mins	2.11 ▲	1.34 ▲	0.5 ■	→		0.44 ▲	→		1.43 ■	1.43*	<1.0	<1.0		<1.0	1.0-2.0	>2.0	0.44	incomplete data
		Maximum Length of Queue	mins	22.0 ▲	24.2 ▼	11.3 ■	→		12.5 ■	→		18.4 ▼	18.4*	<6.0	<6.0		<6.0	6.0-12.0	>12.0	17.4	
RK	Telephone Exchange	Number of Calls Received	No.	77711	72874	73575	→		77043	→		76708	528106	No. Only	No. Only					1559688	1100521
		Calls Answered	%	90.9	91.5	90.8			90.6			90.8	90.4	No. Only	No. Only					82.3	83.6
		Answered within 15 seconds	%	52.9	54.4	51.2			51.7			53.1	51.9	No. Only	No. Only					39.1	43.8
		Answered within 30 seconds	%	69.1	70.7	67.6			67.8			68.8	67.8	No. Only	No. Only					55.5	58.8
		Average Ring Time	Secs	23.8	22.0	24.3			24.1			24.2	24.2*	No. Only	No. Only					28.8	36.0
		Longest Ring Time	Secs	755	800	616			825			412	412*	No. Only	No. Only					695	646
	STRATEGY																				
RK	Referrals	Total By Site	No.	16671 ▼	16585 ■	14543 ■	→		15362 ▲	→			94897	95704	192945		No Variation	0 - 2% Variation	>2% Variation	178070	192945
		Total GP Referrals	No.	11471 ▼	11319 ▼	10254 ■	→		11236 ■	→			65317	62994	127001		No Variation	0 - 2% Variation	>2% Variation	120138	127001
		Total Other Referrals	No.	5200 ■	5266 ▼	4289 ▼	→		4126 ▼	→			29580	32710	65944		No Variation	0 - 2% Variation	>2% Variation	57932	65944
		By PCT - Heart of B'ham	No.	4685 ▼	4733 ▼	3983 ■	→		4027 ▼	→			26061	26093	52604		No Variation	0 - 2% Variation	>2% Variation	49859	52604
		By PCT - Sandwell	No.	8413 ▼	8100 ■	7367 ▼	→		8069 ▲	→			47852	47983	96699		No Variation	0 - 2% Variation	>2% Variation	87779	96699
		By PCT - Other	No.	3573 ■	3752 ▲	3193 ■	→		3266 ▼	→			20984	21648	43642		No Variation	0 - 2% Variation	>2% Variation	40453	43642
		Conversion (all referrals) to New OP Att'd	%	89.0	85.6	76.3	→		90.2	→			84.9	No. Only	No. Only					85.9	85.3
		OP Source of Referral Information	%	1.95 ▼	0.91 ▲	0.86 ▲	→		0.81 ▲	→		1.27 ▼	1.09	=<5.0	=<5.0		No variation		Any variation	10.0	1.4
	ACTIVITY																				
RK	Spells	Elective IP	No.	1049 ■	1033 ▼	940 ▲	→		971 ▼	→		1022 ▲	6958	7496	12641	j	No Variation	0 - 2% Variation	>2% Variation	13106	13722
		Elective DC	No.	4939 ▼	4682 ▼	4221 ▲	→		4624 ▼	→		4486 ▼	31510	27128	45747		No Variation	0 - 2% Variation	>2% Variation	50873	52729
		Total Elective	No.	5988 ▼	5715 ▼	5161 ▲	→		5595 ▼	→		5508 ▼	38468	34624	58338		No Variation	0 - 2% Variation	>2% Variation	63979	66451
		Non-Elective - Short Stay	No.	1369 ■	1432 ▼	1204 ■	→		1238 ■	→		1243 ▼	9981	9239	15712		No Variation	0 - 2% Variation	>2% Variation	12770	18769
		Non-Elective - Other	No.	3736 ■	3918 ▲	3696 ■	→		3784 ■	→		3779 ▼	25705	27343	46502		No Variation	0 - 2% Variation	>2% Variation	56226	47072
		Total Non-Elective	No.	5105 ■	5350 ■	4900 ■	→		5022 ■	→		5022 ▼	35686	36582	62214		No Variation	0 - 2% Variation	>2% Variation	68996	65841
	Outpatients	New	No.	14839 ▼	14200 ▼	12406 ▲	→		14259 ▼	→		13723 ■	96107	92385	155792		No Variation	0 - 2% Variation	>2% Variation	152923	164358
		Review	No.	39287 ▼	37893 ▼	35081 ▲	→		38327 ▼	→		35815 ■	259956	235547	397213		No Variation	0 - 2% Variation	>2% Variation	374867	425850
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	15535 ▼	15208 ▲	14752 ▲	6670 ■	7967 ▲	14637 ■	6605 ▼	8392 ▲	14997 ▼	108516	117217	191845		No Variation	0 - 2% Variation	>2% Variation	191141	190254
	A/E Attendances	Type II (BMEC)	No.	3100 ▲	2998 ▲	3289 ■	→	3217 ▼	3217 ▼	→	3238 ▼	3238 ▼	22079	21466	35133		No Variation	0 - 2% Variation	>2% Variation	30800	34836

Exec Lead	PATIENT ACCESS & EFFICIENCY			June	July	August	September			October			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			08/09 Outturn	09/10 Outturn
				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	10/11						
RK	Waiting Times	Diagnostic Waits greater than 6 weeks	No.	19 ▲	5 ▲	8 ▼	→		9 ▼	→			9*	0	0		0		>0	26	3
	Length of Stay	Average Length of Stay	Days	4.2 ▼	4.2 ■	4.3 ▼	4.3 ▲	4.2 ▼	4.2 ▲				4.2	5.0	5.0		No Variation	0 - 5% Variation	>5% Variation	5.0	4.4
		All Patients with LOS > 14 days	No.	327	319	316	158	136	294	179	141	320	320	No. Only	No. Only					312	356
		All Patients with LOS > 28 days	No.	176	188	170	90	78	168	98	82	180	180	No. Only	No. Only					152	195
		Min. Stay Rate (Electives (IP/DC) <2 days)	%	93.5 ■	93.3 ▼	92.3 ▼	95.6 ▲	91.3 ▲	93.2 ▲	93.6 ▼	91.3 ■	92.2 ▼	93.0	92.0	92.0		No Variation	0 - 5% Variation	>5% Variation	91.6	92.3
	Admissions	Day of Surgery (IP Elective Surgery)	%	88.5 ▼	90.4 ▲	88.9 ▼	93.2 ▲	85.4 ▼	88.5 ▼	91.1 ▼	89.5 ▲	90.1 ▲	88.1	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	79.4	85.5
		Day of Surgery (IP Non-Elective Surgery)	%	70.4	72.1	74.7	78.5	69.9	73.8	74.2	70.7	72.2	72.4	No. Only	No. Only					70.2	69.7
		With no Procedure (Elective Surgery)	%	9.3	6.8	7.6	9.7	10.9	10.4				8.2	No. Only	No. Only					10.6	9.7
		Per Bed (Elective)	No.	5.55 ▲	6.91 ■	5.58 ■	5.79 ■	6.78 ▲	6.30 ■	4.79 ■	6.40 ▼	5.61 ■	5.81	5.90	5.90		No Variation	0 - 5% Variation	>5% Variation	5.33	5.49
	Discharges	Pt's Social Care Delay	No.	34 ▼	27 ▲	24 ▲	15 ■	13 ▲	28 ▼	14 ▲	13 ■	27 ▲	27*	<18	<18	b	No Variation	0 - 10% Variation	>10% Variation		
		Pt.'s NHS & NHS plus S.C. Delay	No.	12 ■	10 ■	3 ■	2 ▲	9 ■	11 ■	7 ■	8 ▲	15 ■	15*	<10	<10		No Variation	0 - 10% Variation	>10% Variation		
	Beds	Occupied Bed Days	No.	26414 ▲	27069 ▲	24918 ▲	12384 ▼	12989 ▼	25353 ▼	13280 ■	13478 ▼	26758 ▼	184412	194621	331946		No Variation	0 - 5% Variation	>5% Variation	342793	331946
		Occupancy Rate	%	86.5 ■	87.7 ■	84.2 ■	89.8 ■	83.3 ■	86.4 ■	91.4 ■	82.0 ■	86.6 ■	86.5	86.5-89.5	86.5-89.5		86.5 - 89.5	85.5-86.4 or 89.6-90.5	<85.5 or >90.5	90.3	86.0
		Open at month end (exc Obstetrics)	No.	921 ■	915 ▲	852 ▲	432	467	899 ▼	460	474	934 ■	934*	930	920		No Variation	0 - 2% Variation	>2% Variation	975	989
	Day Case Rates	All Procedures	%	81.5 ▲	81.1 ▼	80.4 ▼	84.2 ▼	78.9 ▲	81.2 ▲	82.1 ▼	78.6 ▼	80.1 ▼	81.2	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	79.0	79.4
		BMEC Procedures	%	82.7 ▲	75.8 ■	80.2 ■	→	83.3 ▲	83.3 ▲	→	84.3 ▲	84.3 ▲	81.9	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	79.7	79.7
	Non-Admitted Care	New : Review Rate	Ratio	2.65 ▲	2.67 ▼	2.83 ▼	2.87 ▲	2.60 ▲	2.69 ▲	2.78 ▲	2.52 ▲	2.61 ▲	2.70	2.30	2.30	k	No Variation	0 - 5% Variation	>5% Variation	2.45	2.59
		DNA Rate - New Referrals	%	15.1 ▼	13.9 ▲	14.4 ▼	11.9 ■	14.1 ▲	13.4 ▲	12.8 ■	14.3 ▼	13.8 ▼	13.5	<8.0	<8.0		<8%	8 - 12%	>12%	12.0	13.5
		DNA Rate - Reviews	%	13.3 ▼	12.6 ▲	12.9 ▼	12.3 ▲	12.9 ▲	12.7 ▲	11.7 ■	12.7 ▲	12.3 ▲	12.3	<8.0	<8.0		<8%	8 - 12%	>12%	13.5	12.3
		OP Cancs / Rescheduled - Trust Initiated	No.	12157	9799	8285	→		10258	→		8809	75000	No. Only	No. Only						
		OP Cancs / Rescheduled - Patient Initiated	No.	7958	7481	7024	→		7588	→		7461	51566	No. Only	No. Only						
		OP Cancs (<14 days) - Trust & Patient	No.	9506	8656	7791	→		9048	→		9008	61075	No. Only	No. Only						
		OP Cancs (>2 since last app't) - Trust & Pt	No.	3024	2412	1965	→		2685	→		2055	16107	No. Only	No. Only						
		OP App'ts Booked (>14 days notice)	%	60.0	59.8	60.1	→		61.5	→		59.0	59.9	No. Only	No. Only						
	Diagnostic Report Turnaround	Cervical Cytology Turnaround	Weeks	2.4 ▼	1.0 ▲	1.6 ▼	→		2.0 ▼	→			2.0*	<4.0	<4.0		<4.0	4.0-6.0	>6.0	2.7	0.9
	Ambulance Turnaround	In Excess of 30 minutes	%	29.0 ▼	25.9 ▲	23.4 ▲	23.9 ▼	21.8 ▲	22.8 ▲	27.6 ▼	25.6 ▼	26.5 ▼	26.5*	<10.0	<10.0		<10	10 - 12.5	>12.5	19.0	23.9
		(West Midlands average)	%	32.3	30.9	30.4	→		31.8	→		33.7	33.7*	No. Only	No. Only					21.0	25.5
		In Excess of 60 minutes	No.	75 ▼	45 ▲	21 ▲	15 ▼	15 ▼	30 ▼	14 ▲	19 ▼	33 ▼	33*	0	0		0	1 - 5	>5		46
	THEATRE UTILISATION																				
RK	Sitrep Declared Late **Cancellations** by Specialty	General Surgery	No.	4 ■	5 ▼	4 ▲	1	1	2 ▲	4	2	6 ■	46	35	60	a	0-5% variation	5 - 15% variation	>15% variation	104	81
		Urology	No.	12 ■	14 ▼	3 ■	1	6	7 ■	1	4	5 ▲	49	28	48		0-5% variation	5 - 15% variation	>15% variation	102	48
		Vascular Surgery	No.	1 ■	0 ■	5 ■	0	0	0 ■	0	0	0 ■	7	2	3		0-5% variation	5 - 15% variation	>15% variation	7	8
		Trauma & Orthopaedics	No.	8 ■	4 ■	5 ▼	0	10	10 ■	1	2	3 ■	36	42	72		0-5% variation	5 - 15% variation	>15% variation	75	66
		ENT	No.	1 ■	3 ■	1 ■	0	2	2 ■	0	0	0 ■	10	7	12		0-5% variation	5 - 15% variation	>15% variation	23	23
		Ophthalmology	No.	10 ■	6 ▲	5 ▲	0	15	15 ■	0	8	8 ■	75	63	108		0-5% variation	5 - 15% variation	>15% variation	153	139
		Oral Surgery	No.	2 ■	0 ■	1 ▼	0	0	0 ▲	0	0	0 ■	3	5	8		0-5% variation	5 - 15% variation	>15% variation	19	24
		Cardiology	No.	4 ■	0 ■	0 ■	2	1	3 ■	1	0	1 ■	11	12	21		0-5% variation	5 - 15% variation	>15% variation	31	7
		Gynaecology / Gynae-Oncology	No.	0 ▲	8 ■	4 ■	6	3	9 ■	6	0	6 ▲	35	32	54		0-5% variation	5 - 15% variation	>15% variation	71	63
		Plastic Surgery	No.	0 ■	0 ■	1 ▼	0	1	1 ■	0	0	0 ▲	5	7	12		0-5% variation	5 - 15% variation	>15% variation	21	11
		Dermatology	No.	0 ■	1 ▼	1 ■	0	1	1 ■	6	0	6 ■	13	14	24		0-5% variation	5 - 15% variation	>15% variation	24	27
		TOTAL	No.	42 ■	41 ▲	30 ■	10	40	50 ■	19	16	35 ■	290	247	422		0-5% variation	5 - 15% variation	>15% variation	630	497

Exec Lead	WORKFORCE			June	July	August	September			October			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			08/09 Outturn	09/10 Outturn
				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	10/11						
RK	WTE in Post	Total	No.	6285 ▼	6289 ▼	6265 ▲	→		6222 ▲	→		6266 ▼	6266*	6374	6107		No Variation	0 - 1% Variation	>1% Variation	6042	6539
		Medical and Dental	No.	740 ▲	750 ▼	757 ▼	→		756 ▲	→		750 ▲	750*	779	790		No Variation	0 - 1% Variation	>1% Variation	755	825
		M'ment, Admin. & HCAs	No.	2561 ▲	2567 ▲	2669 ▼	→		2554 ▲	→		2489 ▲	2489*	2728	2492		No Variation	0 - 1% Variation	>1% Variation	1852	2046
		Nursing & Midwifery (excluding Bank)	No.	1779 ▼	1780 ▼	1867 ■	→		1742 ■	→		1774 ▼	1774*	1820	1822		No Variation	0 - 1% Variation	>1% Variation	2259	2385
		Scientific and Technical	No.	978 ▲	969 ▲	972 ▼	→		967 ▼	→		988 ▼	988*	1047	1003		No Variation	0 - 1% Variation	>1% Variation	913	1002
		Bank Staff	No.	227	222	218	→		203	→		264	264*	No. Only	No. Only					260	281
		Gross Salary Bill	£000s	21327 ■	21269 ■	21672 ■	→		21391 ■	→		21736 ■	149610	149099	250319		No Variation	0 - 1% Variation	>1% Variation	238674	252557
RK	Bank & Agency	Nurse Bank Fill Rate	%	86.5	87.1	92.5	→		88.4	→		85.2	87.8	No. Only	No. Only	I				81.8	85.1
		Nurse Bank Shifts covered	No.	4239 ▼	4368 ▼	4764 ▼	→		4564 ▲	→		4738 ▼	31323	35946	61621		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	69675	61621
		Nurse Agency Shifts covered	No.	331 ▲	249 ▲	187 ▲	→		334 ▼	→		368 ▼	2168	2780	4765		0 - 5% Variation	5 - 10% Variation	>10% Variation	4765	5388
		Nurse Bank AND Agency Shifts covered	No.	4570 ▲	4617 ▼	4951 ▼	→		4898 ▲	→		5106 ▼	33491	38726	66386		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	74440	67009
		Nurse Bank Costs	£000s	482 ▼	457 ▲	497 ▼	→		413 ▲	→		508 ▼	3185	3736	6404		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	6844	6263
		Nurse Agency Costs	£000s	65 ▲	50 ▲	23 ▲	→		68 ▼	→		93 ■	424	579	992		0 - 5% Variation	5 - 10% Variation	>10% Variation	832	1268
KD		Medical Agency Costs	£000s	189 ▲	239 ▼	314 ▼	→		254 ▲	→		282 ▼	1665	695	1192		0 - 5% Variation	5 - 10% Variation	>10% Variation	2026	2384
		Medical Locum Costs	£000s	230 ▲	237 ▼	239 ▼	→		268 ▼	→		179 ■	1800	1312	2250		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	2747	2896
		Med Ag./Loc Costs as % Total Med Costs	%	6.7	7.6	8.3	→		8.2	→		7.0	7.8	No. Only	No. Only					6.6	7.0
		Med Staff Exp variance from Budget	%	3.2 ▲	3.9 ▼	4.9 ▼	→		4.1 ▲	→		4.5 ▼	3.73	0	0		No Variation	0 - 1% Variation	>1% Variation	2.86	3.24
RK		Other Agency Costs	£000s	159 ▼	249 ▼	289 ▼	→		272 ▲	→		230 ▲	1514	822	1410		0 - 5% Variation	5 - 10% Variation	>10% Variation	3759	2600
RK/KD		Agency Spend cf. Total Pay Spend	%	1.95 ■	2.19 ■	2.19 ■	→		2.19 ■	→		2.78 ▼	2.41	<2.00	<2.00		<2	2 - 2.5	>2.5	2.77	2.47
RO	Recruitment & Retention	Permission to Recruit	wte	76	73	62	→		69	→		75	485	No. Only	No. Only					1124	813
		New Starters	wte	14	27	254	→		93	→		81	544	No. Only	No. Only					1066	1017
		Leavers	wte	45	48	304	→		92	→		75	676	No. Only	No. Only					999	928
		Inductions	No.	43	122	62	→		0	→		82	315	No. Only	No. Only					896	805

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

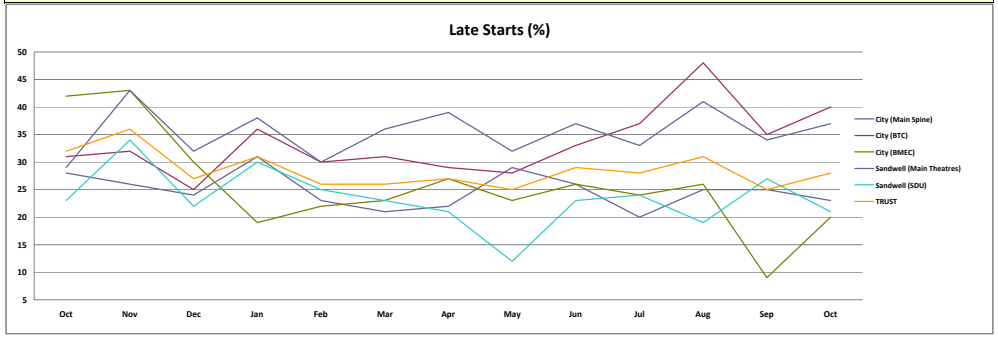
Please note: Although actual performance within the period may have improved, this may not always be reflected by a symbol which reflects this, if the distance from trajectory has worsened

KEY TO FORWARD PROJECTION ASSESSMENT	
●	Maintain (at least), existing performance to meet target
●	**Improvement** in performance required to meet target
● ●	**Moderate Improvement** in performance required to meet target
● ● ●	**Significant Improvement** in performance required to meet target

SUPPLEMENTARY DATA THEATRE UTILISATION

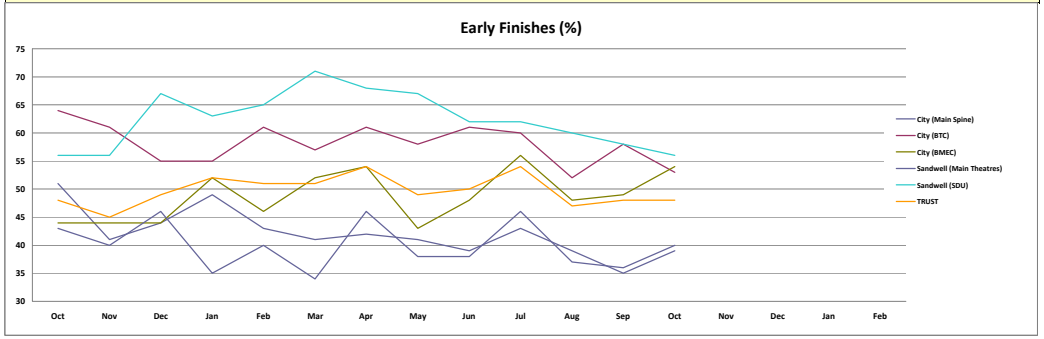
LATE STARTS (%)	2009 / 2010						2010 / 2011										
Theatre Location	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
City (Main Spine)	28	26	24	31	23	21	22	29	26	20	25	25	23				
City (BTC)	31	32	25	36	30	31	29	28	33	37	48	35	40				
City (BMEC)	42	43	30	19	22	23	27	23	26	24	26	9	20				
Sandwell (Main Theatres)	29	43	32	38	30	36	39	32	37	33	41	34	37				
Sandwell (SDU)	23	34	22	30	25	23	21	12	23	24	19	27	21				
TRUST	32	36	27	31	26	26	27	25	29	28	31	25	28				

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



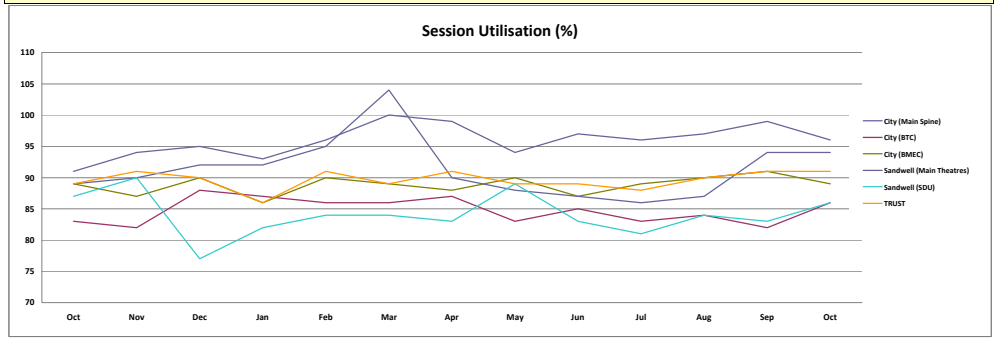
EARLY FINISHES (%)	2009 / 2010						2010 / 2011										
Theatre Location	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
City (Main Spine)	51	41	44	49	43	41	42	41	39	43	39	35	39				
City (BTC)	64	61	55	55	61	57	61	58	61	60	52	58	53				
City (BMEC)	44	44	44	52	46	52	54	43	48	56	48	49	54				
Sandwell (Main Theatres)	43	40	46	35	40	34	46	38	38	46	37	36	40				
Sandwell (SDU)	56	56	67	63	65	71	68	67	62	62	60	58	56				
TRUST	48	45	49	52	51	51	54	49	50	54	47	48	48				

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



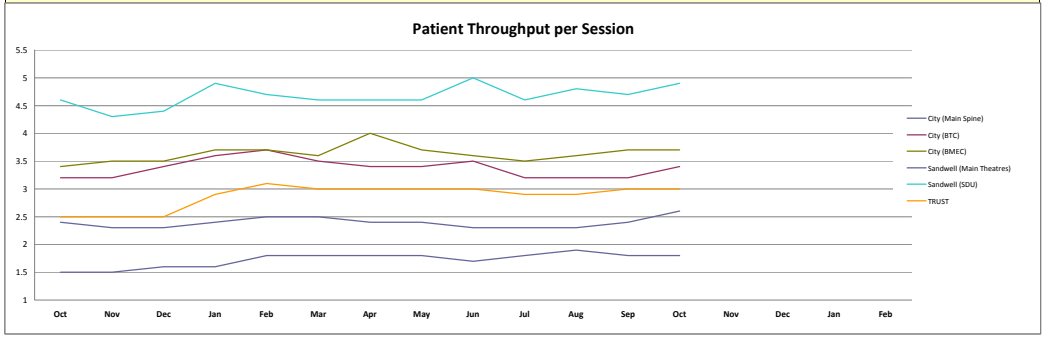
SESSION UTILISATION (%)	2009 / 2010						2010 / 2011										
Theatre Location	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
City (Main Spine)	91	94	95	93	96	100	99	94	97	96	97	99	96				
City (BTC)	83	82	88	87	86	86	87	83	85	83	84	82	86				
City (BMEC)	89	87	90	86	90	89	88	90	87	89	90	91	89				
Sandwell (Main Theatres)	89	90	92	92	95	104	90	88	87	86	87	94	94				
Sandwell (SDU)	87	90	77	82	84	84	83	89	83	81	84	83	86				
TRUST	89	91	90	86	91	89	91	89	89	88	90	91	91				

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



THROUGHPUT / SESSION	2009 / 2010						2010 / 2011										
Theatre Location	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
City (Main Spine)	1.5	1.5	1.6	1.6	1.8	1.8	1.8	1.8	1.7	1.8	1.9	1.8	1.8				
City (BTC)	3.2	3.2	3.4	3.6	3.7	3.5	3.4	3.4	3.5	3.2	3.2	3.2	3.4				
City (BMEC)	3.4	3.5	3.5	3.7	3.7	3.6	4.0	3.7	3.6	3.5	3.6	3.7	3.7				
Sandwell (Main Theatres)	2.4	2.3	2.3	2.4	2.5	2.5	2.4	2.4	2.3	2.3	2.3	2.4	2.6				
Sandwell (SDU)	4.6	4.3	4.4	4.9	4.7	4.6	4.6	4.6	5.0	4.6	4.8	4.7	4.9				
TRUST	2.5	2.5	2.5	2.9	3.1	3.0	3.0	3.0	3.0	2.9	2.9	3.0	3.0				

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary performance assessed against the NHS FT Governance Risk Rating (FT Compliance Report)
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management and Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	25 November 2010

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:
The principal areas influencing the Trust's performance assessment for the month of October relate to Accident & Emergency (4-hour waits), projected RTT (Admitted) performance (in Orthopaedics) and Delayed Transfers of Care.

The overall weighted score for the month of October is calculated as 2.51, with the Trust classified as **PERFORMING.**

Financial Performance:
Financial Performance remains unaltered from the previous month; the weighted overall score remains 2.85 and is classified as **PERFORMING**. Underperformance is indicated in October in 4 areas; Better Payment Practice Code Value, Better Payment Practice Code Volume, Current Ratio and Creditor Days. The Trust did not fail any indicators.

Foundation Trust Compliance Report –
There were no areas of underperformance reported within the framework during the month of October.

The projected overall score for the month of October is 0.0.

The Overall Governance Rating remains **GREEN**.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Accessible and Responsive Care, High Quality Care and Good Use of Resources
Annual priorities	National targets and Infection Control
NHS LA standards	
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:

Financial Management Board on 16 November and Finance and Performance Management Committee on 18 November 2010.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2010/11

Operational Standards and Targets

Indicator	Weight	Thresholds		Q1 2010-11	Score	Weight x Score	Q2 2010-11	Score	Weight x Score	October 2010	Score	Weight x Score
		Performing	Underperforming									
A/E Waits less than 4-hours	1.00	98.00%	97.00%	97.82%	2	2.00	97.83%	2	2.00	96.30%	0	0.00
Cancelled Operations - 28 day breaches	1.00	5.0%	15.0%	<5.0%	3	3.00	0%	3	3.00	0%	3	3.00
MRSA Bacteraemia	1.00	0	>1.0SD	1	3	3.00	2	3	3.00	1	3	3.00
Clostridium Difficile	1.00	0%	>1.0SD	47	3	3.00	40	3	3.00	9	3	3.00
18-weeks RTT (Admitted)	1.00	90.0%	85.0%	>90.0%	3	3.00	>90.0	3	3.00	>90.0*	3	3.00
18-weeks RTT (Non-Admitted)	1.00	95.0%	90.0%	>95.0%	3	3.00	>95.0	3	3.00	>95.0*	3	3.00
18-weeks RTT - achievement in all specialties (Admitted & Non-Admitted)	1.00	0	>0	>0	0	0.00	>0	0	0.00	>0*	0	0.00
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.0%	94.2%	3	1.50	94.1%	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%	93.4%	3	1.50	94.0%	3	1.50	>93.0%*	3	1.50
Cancer - 31 day second or subsequent treatment (surgery)	0.33	94.0%	89.0%	100.0%	3	0.99	99.7%	3	0.99	>94.0%*	3	0.99
Cancer - 31 day second or subsequent treatment (drug)	0.33	98.0%	93.0%	100.0%	3	0.99	100.0%	3	0.99	>98.0%*	3	0.99
Cancer - 31 day second or subsequent treatment (radiotherapy)	0.33	96.0%	91.0%	100.0%	3	0.99	100.0%	3	0.99	>96.0%*	3	0.99
Cancer - 62 day referral to treatment from screening	0.33	90.0%	85.0%	99.0%	3	0.99	100.0%	3	0.99	>90.0*	3	0.99
Cancer - 62 day referral to treatment from hospital specialist	0.33	85.0%	80.0%	96.9%	3	0.99	95.5%	3	0.99	>85.0*	3	0.99
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%	88.6%	3	0.99	86.4%	3	0.99	>85.0*	3	0.99
Reperfusion - Primary Angioplasty (within 150 minutes of call)	0.50	75.00%	60.00%	93.30%	3	1.50	>75.00%*	3	1.50	>75.00%	3	1.50
Reperfusion - Thrombolysis (within 60 minutes of call)	0.50	68.00%	48.00%	no patients	-	-	no patients	-	-	no patients*	-	-
2-week Rapid Access Chest Pain	1.00	98.0%	95.0%	100.00%	3	3.00	100.00%	3	3.00	100%*	3	3.00
48-hours GU Medicine Access	1.00	98.0%	95.0%	100.00%	3	3.00	100.00%	3	3.00	100.00%	3	3.00
Delayed Transfers of Care	1.00	3.5%	5.0%	3.5 - 5.0%	3	3.00	3.5 - 5.0%	2	2.00	4.10%	2	2.00
Stroke (Stay on Stroke Unit)	1.00	60.0%	30.0%	69.00%	3	3.00	68.10%	3	3.00	68.40%	3	3.00
Sum	**15.00**					**39.44**	*projected		**38.44**	*projected		**36.44**
Average Score						**2.72**			**2.65**			**2.51**

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 - 2010/11

Financial Indicators

Criteria	Metric	Weight (%)		SCORING 3	SCORING 2	SCORING 1	2010 / 2011 July	Score	Weight x Score	August	Score	Weight x Score	September	Score	Weight x Score	October	Score	Weight x Score
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	0.00%	3	0.15	0.00%	3	0.15	0.00%	3	0.15	0.00%	3	0.15
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	0.02%	3	0.6	0.02%	3	0.6	0.03%	3	0.6	0.03%	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.	5.91%	3	0.15	5.94%	3	0.15	5.91%	3	0.15	6.09%	3	0.15
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	0.00	3	0.6	0.00	3	0.6	0.00	3	0.6	0.00	3	0.6
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	6.18%	3	0.15	6.15%	3	0.15	6.15%	3	0.15	6.29%	3	0.15
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45
Underlying Financial Position	Underlying Position (%)	10	5	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	0.53%	3	0.15	0.53%	3	0.15	0.53%	3	0.15	0.53%	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	6.18%	3	0.15	6.15%	3	0.15	6.15%	3	0.15	6.29%	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	67.00%	2	0.05	70.00%	2	0.05	76.00%	2	0.05	82.00%	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	68.00%	2	0.05	79.00%	2	0.05	80.00%	2	0.05	87.00%	2	0.05
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	0.94	2	0.1	0.95	2	0.1	0.95	2	0.1	0.98	2	0.1
	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	20.29	3	0.15	20.71	3	0.15	23.40	3	0.15	19.82	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	45.62	2	0.1	46.00	2	0.1	49.33	2	0.1	45.97	2	0.1
						Weighted Overall Score			2.85			2.85			2.85			2.85

*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

MINUTES

Audit Committee – Version 0.2

Venue Executive Meeting Rm, City Hospital **Date** 2 September 2010

Members	In Attendance	Secretariat
Mrs. G. Hunjan [Chair]	Mr. R. White	Miss R. Fuller
Mr. G. Clarke	Mr. P. Smith	
Dr. S. Sahota	Mr. T. Wharram	
	Mr. P. Capener	
	Mrs. R. Chaudary	
	Mr. P. Westwood	
	Ms. M. Key	
	Mrs. S-A. Moore [KPMG]	

Minutes	Paper Reference
1 Apologies for absence	
Apologies were received from Professor Derek Alderson, Mrs Olwen Dutton, Mr Roger Trotman and Mr Simon Grainger-Payne	**Verbal**
2 Minutes of the previous meetings 6th May and 10th June 2010	**SWBAC (5/10) 037** **SWBAC (6/10) 038**
The minutes of the meeting held on 6th May 2010 were approved as a true and accurate reflection of the meeting. The minutes of the meeting held on 10th June 2010 were approved as a true and accurate reflection of the meeting.	
AGREEMENT: The minutes of the meetings held on 6 May and 10 June 2010 were approved	
3 Matters arising both meetings.	**SWBAC (6/10) 037(a)**
There were noted to be no matters arising.	
3.1 Trust's position regarding sickness absence, relative to other	**Verbal**

organisations.	
Mrs. Moore reported that finding comparative data across similar organisations regarding sickness had been difficult, given that only one PCT had given full disclosure of the information. Mrs. Moore advised that she had discussed the position with colleagues in the North and South regions and would report findings to a future meeting.	
ACTION: Mrs Moore to report back sickness absence comparison information, following discussions with colleagues, to a future meeting of the Audit Committee	
4 External Audit Matters	
4.1 External Audit progress report including update on ALE assessment.	**SWBAC (9/10) 049**
Mrs. Moore apologised for tabling the report, advising that the delay related to the recent changes within the NHS including the impact on audit regimes with the Government's announcement of the disbanding of the Audit Commission. Mrs. Moore reported that since the last meeting, KPMG had issued an unqualified report on the annual accounts. The ALE assessment was reported to have been completed, the outcome of which was reported to have been outlined in a letter sent to Chief Executives in August providing organisations' scores. The score for the Trust remained at three; the same as that for 2008/09. Mrs Moore reported that herself and colleagues would discuss the impact of government changes and the audit process in further detail with Mr. White. Mrs. Moore informed the Committee of planned audit work, which included a Value for Money audit. She advised that this audit was necessary given that financial robustness would still be required following curtailment of ALE. A meeting to discuss this would be set up with Mr White and Internal Audit. The Committee was advised that work on Reference Costs was also planned. It was noted that this is a mandatory piece of work and further guidance from the Department of Health was awaited. Mrs Moore advised that some work had already been undertaken before Christmas 2009. Mr. White reported that only a limited number of people would be involved in the audit. Mrs. Hunjan asked for feedback on the work at a future meeting. Finally Mrs. Moore highlighted publications issued since the last meeting, including the KPMG report 'A Bitter Pill to Swallow'.	
ACTION: Mrs Moore to provide a further update on the Value for Money audit and work on reference costs at a future meeting	
4.2 Agreement of Annual Audit Letter	**SWBAC (9/10) 050**

Mrs. Moore reported that the Annual Audit Letter was in draft and the Director of Finance had not had the opportunity to read the report thoroughly due to its late publication. However, the key messages remained the same. The Committee was advised that in 2011/12, two new Value for Money approaches had been issued including securing financial resilience and challenging how economic efficiency and effectiveness is secured. It was noted that these issues will require further consideration once further information is released by the Audit Commission. Attention was brought to Appendix 1 of the report's key recommendations and the required management response and timescale. Mrs. Hunjan asked for clarification of the accounting for fixed assets section and enquired if both the verification and reconciliation exercise between medical engineering and finance could be completed on a quarterly basis. Mr. Wharram advised that medical engineering as part of its role continually updated the EMAT system, however a quarterly report is currently being formalised between the two departments. Mr. Wharram informed the Committee that the medical engineering register and the capital register need to be reconciled which was time consuming, however once completed updating would be simpler. KPMG and internal audit would be regularly updated. Mrs. Hunjan asked if the Annual Audit Letter would be published on the Trust website. Mr. White confirmed the report would be placed on the Trust website with the exclusion of Appendices 1 and 2. Mrs. Hunjan thanked Mrs. Moore for her report.	
ACTION: Mr White to organise publication of the Annual Audit Letter on the Trust's internet page	
4.3 Update on External Audit Recommendations, including action plan to address fixed asset verification recommendation.	**SWBAC (9/10) 045** **SWBAC (9/10) 045(a)**
Mr. White updated the Committee on recommendations made by KPMG as part of the ISA 260 report and actions identified to respond to recommendations. The paper was reported to have been shared with KPMG prior to the meeting. Mrs. Hunjan noted the salary overpayments issue and asked what timescales for payback could be put in place to ensure minimal liabilities. Mr. White noted that there appeared to be issues in some specialities which he suggested were not significant, however quarterly reporting would continue. Mr. Wharram highlighted the issue concerning Operating Segments and how the organisation was managed, where currently reporting is considered in segments by Divisions. However it was recommended that this should be kept under review and Mr. White would provide a report for approval by the Trust Board on management arrangements if the Board approves the migration of the provider arm with the PCT.	

ACTION: Mr White to draft a report for the Trust Board on management arrangements if approval for the migration of the provider arm with the PCT is accepted.	
4.4 Process for the appointment of External Audit.	**Verbal**
Mr. White noted that the item should have been removed from the agenda as the appointment of the Trust's Auditors was managed by the Audit Commission.	
Internal Audit Matters	
5.1 Internal Audit – proposal – Audit Assignment Assurance Opinions.	**SWBAC (9/10) 043** **SWBAC (9/10) 043 (a)**
Mr. Capener presented a report on changes in assurance reporting and a new five-step approach to providing full assurance. An introduction of moderate assurance would be included below significant assurance, as on occasion it has been required to give a significant assurance with certain caveats, which in time could be lost. Likewise issuing a limited assurance in these cases would be inappropriate. The formation of moderate assurance would negate any need to provide a caveat and inform senior officers that significant assurance is attainable. Mr. White queried whether this would this make it impossible to achieve Level 1 of full assurance. Mr. Capener emphasised that moderate assurance would not be used a means of avoiding reporting limited or full assurance where it was warranted. The Committee discussed the plans and agreed to a trial of the new five level approach.	
ACTION: Mr Capener to update the Committee on the outcome of the trial of the new assurance approach at the next meeting	
5.2 Internal Audit progress report, including recommendation tracking update.	**SWBAC (9/10) 048** **SWBAC (9/10) 048 (a)**
Mrs Chaudary presented the summary of work by Internal Audit for the years 2009/10 and 2010/2011. Progress was reported to be currently ahead of schedule. Changes to the audit plan have been discussed with Mr. White and commencement with the audit of Pharmacy stocks was reported to be taking place in September 2010. A review of Access to Medical Records as requested by the Chair of the Audit Committee and a review in the use of the interpreting service and the use of the language line, requested by the Assistant Director of Nursing would also be included. These also have been discussed with and agreed by Mr. White. Mr. White informed the Committee of the extension from 14 days to 28 days for the Payroll department to inform current and ex-employees of overpayments, following a discussion with the Payroll Manager. It was	

highlighted that the ESR system nationally calculates overpayments and as such 14 days was regarded to be unachievable. It was highlighted that 28 days was the upper limit of the notification process as in the majority of cases the Payroll Department informed current and ex-employees earlier. Mr. White also advised that greater focus would need to be given to the medical staffing department as the majority of overpayments arise from junior doctors moving. Mr. White recommended a further 3 – 4 months worth of data be prepared to inform the work. Mr. White also recommended that a termination date should be included on the appointment forms of junior doctors and any staff member on fixed term contracts. Mr. Capener agreed to investigate further within the remit of the audit. Mrs Chaudary informed the Committee that a Freedom of information request had been received which concerned non-medical staff having access to medical records. Following testing it was shown that non-medical staff that had access to medical records did so in the course of their role and it was a requirement of the job. Regarding support and advice to the Trust, the Committee was advised that the Communication review was now completed by the research consultant Robin Burrow, in consultation with the Medical Director and a report would be presented at a meeting of the Trust's Governance Board. It was reported that Internal Audit had attended the first meeting of the ESR User Group in July in an advisory capacity. Work in progress was highlighted to relate to Outpatient clinics, which is expected to be finalised in September 2010; agency staffing, where a draft report is to be completed in September 2010; Safeguarding adults, although work yet to commence and; IT Audit/Information Governance, where there has been some delay in progress but the review now commenced. The recommendation tracking was noted to have been agreed and the actions implemented. Mrs. Hunjan thanked Mrs. Chaudary for an informative report.	
ACTION: **Mr. White to present an update on overpayment to the Audit Committee at a future meeting** **ACTION:** **Mr. Capener to investigate the legitimacy of including termination dates on appointment forms for fixed term contracted staff**	
5.3 KSF – Follow Up Report	**SWBAC (9/10) 044**
Mrs. Chaudary reminded the Committee that the original report on KSF had been presented to the Audit Committee in 2009 and had raised twelve recommendations. Three recommendations had a risk rating of high, seven were medium and two were low. A summary of the current position was reviewed, where it was noted that three actions	

were still showing high risk and as such only limited assurance could still be provided. Mr Capener stated that much work by the Trust had been done, however further work was still required. Mr. Capener also noted the KSF framework was under revision under the NHS Council so more guidance would be sought. Mrs. Hunjan asked the Committee whether it would be helpful to better understand the issues by inviting the relevant managers to a future meeting of Audit Committee. Mr. White highlighted that the progress appeared to be slow but encouraging. He also pointed out that the system designers are not the system users and many problems with KSF are still being addressed. Mrs. Moore agreed that it was good practice to invite officers to the Audit Committee. Mr. White agreed to expedite via the Executive Team the formulation of a handling strategy for the use of the KSF and seek opinion as to whether Miss Rachel Overfield and Mrs Lesley Barnett would need to attend a future meeting.	
ACTION: Mr. White to discuss the development of a handling strategy for the use of the KSF with the Executive Team **ACTION: Mr. White to seek Executive Team opinion as to whether Miss Overfield and Mrs Barnett should attend a future Audit Committee meeting to discuss the KSF issues**	
5.4 Theatre Performance Reporting – Follow Up Report	**SWBAC (9/10) 047** **SWBAC (9/10) 047 (a)**
Mr Capener reminded the Committee that limited assurance had been issued in December 2009 in connection with theatre utilisation. It was noted that some recommendations had been completed and some are in progress. Following the upgrading of IT systems this scheme was reported to now provide moderate assurance, however a number actions remain to be completed. Progress has been made on late starts but no progress to date has been made on early finishes. It was reported that Theatre Performance was also being reviewed by the Finance & Performance Management Committee through Mr Richard Kirby.	
5.5 Counter Fraud Annual Report	**SWBAC (9/10) 041** **SWBAC (9/10) 041 (a)**
Mr Westwood presented counter fraud activity undertaken throughout 2009/10. It was noted that 20 days would be carried over into 2010/11. A number of cases were discussed in detail by the Committee, including Case 2009 – 04, where Mr Clarke asked why the matter of a worker leaving the site during a night shift seen as an issue, given that staff are entitled to breaks. Mr Westwood advised this was a management issue as to how staff are managed, but no case could be proved, as the individual was believed to be leaving the trust for periods of time while on duty. In connection with case 2009 – 10, Dr Sahota asked for confirmation as	

to the employment status of the member of staff involved. Mr Westwood confirmed the employee was employed on a part time basis. The employee had a sick note for the Trust and was reported working elsewhere, however on investigation the second employer had erroneously documented the employee as being in work when the employee was actually off sick. Therefore there was no case to prove. Mrs. Hunjan noted the carry forward days detailed in the report at Appendix 1 was inconsistent with the reference in the conclusion of 19 days. Mr. Westwood advised that Appendix 1 was up to March 2010 however work had been done in April and the carry forward number of days was now 19. Mrs Hunjan thanked Mr. Westwood for his report.	
5.6 Counter Fraud Progress Update	**SWBAC (9/10) 046** **SWBAC (9/10) 046 (a)**
Mr Westwood outlined to the Committee the awareness raising activity undertaken for counter fraud, through the staff induction programme, participation in the national fraud awareness month and a presentation to the Surgery A cluster meeting. It was noted that as awareness is raised, more cases are reported. Mr Westwood reported that the team was currently working on a newsletter with Staff Communications on fraud cases making the headlines. A submission to the national fraud team is required in October and work is progressing with the Finance Department to ensure its timely return. Mr Westwood reported that six referrals had been made since June. Two cases were closed with no further action and five have been carried over from last year. Also reported from the Regional Counter Fraud team was a national fraud involving a scam on bank account changes for suppliers. This involved setting up of a supplier's banking details, shortly after which a phone call is received explaining problems with that bank and the provision of new bank details which is the fraudsters account. The accounts office has been made aware of this scam. Mr Clarke queried whether the Police were called to investigate. Mr Westwood advised that Reading Police were contacted. Following a brief discussion the Committee noted the remaining contents of the report.	
6 Governance Matters	
6.1 Review of losses and special payments	**SWBAC (9/10) 042 (a)** **SWBAC (9/10) 042 (b)**
Mr. Smith presented the report on losses and special payments for noting. It was noted that 140 cases were made with a value of £130k, however there were no unusual or significant issues with the claims. It	

was noted the biggest category outside of public and employee liability related to Pharmacy. Mr White advised that he had met with Dr Brian Hebron the Pharmacy Manager, to discuss stock spoilage/write off, however he agreed to seek to understand the loss of £15k in June 2010 which was noted to be very high. Mrs Hunjan requested a briefing for the next Audit Committee. It was noted that the public liability cases related to slips, trips and falls and not tribunal cases. After a brief discussion the Committee received and noted the contents of the report.	
ACTION: Mr. White to report back on the Pharmacy write-off in June 2010 at a cost of £15k.	
6.2 Assurance Framework Update – Quarter 1	**SWBAC (9/10) 040** **SWBAC (9/10) 040 (a)**
Mr. White presented the Assurance Framework for receiving and noting. It was highlighted that a number of objectives premitigation were at red status, however as progress is made during the year, most would turn to amber and yellow status.	
7. Minutes from Trust Board Committees	
7.1 Finance and Performance Management Committee	**SWBFC (4/10) 047** **SWBFC (5/10) 056** **SWBFC (6/10) 069** **SWBFC (7/10) 083**
The Committee noted the minutes of the Finance & Performance Management Committee meeting held on the 22nd April, 20th May, 17th June and 22nd July 2010.	
7.2 Charitable Funds Committee	**SWBCF (5/10) 11**
The Committee noted the minutes of the Charitable Funds Committee held on 6th May 2010.	
7.3 Governance & Risk Management Committee	**SWBGR (5/10) 035**
The Committee noted the minutes of the Governance & Risk Management Committee held on 20th May 2010.	
8 Any Other Business	**Verbal**
Mr. White suggested that the September meeting of the Audit Committee be moved by a week, as in previous years it falls during the August bank holiday, which made the production and postage of papers challenging. Mrs. Hunjan agreed to this suggestion noting all meetings should adopt a similar policy if they fall during a bank holiday.	

ACTION:	**Mr. White to ensure the schedule of dates reflects the change of the September meeting of the Audit Committee**	
9	**Date and time of next meeting**	**VERBAL**
The date and time of the next meeting will be 2nd December at 10.30am in the Executive Meeting Room, followed by a private meeting between auditors and members of the Audit Committee.		

Signed:……..

Name:……

Date:……

MINUTES

Sandwell and West Birmingham Hospitals NHS Trust

Governance and Risk Management Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 23 September 2010; 1030h – 1230h

Members Present

Professor D Alderson [Chair]
Mr R Trotman
Mrs G Hunjan
Mr J Adler
Mr D O'Donoghue
Miss K Dhami
Miss R Overfield

In Attendance

Mr S Parker
Ms A Binns
Mr D Masaun

Secretariat

Mr S Grainger-Payne

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
The Committee received apologies from Mr Robert White.	
2 Minutes of the previous meeting	**SWBGR (5/10) 035**
The Governance and Risk Management Committee approved the minutes of the meeting held on 20 May 2010 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	**SWBGR (5/10) 035 (a)**
The updated actions list was noted by the Committee.	
3.1 Board assurance of lessons learned from adverse events	**Verbal**
Miss Dhami reminded the Committee of the discussion at the last meeting of the Trust Board where the need for further assurance that lessons were being learned from incidents reported was discussed. Various options were considered and it was agreed that a satisfactory solution would be to expand the existing red incident report to include additional detail, including the number of incidents, number of tabletop reviews held, action plans developed, timescales for completion of action plans and an indication as to whether progress is on track, overdue, delayed or completed. Mr Trotman observed that of crucial importance is addressing the current delays with arranging and completing tabletop reviews, as by the time the review has	

been held, there is potential for a number of similar incidents to have occurred. Mrs Hunjan remarked that the information and process for handling red incidents had improved considerably, however the missing piece of information concerns the actions taken to minimise the chance of an incident reoccurring. It was agreed that a summary report showing the new level of detail should be presented to the Governance and Risk Management Committee, which would also be shared with the Trust Board subsequently. Professor Alderson advised that he supported the new approach and emphasised the need for the report to focus on the correct actions being taken to minimise the risk from the incidents. It was agreed that the summary report would be prepared from 2011. Mr Adler advised that there had been an issue previously with delays in the completion of substantive actions arising from tabletop reviews, however the situation was now much improved. Professor Alderson asked that information be provided to explain the reason for any delays in the completion of actions and the impact of not doing so on time. Miss Binns advised the Committee that work is underway with the Strategic Health Authority to clarify which incidents it expects to be reported to it.	
4 Health and Safety annual report	**SWBGR (9/10) 039** **SWBGR (9/10) 039 (a)**
Mr Dally Masaun reported that the Health and Safety annual report had been reviewed by the Trust Board at a meeting earlier in the year. Professor Alderson asked whether any changes to the definitions as to what constituted an incident had influenced any trends. He was advised that the definition of needlestick injuries had been changed, which had affected the trend of these particular incidents. Mrs Hunjan asked what action had been taken to address the 'Did Not Attend' rates for Heath and Safety training. She was advised that a standard report is issued from the Learning and Development department to managers. Some of the modules were however, reported to have been changed in support of the forthcoming NHS Litigation Authority assessment. Mr Masuan was asked what outcome had been reported following the review of needlestick injuries. He advised that the management of processes after the incident had been found to be good, however there was no proactive policy for managing needlestick injuries in place. To address this, a policy had been drafted and was due for consideration by the Health, Safety and Welfare Committee. Professor Alderson commented that the incidents of violence against staff were a concern. He asked whether there was an actual increase in the trend of violence against staff or whether incident reporting had improved. Mr Masuan advised that the increase in incidents was attributable to both causes. Miss Overfield added that the current way in which detoxifying patients are managed can result in incidents of violence. She also noted that in some instances, the episodes of violence may be perpetuated by the same individual. Mr Trotman asked whether there was a correlation between longer waits in Accident and Emergency and an increase in	

instances of violence. He was advised that this was not the case. Mr Adler reported that he followed up all incidents of violence against staff with a personal telephone call to the individual affected. Mr Adler noted that the number of incidents of violence and aggression against staff did not match the number of red incidents associated with the same. He was advised that instances are classed as red if staff receive an injury requiring attention in Accident and Emergency or need to have time off subsequent to the incident. Mr Adler remarked that effort should be put into reducing the number of instances where the contributing factor behind the incident of violence is reported to be 'not stated'.	
5 Quarterly SABs update	**SWBGR (9/10) 051** **SWBGR (9/10) 051 (a)**
Mr Masaun advised that the Quarterly SABs update now included Health and Safety and Department of Health alerts. The Committee reviewed an update on progress with the overall action plan. Two incidents previously reported as red were noted to have been changed to green status. It was observed that there were no issues of significance outstanding.	
6 NPSA safety alerts update	**SWBGR (5/10) 043** **SWBGR (5/10) 043 (a)**
Miss Allison Binns presented an update on alerts raised through the Central Alerts System (CAS), advising that the Care Quality Commission (CQC) had raised concerns over the Trust's twelve outstanding alerts. The Committee was advised that much effort had been made to chase the actions required to be able to close the alert and identify plans to address those areas still outstanding. All actions were reported to be on track and progress is being monitored on a regular basis. The Committee was advised that the regular process around the management of safety alerts had been reviewed and made more robust. If actions become overdue then the Governance Board would be advised of the situation. The only area identified as being problematic at present was noted to concern the use of tourniquets, although progress against the actions was noted to be good. Professor Alderson asked whether the actions due to be completed by the end of September 2010 were likely to be completed as planned. He was advised that this was the case.	
7 Quarterly integrated risk, complaints and claims update	**SWBGR (9/10) 047** **SWBGR (9/10) 047 (a)**
Miss Binns reported that there had been a declining trend in reporting of incidents and complaints. It was noted that the trend concerning 'near miss' incidents was concerning, although it is hoped that this may be rectified through the use of electronic incident reporting. Mr O'Donoghue asked what the difference is between 'near misses' and 'no harm' incidents. He was advised that the categorisation of incidents into one or the other of these classes was subjective and the possibility of aggregating the categories was being considered. Mr Adler asked when the introduction of electronic reporting was expected. He was advised that it is likely that electronic reporting would be introduced in a few areas from 4 October 2010 for testing purposes, with a view to rolling out more widely	

shortly afterwards.	
8 Update on preparations for the NHS Litigation Authority assessment	**SWBGR (9/10) 044** **SWBGR (9/10) 044 (a)**
Miss Binns reported that the Trust had been successful in achieving accreditation from the NHS Litigation Authority against Level 1 general and maternity standards. The assessment against Level 2 standards was reported to be planned for 17 and 18 February 2010, with an interim visit planned for 11 November 2010. The assessment against CNST maternity standards was highlighted to be planned for March 2012. The Committee was advised that an action plan had been developed in response to issues raised at the Level 1 assessment and in relation to the 'Hot Spots'. Good progress has been made to date to address the issues. The gathering of evidence for the assessments was reported to be underway, including reports and minutes of meetings. Checklists have been developed as a means of determining which evidence is available from operational areas in particular and identifying information that is still outstanding. Spot checks on evidence is planned. A visit to Worcester Hospital was reported to have been conducted to discuss the process for collecting evidence to support the maternity CNST assessment. Professor Alderson asked for assurance that the 'Hot Spots' are being managed. It was agreed that a summary of progress with addressing the 'Hot Spots' should be considered at the next meeting. Mrs Hunjan asked whether time between the interim visit and the assessment was sufficient to allow the implementation of any recommendations arising. She was advised that this is the case as good progress is being made to collect the required evidence in readiness for the assessment. It was emphasised that no further movement of the assessment is planned.	
ACTION: Allison Binns to prepare an update for the Governance and Risk Management Committee on work underway to address the NHSLA 'Hot Spots'	
9 Trust Risk Register update – Quarter 1	**SWBGR (9/10) 041** **SWBGR (9/10) 041 (a)**
The Committee received and noted the updated Trust Risk Register for the first Quarter of 2010/11.	
10 Assurance Framework update – Quarter 1	**SWBGR (9/10) 040** **SWBGR (9/10) 040 (a)**
The Committee received and noted the updated Assurance Framework for the first Quarter of 2010/11.	
11 Dr Foster and CQC alerts update	**SWBGR (9/10) 042** **SWBGR (9/10) 042 (a)**
Mr Simon Parker reported that no new alerts had been received and that more positive alerts had been received than negative. Non-Hodgkinson Lymphoma was noted to continue to be prompting alerts however no new diagnoses were reported to be alerting.	

One mortality outlier was highlighted, concerned with Peripheral Vascular Atherosclerosis, however the Committee was advised that this matter had been fully investigated and a response had been sent to the Care Quality Commission (CQC) which was satisfied with the action plan that was proposed. A reaudit against the diagnosis is planned. The Committee was advised that the relative risk against the ischemic bowel diagnosis had reduced. A further reaudit of the ischemic bowel cases is planned and in particular a review of the coding of this diagnosis. A review of the way in which other Trusts code the diagnosis is planned, where other organisations are willing to share the information. Mr O'Donoghue advised that work to date suggests that there is not a significant issue with this alert and any issues will be considered as part of the mortality reviews. The Committee was advised that a further alert that was being handled concerned emergency readmissions following hernia repair. Following a recent review however, the Committee was advised that a high readmission rate persists. An action plan has therefore been developed and a revised completion date to address the issues has been set for October 2010. The situation behind the alert concerning Non Hodgkinson Lymphoma was reported to be under review as it appears that the Trust has a higher relative risk than peer organisations. Dr Christine Wight, the Clinical Director for Haematology is investigating and reviewing the accuracy of coding this diagnosis.	
12 NICE Quality Standards	**SWBGR (9/10) 045** **SWBGR (9/10) 045 (a)**
Mr Parker reported that the new NICE Quality Standards had been synthesised from NICE guidance and best practice and are key standards that need to be achieved for key disease areas. Three standards have been set to date covering stroke, dementia and VTE, each of which has a number of substandards. The Committee was advised that the intention of the standards is to guide clinicians if they wish to benchmark a service or assist with commissioning decisions. They may also be used as part of the Quality Accounts. Mr Parker reported that a central repository was to be established for the evidence to support the compliance with the standards. It is intended that the National Reports process will be applied to the standards, where by an Executive Lead will be assigned, together with an operational lead who will be responsible for producing a baseline assessment of the Trust's position against the standard and later an action plan to address any gaps identified. It was agreed that the monitoring of the action plans would be considered twice yearly.	
ACTION: Mr Parker to present progress against the NICE Quality Standards action plans at the May meeting of the Governance and Risk Management Committee	
13 Clinical audit forward plan: monitoring report	**SWBGR (9/10) 046** **SWBGR (9/10) 046 (a)**
Mr Parker presented the updated clinical audit forward plan monitoring report, advising that the Trust was on track to complete the mandatory national audits. It was highlighted that there is a slight delay in some internal clinical audits.	

Mr Parker highlighted that there had been a significant number of national reports and audits issued recently, the recommendations from which needed to be considered. Any appropriate to share with the Governance Board and Governance and Risk Management Committee will be presented at a future meeting. Mr Trotman noted that one audit had been delayed due to difficulties with obtaining case notes and suggested that this was an unacceptable reason for this delay. Mr O'Donoghue advised that issues with obtaining retrospective data are not uncommon. Professor Alderson suggested that incentives should be offered for good audits undertaken.	
14 Infection Prevention and Control update	**SWBGR (9/10) 038** **SWBGR (9/10) 038 (a)**
Miss Overfield presented the quarterly update on Infection Prevention and Control, advising that it had been considered by the Trust Board previously. It was highlighted that a further MRSA bacteraemia case was to be included within the figures, although as this was reported to have been incurred prior to 48 hours in hospital, the case would not be classed as being attributable to the Trust. The high number of *C difficile* cases was reported to be reflective of over zealous specimen taking, rather than an issue with the number of infections. Awareness raising is underway to ensure only appropriate stool specimens are submitted.	
15 Governance and Risk Management Committee Chair's annual report	**SWBGR (9/10) 037** **SWBGR (9/10) 037 (a)**
The Committee noted the Governance and Risk Management Committee Chair's annual report and agreed that it may be presented at the next meeting of the Trust Board.	
16.1 – 16.4 Minutes from Governance Board	**SWBGB (6/10) 123** **SWBGB (7/10) 139** **SWBGB (8/10) 165** **SWBGB (8/10) 165 (a)**
The Governance and Risk Management Committee received and noted the minutes from the Governance Board meeting held on 4 June 2010, 9 July 2010 and 6 August 2010. The Committee also noted the actions list discussed at the meeting held on 3 September 2010.	
17.1 – 17.3 Minutes from Clinical Quality Review Group	**SWBGR (9/10) 048** **SWBGR (9/10) 049** **SWBGR (9/10) 050**
The Governance and Risk Management Committee received and noted the minutes from the Governance Board meeting held on 7 April 2010, 5 May 2010 and 7 July 2010.	
18 Any other business	**Verbal**
Mr O'Donoghue reported that concerns had been expressed by a local coroner	

over the impact of compliance with the European Working Time Directive (EWTD), in the context of a recent patient death. While the Committee supported continued compliance with EWTD, it was agreed that attention should be given to improving handover processes and continuity of care where appropriate.	
19 Details of the next meeting	**Verbal**
The date of the next meeting is 18 November at 1030h in the Executive Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Charitable Funds Committee – Version 0.2

Venue Executive Meeting Room, City Hospital **Date** 2nd September at 1430h

Members

Dr. S. Sahota	[Chair]	Mr. P. Smith	
Mr. G. Clarke		Mr. M. Burgess	[Barclays Wealth]
Mrs. G. Hunjan		Miss R.E. Fuller	[Secretariat]
Mr. J. Adler			
Mr. M. Sharon			
Mr. R. White			

Minutes	Paper Reference
1 Apologies and opening comments	**Verbal**
Apologies for absence were received from Mrs. Sue Davis, Prof Derek Alderson, Mr. Donal O'Donoghue, Mr. Roger Trotman, Mrs. Olwen Dutton, Mr. Richard Kirby, Miss Rachel Overfield and Mr. Simon Grainger-Payne. Dr. Sahota welcomed Mr. Mike Sharon, Director of Strategy & Organisational Development to his first meeting of the Charitable Funds Committee. Dr. Sahota also advised that Item 6, concerning the appointment of the investment advisors, would be moved to the end of the meeting as it was a conflict of interest for Mr. Mike Burgess from Barclays Wealth and he should not be present for this item.	**Verbal**
2 Minutes of the previous meeting	**SWBCF (5/10) 11**
The minutes of the meeting held on 6th May 2010 were approved as a accurate record.	
AGREEMENT: The minutes of the previous meeting were approved.	
3 Matters arising from previous meeting	**SWBCF (5/10) 011 (a)**
In connection with action SWBCFACT.035, an amendment was suggested to read, that Mr Smith is to report to next meeting which funds would be affected if amalgamated with a threshold of £5k or below and no activity had been transacted.	
4 Investment update – Barclays Wealth	**SWBCF (9/10) 013**

Mr Michael Burgess presented the investment report for the second quarter to 30th June and updated the Trustees on activity to the present date. It was reported that equity markets were struggling with the global economic situation, including the Greek economy. Financial markets were reported to be down in the second quarter. An increase in safer performing investments i.e. treasury bonds was noted. Since July, most equity markets including the FTSE have increased by 10%. The current value of the portfolio was reported to be £4.8m; an increase of 5%. These increases have paid into the Trust's bank accounts and not reinvested. Mr. Sharon enquired if written objectives were used to advise on short and long term aims of investments. Mr. Burgess confirmed that objectives are available and Barclays next report could include a summary of agreed longer term investments. Mr. Burgess reminded the Committee that if any changes were noted in the market that the protocol was to contact Mr. White and offer advice for appropriate action. Mrs. Hunjan sought clarity as to the reasons why the value of the portfolio was different to the appendix in the quarterly financial report prepared by Mr. Smith. Mr. Burgess explained as funds were continually updated the report and the appendix were not always produced on the same day, and it was agreed to produce a simple explanation on the appendix noting this. The Committee thanked Mr. Burgess for his report.	
ACTION: **Mr. Burgess to include a summary of longer term investments with next investment report** **ACTION:** **Mr. Smith to include an explanation of the portfolio value if different to the Investment Advisors report**	
5 Changes to asset classifications	**SWBCF (9/10) 016** **SWBCF (9/10) 016 (a)**
Mr. White outlined the need to review the upper and lower ranges within which particular assets fall. Changes to these were approved following a meeting with Messrs. Burgess, White and Dr. Sahota on the 23rd August. The change was made due to the current volatility of the markets and some equities were currently positioned too high. Mr. White highlighted the cash percentage range of 2% - 8%. After a brief discussion it was agreed that this figure would be changed to 0% - 0.8% to avoid a breach of the Trust Fund covenant.	
AGREEMENT: **The Trustees approved the revised asset ranges and agreed to receive periodic reports on adherence to these**	

7 Quarterly Finance Report	**SWBCF (9/10) 014 (a) - SWBCF (9/10) 014 (d)**
Mr. Smith presented the list of Charitable Funds transactions from April 2010 to July 2010. Mr. Smith highlighted that the cash position was in deficit by £100k and not in surplus as reported on the summary cover sheet. The report also detailed individual trust fund balances. Mr. Smith reported that the cash in hand figure was £400,743.12, which he explained was a combination of cash held at Nat West and Barclays. The Trust exchequer account was currently being used to top up the balance. Mr. Smith suggested that £125k be drawn down from the Barclays account, as donations received were currently low. Dr. Sahota queried why there was a low donation amount. Mr. Smith advised that few legacies had been received over the last few years, lower dividend returns and a move for Charitable Fund donations to be spent more swiftly than previously all contributed to the position. The possibility of trying to raise the profile of charitable funds was noted to have been discussed, although it was suggested that this would require a full time individual. Mr. Smith reminded the Committee there was currently a cash flow issue, however Dr. Sahota noted the long term future of the funds and donations made to the Trust would need further discussion. The Trustees agreed to revisit fund raising again once work on the OBC had been finalised. Dr Sahota asked whether the Trust should recruit a full time worker to concentrate on fund raising, however it was agreed that at the current time this was not a priority but could be reviewed in the future maybe under the remit of the new hospital plans Dr. Sahota noted that some funds had up to four authorised managers. Mr. White informed the Committee that some funds needed additional managers to enable access to funds more easily.	
AGREEMENT: It was agreed that Messrs White & Smith would monitor the cash flow to ensure no breaches and report to the Committee if necessary.	
8 Review of salaries paid from Charitable Funds	**SWBCF (9/10) 017 SWBCF (9/10) 017 (a)**
Mr. White responded to a query from Trustees as to the level of financial exposure arising from employees whose salary costs were from Trust Funds and what employment contractual obligations the Trust were obliged to. Mr. Smith noted that salaries are paid from the following Trust Funds Fund 0091, Fund 121, Fund 125 and Fund 169, however at present fund balances present no problem with continued payment of salaries. Mr. White informed the Committee that these arrangements would	

be reviewed in the future.	
9 Ratification of previous spending decisions	
9.1 Support for the Trust Ball	**SWBCF (9/10) 015**
Mr. White reported that the request to support the Trust Ball was similar to last year with a view to keeping the cost of the tickets to £25.00 and the Committee was being asked to grant a subsidy of £12,500, an increase of 25% compared to 2009/10. It was noted that an email was forwarded to the Trustees on 3rd August 2010 from the Trust Secretary asking for agreement of the subsidy, which had gained the approval by nine Trustees. It was noted that this was a request which would need approval on each occasion/year. The Committee ratified the decision already agreed to provide a financial contribution to subsidise the Trust Ball.	
AGREEMENT: The Trustees confirmed the request to subsidise the Trust Ball at a cost of £12,500 as noted in the email dated 3rd August.	
Mr. Burgess left the meeting at 3.15pm and was thanked for his attendance.	
6 Process for Appointment of Investment Advisors	**Verbal**
Mr. White informed the Committee the Trust had appointed Gerrards as advisors to the Trust, but with a number of mergers and takeovers no formal tender had been granted for some time. Barclays Wealth the current advisors to the Trust was reported to be the name of the latest company change. In 2008 the Trust launched a formal tendering exercise with a specification of a contract for 3 years, as in financial terms fees paid are minimal. However due to the portfolio performance it was decided to renew Barclays Wealth's contract for a further 12 months in 2009. The Committee discussed the economic situation and the tendering process undertaken in 2009 which was extensive and included presentations from all tendered suppliers. It was decided to review the situation again in May 2011 with a view to formulating a three year contract process.	
AGREEMENT: The Trustees agreed to extend the contract of Barclays Wealth for a further year and review the tender process for investment advisors in May 2011	
10 Any other business.	**Verbal**

There was no other business	
11 Date and time of next meeting	**Verbal**
The date and time of the next meeting would be 2nd December at 2.30pm in the Executive Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……