Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 28 January 2010 at 1430h

Members

Mrs S Davis	(SD)	[Chair]
Mr R Trotman	(RT)	
Miss I Bartram	(IB)	
Dr S Sahota	(SS)	
Mrs G Hunjan	(GH)	
Prof D Alderson	(DA)	
Mr J Adler	(JA)	
Mr D O'Donoghue	(DO)	
Mr R White	(RW)	
Miss R Overfield	(RO)	

In Attendance

Mr G Seager	(GS)
Miss K Dhami	(KD)
Mrs L Barnett	(LB)
Mrs J Kinghorn	(JK)
Miss J Whalley	(JW)
Mr J Cash	(JC)

Guests

Secretariat

Mr S Grainger-Payne (SGP) [Secretariat]

Item	Title	Reference No.	Lead
1	**Apologies for absence**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Chair's opening comments**	**Verbal**	**Chair**
4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 17 December 2009 as true and accurate records of discussions*	**SWBTB (12/09) 257**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (12/09) 257 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	PRESENTATIONS		
7	**Listening into Action update**	**SWBTB (1/10) 014** **SWBTB (1/10) 014 (a)** **SWBTB (1/10) 014 (b)**	**SF**
	MATTERS FOR APPROVAL		
8	**Care Quality Commission registration**	**To follow**	**KD**
9	**Agenda for Change contract of employment**	**SWBTB (1/10) 002** **SWBTB (1/10) 002 (a)**	**LB**
10	**Trust Board reporting cycle**	**SWBTB (1/10) 015** **SWBTB (1/10) 015 (a)**	**SGP**

MATTERS FOR INFORMATION/NOTING			
11	**Quality and Governance**		
11.1	Update on implementation of Service Line Management and the Quality Management Framework	SWBTB (1/10) 003 SWBTB (1/10) 003 (a)	DOD
11.2	Mortality update	SWBTB (1/10) 016 SWBTB (1/10) 016 (a)	DOD
11.3	Audit Commission report: 'Taking it on Trust'	SWBTB (1/10) 020 SWBTB (1/10) 020 (a) SWBTB (1/10) 020 (b) SWBTB (1/10) 020 (c)	RW
11.4	Single Equality Scheme update	SWBTB (1/10) 009 SWBTB (1/10) 009 (a) SWBTB (1/10) 009 (b)	RO
11.5	Patient satisfaction survey update	SWBTB (1/10) 010 SWBTB (1/10) 010 (a)	RO
11.6	Inspection of Safeguarding and Looked After Children Services Report – Sandwell MBC	SWBTB (1/10) 011 SWBTB (1/10) 011 (a)	RO
11.7	Assurance Framework update – Quarter 3	SWBTB (1/10) 004 SWBTB (1/10) 004 (a)	SGP
12	**Strategy and Development**		
12.1	'Right Care, Right Here' programme: progress report	SWBTB (1/10) 021 SWBTB (1/10) 021 (a) SWBTB (1/10) 021 (b)	RK
12.2	New acute hospital project: progress report	Verbal	GS
12.3	Public Arts strategy	SWBTB (1/10) 005 SWBTB (1/10) 005 (a)	GS
12.4	Naming of the new hospital	SWBTB (1/10) 013 SWBTB (1/10) 013 (a)	JK
13	**Performance Management**		
13.1	Monthly finance report	SWBTB (1/10) 006 SWBTB (1/10) 006 (a)	RW
13.2	Monthly performance monitoring report	SWBTB (1/10) 022 SWBTB (1/10) 022 (a)	RW
13.3	NHS Performance Framework monitoring report	SWBTB (1/10) 023 SWBTB (1/10) 023 (a)	RW
13.4	Update on delivery of corporate objectives – Quarter 3	SWBTB (1/10) 007 SWBTB (1/10) 007 (a)	RW
14	**Operational Management**		
14.1	Sustainability update	SWBTB (1/10) 012 SWBTB (1/10) 012 (a) - SWBTB (1/10) 012 (d)	GS
15	**Update from the Board Committees**		
15.1	Finance and Performance Management Committee		
▶	Minutes from meeting held 17 December 2009	SWBFC (12/09) 229	RT

15.2	Governance and Risk Management Committee		
▶	Minutes from meeting held 19 November 2009	SWBGR (11/09) 071	IB
15.3	Audit Committee		
▶	Minutes from meeting held 3 December 2009	SWBAC (12/09) 077	GH
15.4	Charitable Funds Committee		
▶	Minutes from meeting held 3 December 2009	SWBCF (12/09) 021	SS
▶	Minutes from meeting held 14 January 2010	SWBCF (1/10) 005	SS
16	**Any other business**	**Verbal**	**All**
17	**Details of next meeting** *The next public Trust Board will be held on 25 February 2010 at 1430h in the Churchvale/Hollyoak Rooms, Sandwell Hospital*	**Verbal**	**Chair**
18	**Exclusion of the press and public** *To resolve that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).*	**Verbal**	**Chair**

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Board (Public Session) – Version 0.2

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 17 December 2009 at 1430 hrs

Present:	Mrs Sue Davis	Dr Sarindar Sahota	Mr Donal O'Donoghue
	Mr Roger Trotman	Mr John Adler	
	Miss Isobel Bartram	Mr Robert White	
	Mrs Gianjeet Hunjan	Mr Richard Kirby	
In Attendance:	Mrs Lesley Barnett	Miss Kam Dhami	Mr Graham Seager
	Mrs Jessamy Kinghorn	Miss Judith Whalley	Mrs Debbie Talbot
	Dr Bill Thomson [Item 16.2 only]		

Secretariat: Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Miss Rachel Overfield.	
2 Declaration of interests	**Verbal**
No declarations of interest were made in connection with any agenda item.	
3 Chair's opening comments	**Verbal**
The Chair welcomed Mrs Debbie Talbot who was in attendance at the meeting in place of Miss Overfield. The Board was advised that the Chair, on behalf of the Board, had provided an input to the recent NHS Confederation consultation on the proposed revised arrangements for appointing the Chair of the Confederation.	
4 Minutes of the previous meeting	**SWBTB (11/09) 237**
The minutes of the previous meeting were accepted as a true and accurate record of discussions held on 26 November 2009.	
AGREEMENT: The minutes of the previous meeting on 26 November 09 were approved as true and accurate reflections of discussions held	
5 Update on actions from previous meetings	**SWBTB (11/09) 237 (a)**
The updated action list was reviewed. There were noted to be no outstanding	

actions requiring escalation.	
6 Questions from members of the public	**Verbal**
There were no members of the public in attendance at the meeting.	
7 Single tender action: Aloka ultrasound	**SWBTB (12/09) 239** **SWBTB (12/09) 239 (a)**
Mr Seager asked for the Board's approval of a single tender arrangement for payment of £72,110 in respect of the purchase of an Aloka ultrasound system, required to support the implementation of the Endoscopic Bronchial Ultrasound System (EBUS). It was highlighted that the supplier had been chosen to ensure equipment compatibility with current gastrointestinal and respiratory systems. Professor Alderson explained that the equipment would be used to detect tumours and abnormalities in the lymph nodes. It may also be used to take biopsies. The Trust board approved the single tender arrangement.	
AGREEMENT: The Trust Board gave its approval to the single tender arrangement for the purchase of Aloka ultrasound equipment	
8 Single tender action: Phillips Intellivue monitors	**SWBTB (12/09) 240** **SWBTB (12/09) 240 (a)**
Mr Seager asked for the Board's approval of a single tender arrangement for payment of £68,726 in respect of the purchase of five operating theatre monitors. Dr Sahota asked why the monitors were being sourced from a specific supplier. He was advised that the supplier had been chosen to ensure compatibility with equipment already in place within the theatres. Mr O'Donoghue added that the use of different monitors would require additional training for theatre staff. The Trust Board approved the single tender arrangement.	
AGREEMENT: The Trust Board gave its approval to the single tender arrangement for the purchase of Phillips Intellivue monitors	
9 Single tender action: private work for Trauma and Orthopaedics	**SWBTB (12/09) 241** **SWBTB (12/09) 241 (a)**
Mr Kirby asked the Board to ratify payment of £200,000 to Birmingham Orthopaedics Services Ltd. for performing 55 of the Trust's orthopaedics cases. The Board was advised that this measure had been taken as the requirement to meet the 18 weeks waiting time target continued to be challenging. The use of internal premium rate capacity and other local Trusts had been considered however, insufficient capacity had been available to accommodate the additional work required. The Board was asked to note that as the cost to the Trust matched the income received for doing the work from the PCT, the arrangement was cost neutral and represented the best value option available. It was noted that the consortium comprises a number of the Trust's own surgeons	

performing the work in a private capacity. Mr O'Donoghue advised that an orthopaedics taskforce is to be established to consider the delivery of this work in an alternative way in future months. Professor Alderson asked what plans were in place in the event that an operation being performed by the consortium became problematic. He was assured that contingency plans are in place to ensure that the patient is transferred as a priority to a NHS hospital for treatment. It was highlighted that screening of cases is also undertaken to ensure only those appropriate to be undertaken outside of the Trust are performed by the consortium. Assured that every effort had been made to seek alternative internal arrangements, and cognisant of the need to meet the associated waiting times target, the Trust Board ratified the payment to Birmingham Orthopaedics Services Ltd.	
AGREEMENT: The Trust Board ratified the payment to Birmingham Orthopaedics Services Ltd for Trauma and Orthopaedics work	
10 Amendment to the Trust's bank mandate	**SWBTB (12/09) 242**
Mr White sought the Trust Board's approval to amend the Natwest signatory list, to remove Steven Ball and Colin Holden, as the officers no longer work for the Trust. The Trust Board approved the request.	
AGREEMENT: The Trust Board approved the request to remove Steven Ball and Colin Holden from the Natwest signatory list	
11 Revisions to the disciplinary policy	**SWBTB (12/09) 243**
Mrs Barnett reminded the Trust Board that it had approved the revised disciplinary policy at the November Board meeting. She presented a proposed revision to the disciplinary policy to clarify the most appropriate policy to be used for medical staffing disciplinary matters. Matters of personal and professional misconduct are to be handled through the general disciplinary policy, while matters of competence and capability are dealt with through the medical staffing disciplinary policy. The proposed amendment was reported to have been discussed and agreed with the Trust's solicitors. The amendment was approved.	
AGREEMENT: The Trust Board approved the amendment to the disciplinary policy.	
12 Annual fire safety report	**SWBTB (12/09) 249** **SWBTB (12/09) 249 (a)**
Mr Seager presented the annual update on fire safety, which had been prepared to inform the Board's decision to approve the signing of the certificate of compliance for fire safety. The Board was advised that the Fire Safety Committee had met on a regular basis throughout the year and a review of the fire safety policy had been undertaken.	

Fire training was noted to have been delivered in a variety of courses. A fire safety manual had been completed to determine areas where additional measures could be implemented to strengthen the Trust's overall compliance with fire safety. A plan for City Hospital has been devised, which has progressed well, although some work remains in progress due to recent pressure on wards. It was reported that the number of fire alerts and incidents have increased, although work is underway to reduce the number of incidents to minimise the disruption caused, particularly those from false alerts. The single attempt to deliberately start a fire in the Trust was noted to have been investigated and addressed. Mr Seager was asked why no action had been taken in connection to this case. He advised that although the matter was concerning, it had not been a serious case and did not represent a significant threat to patient, public, staff or the estate. Mr Seager was asked how accidental breakage of fire alarms occurs. He advised that the covering of the mechanism which triggers an alarm is sensitive to small movements, therefore there is an expectation that there will be a small number of false alerts due to accidental damage. Mr Adler noted that there had been much work undertaken in respect of fire safety, some of which had been included in mandatory training courses. The Trust Board was asked for and gave its approval to the Chief Executive signing the annual declaration of fire safety.	
AGREEMENT: The Trust Board gave its approval to the Chief Executive signing the annual declaration of fire safety	
13 Quality and Governance	
13.1 Update on delivery of single sex accommodation	**Hard copy papers**
Mr Kirby presented progress with delivery of the plans to provide single sex accommodation across the Trust, in line with Department of Health guidelines on the matter. The Board was advised that all breaches of the guidelines are now recorded and the apparent worsening position is largely reflective of the additional areas now being monitored for breaches, although current operational pressures were noted to also be contributing. The primary consideration was reported to be the method by which single sex accommodation requirements are delivered in the Nightingale wards at City Hospital. Currently men and women are located at opposing ends of the wards, each sex having their own washing and toilet facilities. It is unavoidable however, that the patients at the end of the ward need to travel through the area dedicated to the opposite sex in order to leave the ward. As this is regarded as technically being non-compliant with the single sex guidelines, options to address the situation have been considered. Retention of the current configuration was proposed as an option, acknowledging that all practical measures are undertaken to separate patients of the opposite sex. Alternatively, it was proposed that delivery of same sex accommodation should be regarded as the overriding priority and reconfigure wards into single sex, mixed speciality areas.	

A project team was reported to have been established, which scored the various options, taking into account compliance with the single sex regulations, together with staff and patient feedback. The outcome of the exercise suggested that it was not practical to deliver a wholly single sex solution, given the potential disruption by mixing specialities. Instead it was recommended that as many of the wards as possible should be moved to a single sex basis, with bed planning work due to be undertaken in April 2010, being incorporated into the plans where possible. This was proposed to be a sensible interim solution, given that the configuration of the new hospital has been designed to meet fully the requirements of the single sex guidelines. A number of risks were noted to have been identified with the proposed approach. Firstly, there is a risk that because the single sex accommodation guidelines have not been fully met, patients may choose to be treated elsewhere. Inpatient surveys were highlighted to provide a means of tracking patient opinion in this respect. A further risk was reported to be any financial penalties that may be introduced for breaches to the guidance, although as the local commissioners have been involved with reviewing the available options, it was noted that this risk may not be realised. It was reported that the Strategic Health Authority had also been engaged with the options and was content with the proposed approach in the context of the plans for the new hospital. Professor Alderson asked how the Trust stood in relation to other local trusts. He was advised that by the nature of the estate, it was possible that the Trust would be one of the few locally that was experiencing difficulty in meeting the requirements. Mr Adler reported that the Trust had been showcased by the Department of Health as an example of a trust attempting to comply with the regulations in difficult and problematic circumstances. Mrs Talbot advised that the recent privacy and dignity campaign had revealed a heightened awareness of single sex accommodation issues. There had also been very few if any, formal complaints reported in connection with privacy and dignity. Taking into account the need to balance issues of clinical quality and privacy and dignity, the Trust Board approved the retention of the speciality-based wards, although it was agreed that an update should be presented in March 2010.	
ACTION: **Mr Kirby to present an update on delivery of single sex accommodation requirements at the meeting of the Trust Board in March 2010** **AGREEMENT:** **The Trust Board approved the proposed single sex accommodation approach, whereby speciality-based wards are retained on the basis that all measures to ensure high levels of privacy and dignity are undertaken**	
13.2 Care Quality Commission inspection report of the prevention and control of infections	**SWBTB (12/09) 244** **SWBTB (12/09) 244 (a)**
Miss Overfield presented a copy of the recent report by the Care Quality Commission, which outlined the outcome of a recent unannounced inspection against the Hygiene Code standards.	

The report highlighted that there had been no breaches of the hygiene standards. All staff had been congratulated on the successful outcome.	
14 Strategy and Development	
14.1 'Right Care, Right Here' programme: progress report	**SWBTB (12/09) 245** **SWBTB (12/09) 245 (a)** **SWBTB (12/09) 245 (b)**
Mr Kirby presented the latest update on progress with the 'Right Care, Right Here' programme. He advised that the outputs of the Strategic Models of Care work are being prepared. Changes to the Birmingham Urgent Care Centre are currently being finalised. The Chair noted that information concerning community non-consultant led outpatient activity was not available. Mr Kirby advised that it was not the remit of the Trust to provide this information. Miss Bartram asked if there was any further update on plans for Rowley Regis Community Hospital. She was advised that both long term and shorter term options were being considered at present. There is a possibility that the hospital may play an increasing role in social as well as health care.	
14.2 New Acute Hospital project: progress report	**SWBTB (12/09) 246** **SWBTB (12/09) 246 (a)**
Mr Seager reported that the Compulsory Purchase Order process for the land on which the new hospital is to be built is continuing. Some small issues had been raised by the Department of Health over the title of the land as a consequence of the objections received. These issues need to be resolved prior to the Secretary of State confirming that the order is valid and whether an enquiry is needed. A clearer view of the project finances is due to be gained shortly as part of work on the wider 'Right Care Right' Here programme. A workstream around the design vision of the new hospital has been established. Allied to this, programmes on information technology and arts are underway. Pre-procurement plans are being executed at present.	
15 Performance Management	
15.1 Monthly finance report	**SWBTB (12/09) 247** **SWBTB (12/09) 247 (a)**
Mr White reported that there had been steady progress in addressing the financial position in month and a surplus of £135k had been achieved against a target of £118k. A year end surplus of £2.3m continues to be forecast. A small fall in the number of WTEs has been seen in month. Additional costs due to operational pressures continues to be largely matched by the associated income received.	

Small amendments to the capital programme were noted. Mr Trotman confirmed that the Finance and Performance Management Committee continued to see a steady progression towards the forecast year end targets.	
15.2 Monthly performance monitoring report	**Hard copy papers**
Mr White reported that cancelled operations increased during the month, although these were confined mainly to ophthalmology, general surgery and oral surgery. There had been a slight improvement in performance against the delayed transfers of care target, although winter pressures may risk a deterioration in coming months. Performance against the stroke care target was noted to be disappointing, although there is optimism that the position may be addressed in the new year. In terms of performance against the CQUIN targets, greater focus is due to be given the smoking cessation referrals in coming months. Compliance with attendance at mandatory training was noted to be 41.4%, although more recent indications suggest this to be closer to 54% of staff having attended all necessary mandatory training sessions.	
15.3 NHS performance framework monitoring report	**Hard copy papers**
Mr White presented the NHS Performance Framework monitoring report. The Board was pleased to note that the score for November was 2.84, classifying the Trust as a 'performing' organisation. It was noted that the performance against the stroke and delayed transfers of care targets is at amber status and the Accident and Emergency waiting times target was at red status due to recent operational pressures.	
16 Operational Management	
16.1 Communications and engagement strategy update	**SWBTB (12/09) 251** **SWBTB (12/09) 251 (a)**
Miss Kinghorn presented the annual update of the communications and engagement strategy. The Board was asked to note that the shadow FT membership had increased, although three constituencies require further representation. The Board reviewed a breakdown of the current membership. Mr Trotman suggested that the use of resources to further increase the membership should be reconsidered. Mr Adler advised that all of the options currently under consideration for the future form of the Trust included a membership element.. He did acknowledge however, that there was significant cost attached to maintaining the membership. Miss Kinghorn stressed that recruitment of members was confined to specific areas only. In terms of media coverage, the Board was advised that the communications team had been restructured to better support the operational management structure and as a result, media handling and coverage had been more positive and efficient.	

Progress against the communications and engagement action plan was reviewed and it was noted that a number of actions need to be assigned revised completion dates. It was agreed that a refresh of the strategy should be presented at the May meeting of the Trust Board.	
ACTION: Jessamy Kinghorn to present an update of the communications and engagement strategy at the May meeting of the Trust Board	
16.2 Annual radiation protection report	**SWBTB (11/09) 220** **SWBTB (11/09) 220 (a)**
Dr Bill Thomson joined the meeting to present his annual report on radiation protection within the Trust. He advised that there were no serious matters that the Board needed to be made aware of. Dr Thomson reported that during the year there had been a shortage in nuclear medical consumables, thereby affecting the Trust's ability to undertake particular techniques in this area. The consumable is however, anticipated to be more readily available during 2010. In terms of staff radiation safety, the Board was advised that the majority of staff are not exposed to radiation. There had been two cases of nuclear medicine staff receiving doses above expected levels from fluoroscopy x-ray use, although it was noted that the measured dose levels were well within the level for a classified worker. Routine monitoring of all staff exposed to radiation takes place and equipment is checked prior to clinical use. Dr Thomson advised that a number of radiation protection training events had taken place during 2009. Mr O'Donoghue asked where any incidents that are required to be reported to the Care Quality Commission are considered internally. He was advised that these would be through the usual risk management process. It was agreed that consideration should be given to establishing a formal reporting process. Dr Thomson advised that the Governance Board was due to consider the radiation protection policy at its next meeting and the reporting process would be included within this policy. Dr Thomson was thanked for his useful and informative report.	
17 Update from the Committees	
17.1 Finance and Performance Management	**SWBFC (11/09) 220**
The Board noted the minutes of the Finance and Performance Management Committee meeting held on 19 November 2009.	
18 Any other business	**Verbal**
There was none.	
19 Details of the next meeting	**Verbal**

The next meeting is scheduled for Thursday 28 January 2010 at 14.30pm in the Anne Gibson Boardroom at City Hospital.	
20 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1 (2) Public Bodies (Admission to Meeting Act 1960).	

Signed ……

Print……

Date ……

Next Meeting: 28 January 2010, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

17 December 2009 - Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT). Ms I Bartram (IB), Mrs G Hunjan (GH), Dr S Sahota (SS), Mr J Adler (JA), Mr D O'Donoghue (DO), Mr R White (RW), Mr R Kirby (RK)

In Attendance: Mrs L Barnett (LB), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Miss J Whalley (JW), Mrs D Talbot (DT)

Apologies: Miss R Overfield (RO)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 21 January 2010

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 085	New acute hospital: progress report	Verbal	30-Apr-09	Present the process for consultation on the name of the new hospital at the next Trust Board meeting	GS	28-May-09	Deferred to next financial year.	Future	29-Apr-10
SWBTBACT. 084	MRI business case	SWBTB (4/09) 093 SWBTB (4/09) 093 (a)	30-Apr-09	Present a post implementation review of the City Hospital MRI scanner	RK	29-Apr-10	**ACTION NOT YET DUE**	Future	
SWBTBACT. 113	Update on delivery of single sex accommodation	Hard copy papers	17-Dec-09	Present an update on delivery of single sex accommodation requirements at the meeting of the Trust Board in March 2010	RK	25-Mar-10	**ACTION NOT YET DUE**	Future	
SWBTBACT. 114	Communication and engagement strategy update	SWBTB (12/09) 251 SWBTB (12/09) 251 (a)	17-Dec-09	Present an update on the communications and engagement strategy at the meeting of the Trust Board in May 2010	JK	27-May-10	**ACTION NOT YET DUE**	Future	
SWBTBACT. 099	Single Equality Scheme update	SWBTB (6/09) 126 SWBTB (6/09) 126 (a)	25-Jun-09	Include benchmarked data and contextual information into future versions of the Single Equality Scheme update	RO	24-Sep-09	Included within SES update	Completed Since Last Meeting	
SWBTBACT. 106	Response to the HCC report into Mid Staffs NHS FT	SWBTB (8/09) 164 SWBTB (8/09) 164 (a) SWBTB (8/09) 164 (b)	27-Aug-09	Present an update on the Quality Management Framework at the January 2010 meeting of the Trust Board	DOD	28-Jan-10	Included in joint Service Line Reporting/QMF paper. Further update planned for February 2010 meeting.	Completed Since Last Meeting	
SWBTBACT. 109	Public Health Matters	Presentation	29-Oct-09	Schedule a presentation by the Director of Public Health for Sandwell at a meeting early in the new year	SGP	25-Mar-10	Presentations scheduled for February (HoB tPCT), May (Sandwell PCT) and August (Sandwell PCT)	Completed Since Last Meeting	

Next Meeting: 28 January 2010, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

17 December 2009 - Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT). Ms I Bartram (IB), Mrs G Hunjan (GH), Dr S Sahota (SS), Mr J Adler (JA), Mr D O'Donoghue (DO), Mr R White (RW), Mr R Kirby (RK)

In Attendance: Mrs L Barnett (LB), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Miss J Whalley (JW), Mrs D Talbot (DT)

Apologies: Miss R Overfield (RO)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 21 January 2010

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.137	Minutes of the previous meeting	SWBTB (11/09) 237	17-Dec-09	The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held
SWBTBAGR.138	Single tender action: Aloka ultrasound	SWBTB (12/09) 239 SWBTB (12/09) 239 (a)	17-Dec-09	The Trust Board gave its approval to the single tender arrangement for the purchase of Aloka ultrasound equipment
SWBTBAGR.139	Single tender action: Phillips Intellivue monitors	SWBTB (12/09) 240 SWBTB (12/09) 240 (a)	17-Dec-09	The Trust Board gave its approval to the single tender arrangement for the purchase of Phillips Intellivue monitors
SWBTBAGR.140	Single tender action: private work for Trauma and Orthopaedics	SWBTB (12/09) 241 SWBTB (12/09) 241 (a)	17-Dec-09	The Trust Board ratified the payment to Birmingham Orthopaedics services for orthopaedics work
SWBTBAGR.141	Amendment to the Trust's bank mandate	SWBTB (12/09) 242	17-Dec-09	The Trust Board approved the amendments to the Trust's bank mandate
SWBTBAGR.142	Revisions to the disciplinary policy	SWBTB (12/09) 243	17-Dec-09	The Tryst Board approved the proposed revisions to the disciplinary policy
SWBTBAGR.143	Annual fire safety report	SWBTB (12/09) 249 SWBTB (12/09) 249 (a)	17-Dec-09	The Trust Board gave its approval to the Chief Executive signing the annual declaration of fire safety
SWBTBAGR.144	Update on delivery of single sex accommodation	Hard copy papers	17-Dec-09	The Trust Board approved the proposed single sex accommodation approach, whereby speciality-based wards are retained on the basis that all measures to ensure high levels of privacy and dignity are undertaken

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Listening into Action: Looking Ahead
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	Sally Fox. Listening into Action Facilitator
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

This paper sets out a proposed approach to embedding the LiA approach across the organisation over the coming months.

The suggested approach focuses on maintaining momentum, developing internal LiA capacity and expertise ,creating the right culture, holding leaders to account, giving people the right tools to support them in using LiA and working on establishing 'engaging' leadership.

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

Approval	Receipt and Noting	Discussion
X		**X**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to DISCUSS and APPROVE the suggested approach.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to spread staff engagement through Listening into Action, including the delivery of the LiA 'Enabling our People' projects
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Paper has been previously discussed by the Executive Team on 8 December 2009 and by the Trust Management Board on 19 January 2010

Listening into Action: Looking Ahead

Discussion Paper for the Trust Board: 28 January 2010

1. Introduction

The purpose of this discussion paper is to stimulate debate on the future of Listening into Action (LiA) and to agree a way forward. The programme has now been in place since April 2008, and the Trust now needs to consider how the philosophy of LiA can be embedded across the organisation over the next 12 months and beyond.

2. Current position and context

2.1

Listening into Action is now being used by over 60 teams within the Trust, including 20 Optimal wards and 20 clinical departments. The balance is made up by teams within non clinical areas such as Estates and Facilities, and an increasing number of wider corporate work streams in addition to the initial enabling projects. (eg sustainability, cycling etc) (A briefing on the current activity and the teams involved is attached for information)

2.2

The initial focus of a lot of the LiA work was on improving specific service areas for patients and staff, but over the last few months the way in which LiA is used is gradually expanding to embrace any significant change. For example, teams within Maternity and Gynaecology have used the methodology to address the medium term configuration of services and to gain staff's views about the management of change process, with an emphasis on learning from the past. Neonatal services plan to do something similar in the New Year.

2.3

On a broader level, there has also been an increase in the use of LiA to address specific corporate challenges-from developing a cycling strategy, to addressing the sustainability agenda as a whole, improving standards of privacy and dignity and developing an approach to commissioning the new acute unit.

The recent decision to use LiA methodology to inform the QuEP process at a corporate and directorate level reinforces the importance of maintaining high levels of staff engagement, however difficult, in more challenging times.

2.4

There is no doubt that a great deal has been achieved by many of the teams, and there have been positive outcomes for patients and staff in many areas. There has also been a welcome shift in the staff survey results and the inpatient survey results, which has been well documented.

2.5

However, it is probably fair to say that the initial 'honeymoon period' of excitement, novelty and enthusiasm has now passed. It is relatively easy to generate enthusiasm for a new approach which staff see as a way of making their voices heard and perhaps 'getting what they want' in the short term. It is much harder to sustain it in the longer term, when progress is not as fast as people hoped, or some of their ideas cannot be implemented for sound financial or business reasons. This may be a particular challenge during the lifetime of the QuEP.

2.6

The recent changes in the Divisional review process (which now includes discussion about the staff survey results) and the changes to the reporting arrangements to the Executive LiA Sponsor Group mean that Directorates/Divisions are increasingly held to account for their performance in relation to staff engagement. This is an important step in embedding the approach across the organisation.

2.7

On the assumption that the Trust wishes to continue developing this approach to staff engagement, the critical question is how can we make LiA 'the way we do things round here?' This paper presents some ideas about the potential way forward for discussion and approval.

3. Embedding LiA across the Trust

3.1 Maintaining Momentum on current work streams

There is a huge amount of LiA activity being undertaken within the Trust, and it is critical that momentum is maintained. The responsibility for this lies with the individual Sponsor Groups and LiA leads, but the Executive Sponsor Group members must continue to offer help and support to individual teams who appear to be faltering or facing organisational barriers. The LiA Facilitator

should also continue to have a key role in providing additional support and encouragement.

It is critical that staff continue to see progress, and are kept up to date with activity and **understand** when certain things cannot be achieved for legitimate financial or business reasons. The communications strategies employed by the individual teams are critical here. Lack of progress/ poor communication of outcomes lead to cynicism and a loss of faith in the LiA process, so getting this right is absolutely critical to the successful continuation of LiA. Some teams may need some further support here.

3.2 Developing internal LiA capacity and sharing learning

At present there is no systematic way to share learning and discuss problems/issues amongst those leading the Sponsor Groups around the Trust. The Trust LiA Facilitator makes links across different work streams where possible, but this is no substitute for peer group learning,and it seems appropriate to consider establishing a forum for LiA leads.

This forum could also assist in identifying common organisational barriers and provide an opportunity to address them. It could be used as a 'barometer' to gauge how much progress is really being made. Common learning needs for managers using LiA could also be identified and addressed through the forum itself or by other means. (Eg how to manage staff expectations, how to complete a specific LiA phase, how to maintain momentum...)

It is possible that at a later date some of the participants in this group who have achieved success with LiA could help 'mentor' others. There is a pressing need to build internal capacity and expertise prior to the departure of the LiA Facilitator in November 2010, and it is important to start preparing for this now.

3.3 Communication and maintaining the profile

It is critical that we continue with a high profile communication campaign, which constantly reinforces progress, and highlights changes which make things better for patients and for staff.

There is also a need to review the success of the communication methods that we have employed to date, and consider whether some fresh approaches/methods are needed to re- invigorate the process and generate interest.

Focusing on some of the latest uses of LiA in managing change and addressing difficult problems-like generating ideas for the QuEP, could be a useful way of emphasising the Trust's commitment to leading in an engaging way, despite the challenges and difficulties we face.

It may be that we have reached an appropriate point to commission a further DVD which could also include resource materials for managers.

3.4 Celebrating Success

An important part of LiA has been the recognition and celebration of success. This has been achieved by various means-such as stories in internal newsletters, articles in Heartbeat, the addition of an LIA award category in the Staff Awards etc

Given the need to maintain the profile and interest in LiA it would seem appropriate to hold a celebratory event to mark the 2 year anniversary point in April/May 2010. This could be a means of showcasing the best of what has been achieved to date, inspiring others and rewarding all the effort that has been put in to the existing work streams.

This could also be a 'call to arms' for interested LiA leads to come forward to advise and support others in the future. (This also has the benefit of allowing a period of 6 months for support and training from the current LiA Facilitator.)

3.5 Creating the right culture for LiA to flourish

It is important that both managers and staff understand the concept that LiA is a way of leading, not a series of one off 'projects'. There is a need to constantly reinforce this expectation, so that staff **expect** to be involved and engaged in change and improvement, and, equally, managers expect to lead in this way.

Successful LiA work should lead to improvements that frontline staff can see and experience. There needs to be a mechanism to 'take the temperature' at the frontline to test out the reality of what is happening. This could be done in a variety of ways, but one method would be to arrange a series of Chief Executive visits to selected areas of the Trust currently using LiA. This approach would have the advantage of demonstrating the Chief Executive's continuing personal commitment to LiA, and give frontline staff the opportunity to share their experiences directly.

The visits could focus on 3 key areas:

What has been achieved to date?

What have been the key barriers?

Where next with LiA ?

3.6 Holding leaders to account

The current arrangements at Divisional review, where there is now a focus on staff engagement (in addition to finance, activity and quality) need to be continued so there is a clear understanding that performance in this area is just as important as performance in any other area of responsibility.

The Executive Sponsor Group needs to continue to meet and review progress against the individual LiA work streams with direct input from the DGMs and the LiA leads. In time, it may be appropriate to change these arrangements, but not until the approach is more securely embedded.
There is also a need for staff engagement to be built in to the PDR process, which will be addressed later in this paper.

3.7 Giving people the tools

At present staff wishing to use LiA have access to the LiA Facilitator, and support in the form of an 'Easy Guide to LiA'. This guide is useful in setting up an LiA event, but there is now a need for something further which develops some of the ideas and reinforces what leading in this way means-aswell as debunking a few myths about LiA and giving some practical tips.

This guide needs to confirm that LiA can happen anywhere in the Trust-it does not need external venues, and does not need to involve any very significant costs. Its success depends on leadership, the involvement of the right people and the commitment of those concerned, as much as having the right structures in place to take the work forward. This guide could also include some general tips on leading in an engaging way, and some of the techniques that can be used to do so.

Addressing the issues identified above will help to embed LiA and ensure its sustainability in the short term, but there are other longer term issues to consider when trying to achieve a significant and sustainable shift in the way the organisation is led at all levels. The next part of this paper attempts to address these.

4. Establishing and embedding 'engaging leadership'

Listening into Action requires a different sort of leadership, one which enables and empowers, and helps unblock the way so staff can achieve change and reach their own potential.

If the Trust is to attract, retain and develop these leaders for the future there is a need to review and amend some of our organisational processes to ensure that they deliver the right kind of leaders.

4.1 Recruitment/selection techniques

The Trust needs to ensure that the selection methods used for leadership posts are robust enough to identify those with the right attitudes and aptitudes for leading in an engaging way. Some research would be needed to identify the most appropriate ways of testing this out, but it is important to recruit leaders who are able/or have the potential to lead in this way.

4.2 Performance management

The Trust needs to use the PDR process to reinforce the value that is placed upon successful staff engagement. It may be appropriate for example for all managers to have an objective/duty around staff engagement.

This might be a generalised objective about managing change using appropriate staff engagement techniques, for example, but it could also be something very specific about working with a particularly 'disengaged' staff group-perhaps as identified by the staff survey.

Managers reviewing individual performance need to become accustomed to asking how individuals have engaged with staff in delivering their service/achieving their other objectives. This will lead to an understanding amongst those being reviewed that as part of their appraisal process they will need to provide some evidence of staff engagement activity.

4.3 Development interventions

The LiA Facilitator is currently undertaking a review of the Trust's leadership/management development provision. There is a range of activity in this area, although there is no overarching framework which brings it together into a coherent whole. The Board has recently defined the sort of leadership the Trust wants to encourage and endorse, and there is a need to review current activity to ensure it is congruent with developing leaders with the preferred leadership styles/behaviours.

The concept of staff engagement and the LiA methodology needs to be incorporated in development activities as appropriate-and whilst it is included in some programmes, there is more work to do in this area.

4.3.1 Focusing on front line managers

The LiA process is often initiated by senior managers, rather than those directly at the front line. Indeed, sometimes any reluctance to work in a more engaging way often comes from more junior managers. There may be some issues of confidence here, and also a lack of expertise/experience in using this style of leadership.

There is a need for some investment in appropriate development initiatives at this critical level in the organisation. A redeveloped guide to LiA will assist with this, but it will need to be supported by some workshops and possibly coaching interventions where appropriate.

4.4 Reward and recognition

Whilst recognising that the Trust is currently subject to the national terms and conditions of Agenda for Change for the majority of its leaders, it is still worth

considering how its approach to reward and recognition reinforces (or otherwise) the practice of engaging leadership.

Well designed reward strategies recognise and reward the behaviours that the organisation wishes to encourage **in a currency that is valued by the individual.**

This 'currency' does not have to have a financial value-it can be based on a range of benefits and methods of reward/recognition-a 'cafeteria' approach.

This is an area that needs very careful handling, and one which will need to be informed by any new organisational models which emerge as a result the ongoing work around taking the staff engagement model further.

5. Designing an overall approach to Organisational Development

The Trust does not currently have a comprehensive OD strategy, but is using a variety of techniques to achieve service/organisational improvement. These include:

Listening into Action

Service Improvement

Right Care Right Here interventions

Productive Ward techniques

LEAN methodology

In order to maximise the benefit of all of these approaches and the resources associated with them, consideration needs to be given to how these elements fit together as part of an overarching approach to OD. How can we maximise their impact and ensure there is a coherent and flexible OD strategy designed to meet the changing business needs of the Trust?

6. Resourcing

LiA is supported by one part time (22.5 hours) Facilitator on a fixed term contract which is due to end in November 2010. There is sufficient income in the budget at present to support some administrative support on a bank basis.

There will be sufficient funding to support some further corporate events.

It is assumed that there will be no further funding from the SHA for LiA, and thought will need to be given to how the programme might be funded in future.

7. Evaluation of LiA

The SHA is in the process of developing a tender specification for the evaluation of the LiA work within the West Midlands-at Sandwell and West Birmingham, Birmingham Children's Hospital, Walsall and Wolverhampton Acute Trusts.

It might also be worth considering further work on how we evaluate the outcomes of LiA worksteams within the Trust. At present we do not necessarily set specific objectives at the beginning of an LiA process, but there might be some merit in doing so.

3. Conclusion

Listening into Action has achieved some significant successes for teams within the Trust, and has received a level of external recognition within the NHS.

In many ways the programme has reached a critical point in its development. The focus now needs to be on taking all the necessary steps to ensure that it is successfully embedded within the organisation and becomes self sustaining.

Sally Fox
LiA Facilitator
Revised 18 January 2010

LiA Work Streams

Ward areas

D16
D7
Lyndon 3
Priory 5
Newton 4
D21
D24
D11
D27
MAU
Newton 3
Mc**C**arthy
D12
D15
D18
D41
Priory 4
D43
D47
D26

Other clinical areas

Community Midwifery
Maternity –Midwifery Led Birthing Unit

Imaging
-Exemplar service
-Imaging Division
-Breast Screening

Pharmacy
Audiology

Pathology
-Phlebotomy
-Haematology

Neurophysiology

Critical Care-Follow Up Service

Theatres

Birmingham and Midland Eye Centre
-Patient experience
-Theatre experience

Physiotherapy

Stroke Care

Cancer Services

Paediatrics

Neo natal services

Occupational Health

Non clinical areas

Medical records

Elective Access

Estates

Facilities
-First line managers/supervisors and trade unions
-Hotels services
-Transport
-Catering
-Portering and security

Improving discharge (Medicine)

Corporate work streams

Customer care

Leading through engagement

Time to Learn

Valuing our people

Equipment fit for the job

Working with trade unions

Trust wide communications

Ward leadership development

Sustainability

Cycling

QuEP

Privacy and Dignity

Commissioning for the new hospital

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Contract Of Employment
SPONSORING DIRECTOR:	Lesley Barnett, Acting Director of Workforce
AUTHOR:	Nick Bellis, Acting Head of Human Resources
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

The Trust Contract of Employment has been revised to reflect current legislation, Agenda for Change terms and conditions, Department of Health requirements, revised Trust policies and best practice.

Amendments and additions are highlighted and include important sections concerning infection control, safeguarding, major incidents/pandemics, mandatory training, whistleblowing, criminal convictions and retirement age.

It is proposed to issue this contract to all new employees as soon as possible.

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 approve the new policy.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

Financial		
Business and market share		
Clinical		
Workforce	**x**	Affects all new staff joining the Trust
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

PPAC – May/June 2008
JCNC – 4 November 2009
TMB – 19 January 2010

STATEMENT OF PRINCIPAL TERMS AND CONDITIONS OF EMPLOYMENT

BETWEEN

XXXXXXXXXX (Employee)

and

Sandwell and West Birmingham Hospitals NHS Trust

(Hereinafter referred to as the Trust)

This document details your principal terms and conditions of employment relating to your appointment, as required by the Employment Rights Act 1996 and together with your letter of appointment constitutes your contract of employment with the Trust. This contract of employment will supersede any previous contract of employment with the Trust and should be read in conjunction with all relevant Trust Polices and Procedures. For details of current polices please refer to the Sandwell and West Birmingham Hospitals intranet.

Section 1 – SUMMARY

Appointment Details:		**Please refer to section**
Post title:		
Responsible to: (hereinafter referred to as your "manager")		
Location/Base:		13
Date of Appointment:		
Date of Commencement with Trust:		4
Date of Commencement of Continuous NHS Service:	**To be confirmed by Payroll**	**5**
Nature of appointment:	Substantive	
Pay Band:		
Salary scale:		
Basic salary: (full time equivalent)		
Basic salary: (actual for part time)		
Recruitment/Retention premium:	**N/A**	**7**
Recruitment/Retention premium payable:	**N/A**	**7**
Incremental date:	**Subject to confirmation of previous service**	**9**
Method of Payment:	Monthly	11
Contracted hours per week:		
Standard full time hours per week for staff group:		14
Annual leave entitlement: (calculated in days for full time equivalent)		15
General Public Holiday entitlement: (full time equivalent)		15
Annual leave/public holiday entitlement: (calculated in hours)		15
Minimum notice period from the Trust:		20

SPECIAL CONDITIONS RELATING TO APPOINTMENT: Your appointment may be subject to a Criminal Records Bureau check and if this check reveals any offences that you have not previously declared your employment may be terminated.

ACCEPTANCE: I confirm that I have read, understood and accept this appointment on the terms and conditions set out above and consent to the processing of personal data, including personal sensitive data, within the meaning of the Data Protection Act in relation to my employment. I accept that this contract replaces any existing contract I may have with this Trust. I hereby authorise the Trust to make lawful deductions from my salary or any other money due to me. I have retained a copy of this statement for my own information.

Signed for the Employer by: ..... **Name: (block capitals):**…….

Designation: ..... **Date:** ……..

Applicant / Employee signature: ..... **Date:** .....
Please sign both copies of this statement and return one copy to the Recruitment Office.

2. DUTIES/POST

The duties and responsibilities of the post are as set out in your job description.

3. DATE OF APPOINTMENT

The date of appointment to this post is as set out in section 1.

4. CONTINUITY OF EMPLOYMENT

For the purposes of statutory employment rights, your continuous employment started from the date of commencement with the Trust (as set out in section 1).

5. CONTINUOUS NHS SERVICE

Continuous previous service with an NHS employer will count as reckonable service in accordance with the relevant NHS agreements on redundancy, occupational maternity leave/pay, and occupational sick pay. Please refer to the relevant Trust policies for details of qualifying periods. Annual leave entitlement will be calculated on the basis of aggregated proportional NHS service.

Employment outside of the NHS, where it is judged to be relevant to your NHS employment, may be counted as reckonable and aggregated service. Any non-NHS service to be taken into account as reckonable service will be agreed in principle at the time of appointment but will be subject to confirmation from your previous employer(s).

Your NHS continuous service date is subject to confirmation from your previous NHS employer(s).

6. ARRANGEMENTS FOR DETERMINING PAY AND CONDITIONS OF SERVICE

This appointment is subject to the National Terms and Conditions of Service that are agreed by the NHS Staff Council.

The Trust agrees local terms and conditions of employment and employment policies and procedures with locally recognised Staff Side Organisations via the Joint Consultation and Negotiation Committee. Any changes to your contract of employment will only be made by agreement with you individually or by collective agreements with the JCNC or the NHS Staff Council.

7. REMUNERATION

Annual Basic Salary

The pay band and salary scale for this post is as set out in section 1.

The annual salary payment of full time employees who are paid monthly shall be apportioned as set out below:

One twelfth of the annual salary	The monthly sum divided by the number of days in the particular month

The annual salaries of part time or sessional employees who are paid weekly or monthly should be apportioned as above, except in the months or weeks in which employment commences or terminates, when they should be paid for hours or sessions worked.

Your full time equivalent basic salary and for part time staff, your actual basic salary, is as set out in section 1. Part time employees will be paid a salary based on their contracted hours as a proportion of the full time equivalent hours for that post (as set out in section 1).

Previous NHS service may be taken into account in determining your commencement salary in accordance with the relevant Terms and Conditions of Service and guidance contained with the Trust's Recruitment and Selection Policy. Your commencement salary has been determined from the information provided by you on your application form; however, this is subject to confirmation of relevant service from your previous NHS employer. When this information has been obtained, your commencement salary will be adjusted if necessary and details will be shown on your payslip.

Recruitment and Retention Premium

This is a premium that can be paid in addition to basic pay for either an individual post or a specific group of posts where market pressures would otherwise prevent the Trust from being able to recruit staff to and retain staff in sufficient numbers for the posts concerned at the normal salary for a job of that weight. If this post attracts a recruitment/retention premium details are as set out in section 1. Only the payment of a long-term premium is pensionable.

Withdrawal of a short-term premium is subject to a six month notice period.

8. PAY PROGRESSION AND GATEWAYS

Newly appointed or promoted staff joining a pay band will normally serve an initial foundation period of up to twelve months. During this initial period all staff will have at least two discussions with their manager or supervisor to review their progress guided by the Knowledge and Skills Framework. Once progression has been agreed staff will normally progress to the next point on their pay band twelve months after appointment and to subsequent points every twelve months thereafter subject to meeting the criteria for progression when they will pass through the second gateway point. Clinical staff joining pay band 5 as new entrants will have accelerated progression through the first two points in six monthly steps subject to demonstrating satisfactory practice. This twelve month period will be referred to as "Preceptorship" and will be applied in accordance the Agenda for Change Terms and Conditions of Service.

9. INCREMENTAL DATE

For newly appointed or promoted staff the incremental date will be the date they take up their post. Staff who were subject to assimilation to the new National Terms and Conditions of Service will retain their existing incremental date or be assigned an incremental date of the anniversary of the effective date of assimilation (as set out in section 1).

10. STAFF DEVELOPMENT REVIEW

You will be required to take part in a regular staff appraisal in accordance with Trust procedures.

11. METHOD OF PAYMENT

Your salary will be paid as stipulated in Section 1 by bank credit to the bank/building society of your choice at monthly intervals.

12. FLEXIBILITY

In order to ensure the Trust's ability to respond to changes in the needs of the service, after appropriate consultation and discussion with you (including consideration of personal circumstances, current skills, abilities and career development) the Trust may make a change to your location, duties and responsibilities that are deemed reasonable in the circumstances.

13. PLACE OF WORK

Your normal place of work will be as set out in section 1 but you may be required to work in other designated locations of the Trust to meet the needs of the service.

14. CONTRACTED HOURS

Your contracted hours (exclusive of unpaid meal or rest breaks) for this appointment are as set out in section 1.

Staff subject to assimilation to the new national terms and conditions of employment, and whose current full time equivalent standard working week is either greater than or less than 37.5 hours per week, will be subject to transitional arrangements as per the new national terms and conditions of employment.

Your normal pattern of work will be agreed with you by your manager subject to the needs of the Trust, flexible working arrangements (agreed by you and your manager) and the Working Time Regulations. The Working Time Regulations state that you should not work more than an average of 48 hours per week based on a 17week period unless you have signed an opt out clause agreeing to work more than 48 hours over a 17 week reference period. As such the Trust is required to be aware of all the hours you work regardless of whether this is for the Trust as overtime, bank/casual, agency work or with another employer. You are, therefore, required to notify your manager of any such hours worked.

Subject to your agreed contractual hours, you may be requested to work additional hours as necessary for the full performance of your duties, including undertaking such cover as may be necessary from time to time to sustain the service in the absence of colleagues. Occasional overtime may be requested and this will be arranged in consultation between you and your Head of Department. You may also be expected to participate in any standby or on-call duties where these are deemed appropriate within your department. Remuneration will be in accordance with the national terms and conditions of employment.

The post is an essential part of a seven-day health service, which may require you to work at weekends and on public and designated holidays. Any requirement to work on these days will be in accordance with normal working rotas or by local arrangement with your Head of Department.

15. ANNUAL LEAVE ENTITLEMENT/GENERAL PUBLIC HOLIDAYS

The full time equivalent entitlements are as per the following table and your full time equivalent entitlement is as set out in section 1.

Length of service	**Annual leave and General Public Holidays in days**	**Annual leave entitlement in hours** **(Based on 37.5 basic contracted hours)**	**Public Holiday entitlement in hours** **(Based on 37.5 basic contracted hours**
On appointment to NHS	27 days + 8 days	202.5	60.0
After 5 years NHS service	29 days + 8 days	217.5	60.0
After 10 years NHS service	33 days + 8 days	247.5	60.0

The above entitlements are based on staff working shifts of 7½ hours, excluding meal breaks. All staff (full and part time) will have their annual leave and general public holiday entitlements calculated on an hourly basis to prevent staff working a shift pattern other than standard shift of 7 ½ hours receiving more or less leave than colleagues on standard shifts. Part time staff will have their annual leave (and general public holidays) entitlement calculated on a pro-rata basis based on their contracted hours per week as a percentage of the full time equivalent. Further details are contained in the Trust's Leave Policy.

The Trust's annual leave year runs from 1 April to 31 March each year. Staff may take leave at any time in the year subject to the agreement of their line manager and dependant on the needs of the service.

For incomplete years of service the leave entitlement is calculated on a pro-rata basis at the rate of 1/12th of your annual leave entitlement per full month of service.

On termination of your employment if you fail to give the correct contractual notice, the Trust reserves the right not to pay any monies in respect of annual leave, in excess of your entitlement under the

Working Time Regulations 1998, that has been accrued but not taken at the date your employment terminates.

During your notice period the Trust may or may not require you to take any untaken accrued annual leave.

Subject to the following paragraph, upon termination of employment, staff will be entitled to any holiday pay accrued during completed month's of work .

Should you have taken more holiday than you are contractually entitled at the date of termination of employment payment will be deducted from your final salary in respect of such leave taken in excess of entitlement unless you have agreed in writing alternative arrangements in advance with the Trust.

Staff must take at least four week's annual leave (pro rata) each leave year. Where employees are prevented by the Trust from taking the full allowance of annual leave before the end of the leave year they shall be allowed to make up the deficiency during the ensuing leave year at a time to be mutually agreed.

Staff whose employment is terminated on grounds of ill health will be able to take any accumulated statutory annual leave as a payment.

Employees may carry forward one week pro-rata annual leave with the approval of the relevant line manager.

16. DEDUCTIONS FROM PAY

The Trust reserves the right to make all deductions required by law or made with your separate written consent.

These deductions may include for example (as appropriate): -

- Residential accommodation fees
- Trade Union dues
- Meals
- Beverages
- Telephone Charges
- Salary overpayments
- Criminal Records Bureau Check Charges
- Nursery Fees
- Library Fees
- Car Loan Charges
- Car Parking Fees
- Home Computing Initiative
- Salary advances
-

Staff who terminate their employment with outstanding charges, agree as part of this contract of employment, that the balance can be deducted from their final salary payment. When large amounts are outstanding discussion will take place with you regarding methods of payment.

Furthermore, the Trust also reserves the right, following investigation, to withhold payment or deduct a day's pay for each day of any unauthorised absence.

17. MATERNITY LEAVE AND PAY

Statutory and occupational maternity leave, pay and other related rights are laid down in current legislation and the National Terms and Conditions. Full details are covered in the Trust's Family Leave Policy.

18. SICKNESS ABSENCE

Sickness absence is managed as per the Trust's Sickness Absence Policyand it is your responsibility to ensure that you adhere to local reporting and operational arrangements as detailed in thepolicy and as

communicated to you locally. If you do not adhere to the local reporting arrangements any absence following investigation may be deemed to be unauthorised for which you may not receive occupational sick pay and for which disciplinary action may be taken.

Statutory Sick Pay

The Trust is responsible for paying its employees (except those excluded) Statutory Sick Pay for the first 28 weeks of absence through sickness in any one period (subject to the criteria of the scheme). This is paid on behalf of the State and is subject to PAYE tax and NI contributions. Your qualifying days are Monday to Sunday inclusive.

Occupational Sick Pay

Occupational Sick Pay based on reckonable service as set out in section 5. Further details can be obtained in the Agenda for Change Terms and Conditions of Service Handbook. Payment is subject to correct notification of absence, as follows:

During the first year of service:	1 months full pay and 2 months half pay
During the 2nd year of service:	2 months full pay and 2 months half pay
During the 3rd year of service:	4 months full pay and 4 months half pay
During the 4th and 5th years of service:	5 months full pay and 5 months half pay
After 5 years service:	6 months full pay and 6 months half pay

Full Pay

Full pay is the Occupational Sick Pay Allowance made to an employee on paid sick leave inclusive of Statutory Sick Pay and shall not exceed the employee's normal pay for the period. Where it does, the occupational sick pay allowance will be reduced accordingly.

Half Pay

Half pay means half the amount normally payable for the period except that half pay plus SSP, or State Benefit together must not exceed full pay. Where it does the half pay will be reduced accordingly.

19. HEALTH, SAFETY AND WELFARE

The Trust is committed to improving the health, safety and welfare of all its employees. Information relating to identified hazards; for example, chemicals, stress etc. will be provided as part of the Trust's Induction process or will be available from the Department of Occupational Health, Safety and Welfare. Should you at any time have any concerns about your health at work, please discuss these with your manager or the Occupational Health Service.

Health Assessment

The Trust may at any time request an employee to undergo a medical examination by a registered medical practitioner nominated by the Trust subject to rights under the Access to Medical Reports Act, which may include reasonable testing and diagnostic procedures.

Prior to commencement staff may be required to demonstrate immunity or non-infectivity for specific infectious diseases. This is particularly important for employees undertaking surgical, midwifery or dental type duties. Employees will also be offered relevant immunisation against certain illnesses, which the Trust deems necessary in order to protect the Health and Safety of employees and/or to minimise the risk to patients.

Health and Safety at Work Act

In addition to the responsibilities of the Trust under Health and Safety legislation you are reminded of your responsibilities for health and safety at work under the Health and Safety At Work Act 1974 as amended and associated legislation. These include the duty to take reasonable care for the health and safety of yourself and of others in your work activities or omissions, and to co-operate with your employer in the discharge of its statutory duties. You must adhere strictly to the policies and procedures on health and safety, and report all accidents, dangerous occurrences, unsafe practices or damage to your manager promptly using the Trust's incident reporting system. You must make use of appropriate training, safety equipment, protective clothing and footwear and attend training. Failure to comply with these requirements may result in disciplinary action.

Infection Control

The Trust is committed to reducing the risk of health care acquired infection. It is essential that you adhere to all infection control policies, procedures and protocols (to include hand decontamination, correct use of PPE and care and management of patients with communicable infections).

You should ensure that you are aware of the correct use and application of any Personal Protective Equipment worn and attend infection control education and training sessions as applicable to your work. You must report any violations promptly using the Trust's incident reporting system.

It is the responsibility of staff to ensure they report any known or suspected symptoms of a communicable infection to Occupational Health and Infection control. (e.g - infectious symptoms e.g. diarrhoea and /or vomiting, rashes etc.). If off sick they should ensure that their line manager is updated of progress and possible cause.

For line Managers -
It is the responsibility of line managers to ensure:-

- All staff working in their area understand and are familiar with all infection control policies, procedure and guidelines(to include hand decontamination, correct use of PPE and care and management of patients with communicable infections). Where staff are required to wear PPE, you are responsible for ensuring that PPE is readily available and staff understand and are competent in the use of PPE worn.
- All staff in their area are aware of and adhere to the hand hygiene policy.
- Ensure any staff with known or suspected symptoms of a communicable infection are reported to Occupational Health and Infection control. (e.g - infectious symptoms such as diarrhoea and /or vomiting, rashes etc.) The employee should be asked to maintain regular contact with their manager and inform them as soon as possible of their expected date of return, (as a minimum the employee should endeavour to give 24 hours notice of their intended return to duty)
- It is imperative that staff do not attend or remain at work whilst infected with organisms that have the potential to cause outbreaks or severe infection among patients and colleagues. Should a member of staff have any of the conditions or infections below, whilst at work, they should contact Occupational Health (or Microbiology out of work hours) to evaluate their fitness to work.

    - Severe skin problems – rashes, infections, lesions, uncontrolled eczema or psoriasis
    - Gastro Intestinal Problems – diarrhoea/vomiting
    - Respiratory Problems – flu symptoms or suspected tuberculosis.

20. NOTICE PERIODS

For AFC Pay Bands 1 to 6
Unless there is mutual agreement that a different period should apply, you will be required to give 4 weeks' notice of termination of your employment,

For AFC Pay Bands 7 to 9

Unless there is mutual agreement that a different period should apply, you will be required to give 12 weeks' notice of termination of your employment

If the Trust gives you notice to terminate your employment, you will receive the following notice:-
For staff with 4 weeks or more but less than two years continuous service – 1 week

For staff with 2 years or more continuous service – 1 week per complete year of continuous service subject to a maximum of 12 weeks.

The Trust shall have the discretion to terminate your employment lawfully without any notice or on notice less than the notice period set out above by paying you a sum equal to, but no more than your basic annual salary detailed in section 1 in respect of that part of the period of notice which the Trust has not given you, less any appropriate tax or other statutory deductions. Basic pay will include any recruitment and retention premium that was payable at the date of termination.

The above does not affect the right of either party to terminate the contract without notice and without a payment in lieu of notice by reason of conduct of the other party.
Notice must be given in writing.

The Trust reserves the right to require you to remain away from your work during your notice period for as long as the Trust deems appropriate. When you are required to remain away from your work you will receive full pay. You are not permitted to commence work for any other NHS Organisation, person, firm or corporation, nor on your own behalf without the Trust's prior permission during this period. You will be required to comply with any reasonable conditions laid down by the Trust.

If your employment terminates you must return to the Trust any Trust property (including protective clothing and uniforms) or Trust documentation. You and your line manager will be required to sign an undertaking that all Trust property has been returned before final payment can be made.

There is no entitlement to notice or payment in lieu of notice in the event of summary dismissal.

21. PENSIONS

Membership of the NHS Pension Scheme is available to all employees over the age of 16. Membership is subject to the regulations of the NHS Pension Scheme, which is administered by the NHS Pensions Agency.

Membership is voluntary; however employees will be automatically included in the scheme unless they choose to opt out. Employees not wishing to join the Scheme or who subsequently wish to terminate their membership must complete an opting out form - details of which will be supplied on request. A contracting-out certificate under the Pension Schemes Act 1993 is in force for this employment and, subject to the rules of the Scheme, if you join the Scheme your employment will be contracted-out of the State Earnings Related Pension Scheme (SERPS).

22. RETIREMENT AGE

The Trust has a retirement age of 65 years of age. You will be given notice of retirement in accordance with the Trust's Retirement Policy prior to your 65th birthday. You will have the right to request to continue working beyond your 65th birthday in accordance with the policy, but if you make this request and it is not granted, your retirement will take effect on your 65th birthday. However, if you are a member of the NHS Pension Scheme you may choose to access your pension from age 50 onwards subject to the rules of the scheme.

23. REGISTRATION

In line with the Trust's Professional Registration Policy staff undertaking work which requires professional/state registration are responsible for ensuring that they are so registered and that they comply with any Codes of Conduct applicable to that profession. Proof of registration must be produced

on appointment and, if renewable, proof of renewal must also be produced. Failure to maintain registration or loss of registration will be treated as a breach of your terms and conditions of employment and may result in your dismissal; transfer to other employment not requiring professional/state registration, and may involve suspension from duty without pay pending investigation.

24. QUALIFICATIONS AND EXPERIENCE

Your employment, and continued employment, is conditional upon having and retaining all the relevant educational, vocational, professional and any other relevant qualifications that you have stated you had when you completed your application form and undertaking update and new training as may be required to undertake your duties. It is also expected that the grades of all examinations taken conform to those that you have stated on your application form. The Trust also expects that you have had the work experience that you have stated in your applications and at your interview. If it is discovered that you do not have the said qualifications or experience or, where for whatever reason you fail to acquire any appropriate examination or licence, become disbarred from an appropriate Regulatory body or Authority, it may result in your dismissal.

25. PERSONAL PROPERTY

Your attention is drawn to the fact that the Trust cannot be held responsible for any loss or damage to the personal effects of members of staff by reason of fire, theft, or any other cause and staff are advised to take out insurance cover against such risks.

26. MANAGING DIVERSITY

The Trust is committed to managing diversity in employment in line with the Trust's Single Equality and Diversity schemes. It recognises that discrimination is unacceptable and that it is in the best interest of the Trust and the population it serves to utilise the skills of the total workforce. Failure to comply with or adhere to the Trust's Equal Opportunities Policy will be treated as misconduct under the Trust's Disciplinary Policy, which may result in dismissal.

27. HARASSMENT AT WORK

Harassment at Work will not be acceptable in any form. Failure to comply with or adhere to the Trust's Dignity at Work Policy will be treated as misconduct under the Trust's Disciplinary Policy, which may result in dismissal.

28. STANDARDS OF CONDUCT

You are bound by the provisions of the Employees Charter published by the NHS Executive and which are contained in the Trust's Standing Orders. You are directed to read these standards, which are available from your manager. Staff whose roles include handling monies and/or procuring goods and services must adhere to the Trust's Standing Orders and Standing Financial Instructions, which are available from your manager. It is the responsibility of staff to ensure that they are not placed in a position which risks or appears to risk conflict between their private interests and their NHS duties. Failure to comply with or adhere to the Standards of Business Conduct will be treated as misconduct under the Trust's Disciplinary Policy , which may result in dismissal.

You must notify the Chief Executive immediately in writing of any Trust contracts and/or proposed Trust contracts in which you have a financial interest (whether direct or indirect) and whether or not the contract/proposed contract is one to which you are personally a party.

29. EMPLOYMENT CHARTER, NHS CONSTITUTION AND CODE OF CONDUCT

The Trust expects all employees to act at all times in accordance with this code of conduct. A copy of the Employment Charter, NHS Constitution and Code of Conduct is available on the intranet.

30. GIFTS AND HOSPITALITY

Gifts offered by contractors or others should be politely but firmly refused, so as not to constitute an offence under the Prevention of Corruption Acts 1906 and 1916. Articles of low intrinsic value such as calendars, or diaries or small tokens of gratitude from patients or their relatives need not necessarily be refused. In cases of doubt take advice from your line manager or politely refuse acceptance.

The Trust considers it to be a serious offence for any employee, in connection with their employment, to accept gifts and hospitality, other than by way of a token nature, from any person or business with whom you or the Trust is involved. This also includes an offer to a third party or acceptance of any benefit whether financial or in kind from any other party (other than the proper remuneration from the Trust). Further guidance is provided in the Trust's Hospitality Policy. If in doubt you should seek advice from your manager or the Directorate of Governance Development. Any breach of this clause will be treated as misconduct under the Trust's Disciplinary Policy , which may result in dismissal.

31. WHISTLEBLOWING

The Trust recognises that all employees have both a right and a duty to raise concerns they may have relating to the delivery of patient care and the provision of health care. Any concerns should be raised in line with the Trust's Whistleblowing Policy.

32. CODE OF CONFIDENTIALITY

You must at all times be aware of the importance of maintaining confidentiality of information gained by you during the course of your duties. This will in many cases include access to personal information relating to service users. You must treat all information in a discreet and confidential manner and particular attention is drawn to the following:

- Information regarding service users must not be disclosed either verbally or in writing to unauthorised persons. It is particularly important that you should ensure the authenticity of telephone enquiries.

- Written records, computer records and correspondence pertaining to any aspect of the Trust's activities must be kept securely at all times.

- You have an obligation to ensure that computer systems which you use are protected from inappropriate access within your direct area of practice e.g. by ensuring that personal access codes are kept secure.

  All data held, its management and procedures must conform to the requirements of the Data Protection Act (1998). Under the Act service users and staff have a right of access to their records on application to the appropriate manager. This can be read in conjunction with the organisation's Data Quality / Information Security Polices. If it is necessary to share information in order to effectively carry out your work, you must make sure that as far as is reasonable this information will be exchanged on a strictly 'need to know' basis, using the minimum that is required and be used only for the purpose for which the information was given.

- If unsure seek advice from the Trust's Caldicott Guardian, details available from the Workforce Directorate.

- Conversations relating to confidential matters affecting clients should not take place in situations where they may be overheard by passers-by, e.g. in corridors, reception areas, lifts and cloak rooms.

- The same confidentiality must also be observed in dealing with work related matters appertaining to work colleagues.

- Any breach of confidentiality may be regarded as misconduct and may be subject to disciplinary action.

- The Data Protection Act 1998 governs personal information recorded on computer and unauthorised disclosure of such information is unlawful.

- The Trust will from time to time wish to process information about you for reasons related to your employment with the Trust. You hereby explicitly consent to the Trust collecting, holding and otherwise processing personal data (including "sensitive personal data") relating to you. The Trust will process such data only for legitimate reasons, and will do so in a way that does not unjustifiably prejudice your own interests.

- You are required at all times to be aware of and comply with the requirements of the Trust's Data Quality / Information Security Polices

33. I.T. USER POLICY

In providing access to E-mail, Intranet and Internet facilities, the Trust does so to facilitate communications and support and to encourage appropriate legitimate use for Trust related activities, particularly research, access to on-line library resources and E-mail correspondence. Any member of staff who is found to have inappropriately used IT facilities may be subject to action under the Trust's Disciplinary Policy .

34. OWNERSHIP OF INFORMATION

The Trust wishes to stress that all papers and files created in the course of Trust business are the property of the Trust and remain so irrespective of origin or authorship. If you require copies of Trust documentation as evidence for your professional development written consent must be obtained from your line manager.

35. GRIEVANCE AND DISPUTES

The Trust's Grievance and Disputes Procedure enables you to pursue a grievance in a systematic manner without fear of recrimination. A copy is available from your manager, the Trust intranet or from the Workforce Directorate.

36. DISCIPLINARY PROCEDURES

The Trust expects all staff to observe a high standard of personal and professional conduct, to follow its rules and to adhere to its procedures and polices. Failure to meet the required standards may result in disciplinary action in accordance with the Trust's Disciplinary Policy .

A copy is available from your manager, the Trust intranet or from the Workforce Directorate.

37. PROFESSIONAL/STAFF ORGANISATIONS AND TRADE UNION MEMBERSHIP

The Trust is committed to working in partnership with Staff Side organisations (Trade Unions) and this means that the Trust is committed to jointly resolving problems and joint decision making in partnership with the Staff Side Organisations. The Trust actively encourages you to join any Trade Union, or Professional Body of your choice; subject to any rules for membership that the organisation may apply. A list of recognised Trade Unions/Professional Associations can be obtained from the Workforce Directorate. As the Staff Side negotiate on your behalf, it is sensible for you to be a member of a trade union that is recognised.

38. REQUIREMENT TO BE FAMILIAR WITH TRUST POLICIES

You must ensure that you have read and fully understand Trust Policies and Procedures relevant to this appointment and in a particular all employment policies relating to diversity and harassment. Copies of all these documents are available from your manager, the Trust intranet or from the Workforce Directorate.

39. SMOKING POLICY

In the interests of the health of staff, patients and visitors, the Trust is a non-smoking organisation. It is a condition of employment that you do not smoke on Trust property, including grounds, car parks or entrances. Failure to comply with this requirement will result in disciplinary action being taken.

40. STAFF IDENTIFICATION SYSTEM

It is the Trust's policy that each employee is issued with an identification card and badge and that these are worn and are clearly visible at all times whilst on the Trust's premises/grounds.

41. RESEARCH AND DEVELOPMENT

When undertaking research staff must adhere to the Trust's Research and Development Policy (copy available on the Trust intranet).

42. PATIENT AND PUBLC INVOLVEMENT

Section 11 of the Health & Social Care Act 2008 places a legal duty on NHS organisations to involve and consult patients and the public in the planning of service provision, the development of proposals for change and decisions about their care and how services should operate. Patient and public involvement is a process of listening, learning and improving and the trust has made a commitment that this approach will be adopted in everything we do. The trust expects all staff to work towards this goal. It is being worked in to the business planning and staff appraisal processes and will form part of the Key Skills Framework that is central to Agenda for Change.

43. OTHER CHANGES

In order that our central workforce information system can be updated and maintained, it is very important that you inform your manager of any changes to your personal circumstances.

44. DRIVING LICENCE

If your post requires you to hold a driving licence, you must inform your manager of any driving offences that you may receive including penalty points or disqualification.

45. CRIMINAL CONVICTIONS

Due to the nature of the organisation for which you work, and dependent on the nature of work you carry out for the Trust, you are required to inform your manager or the Human Resources Directorate of all criminal convictions including cautions that apply to you during the course of your employment with the Trust. Any information given will be confidential and will only be considered in relation to your post. Should concerns be raised that may impact on the safety of patients or other staff you may be asked to complete a CRB at any time.

46. GOVERNING LAW AND JURISDICTION

This contract shall be governed by English law and parties submit themselves to the exclusive jurisdiction of the English courts.

47. EXCLUSIVITY OF SERVICE

You are required to devote your full time, attention and abilities to your duties during your working hours and to act in the best interests of the Trust at all times. Accordingly, you must not, without the written

consent of the Trust, undertake any employment or engagement that might interfere with the performance of your duties or conflict with the interests of the Trust.

You are required to notify your line manager if you intend to undertake any employment or engagement (including any such employment or engagement which commenced before your employment under this Contract). It is expected that permission will not be unreasonably withheld, however, should an employee believe that this is the case; advice should be sought from the Directorate of Workforce who will make the final decision.

48. SAFEGUARDING

If you are employed in a role where you are required to carry out work for the Trust and who has access to children/young people/vulnerable adults and/or privileged information concerning children/young people/vulnerable adults as part of their role within the Trust then you will be subject to the terms of the Trust's Safeguarding Policy which will be supplied to you. You may be subject to a CRB check at any time should the policy or any subsequent national guidance dictate this is necessary.

49. MAJOR INCIDENTS/PANDEMICS

As an employee of the Trust you are subject to the terms and special conditions relating to the Trust Policies relating to these situations, some of which may supercede existing terms and conditions and policies in extreme circumstances.

50. MANDATORY TRAINING

You are required to attend mandatory training including update training as required by your role.

51. OWNERSHIP OF INTELLECTUAL PROPERTY (IP)

Trust employees have the potential to generate valuable Intellectual Property (IP) from both within and outside research and development activities. In accordance with UK law, all intellectual property generated by Trust employees in the course of their normal duties is owned by the Trust. In some cases it will be necessary to protect and commercially exploit this IP, to ensure that it benefits the health of patients, the interests of inventors and the financial position of the Trust. The Trust IP policy sets out the overarching arrangements for the reporting and management of IP arising from employees.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Board Reporting Cycle 2010
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

The Trust Board reporting cycle for 2010 is presented for approval.

The reporting cycle is similar to that for 2009, being based on the model included in the Appointment Commission's 'The Intelligent Board' publication, together with some items of specific relevance to the Trust.

New items added into the reporting cycle include:

- Quarterly update on sustainability
- CQC annual declaration, which replaces the previous declaration against Core Standards
- Quality Accounts

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

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically but supports good corporate governance arrangements in the Trust
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Governance and Risk Management Committee on 21 January 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD REPORTING CYCLE 2010

	QUARTER 4		
	JANUARY	**FEBRUARY**	**MARCH**
QUALITY AND GOVERNANCE	▪ Assurance Framework update (Q3) (KD) ▪ Annual cycle of business for Trust Board (SGP) ◆ ▪ Single Equality Scheme update (RO)	▪ Infection control quarterly report (BAO) ▪ Infection control assurance framework (RO) ▪ Matrons' report (RO) ▪ Cleanliness report (RO)	▪ Patient Experience Action Plan (RO) ▪ Safeguarding Adults update (RO) ▪ Safeguarding Children update (RO) ▪ Sign off annual external audit plan (RW) ◆ ▪ Integrated risk, complaints and claims report (Q3) (KD)
STRATEGY AND DEVELOPMENT	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS)	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS)	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS) ▪ Board Development Plan ▪ CQC annual declaration ◆
PERFORMANCE MANAGEMENT	▪ Financial performance (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW) ▪ Progress against corporate objectives (Q3) (RK)	▪ Financial performance (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW) ▪ Update on preparations for ALE (RW)	▪ Financial performance (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW) ▪ Annual plan and budget (RK/RW) ◆
OPERATIONAL MANAGMENNT	▪ Sustainability	▪ Presentation by the Director of Public Health (HoB tPCT)	▪ Staff survey report and action plan (DoW)

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

◆ Denotes items for approval

	QUARTER 1		
	APRIL	**MAY**	**JUNE**
QUALITY AND GOVERNANCE	▪ Assurance Framework update (Q4) (KD) ▪ Approve register of seals (SGP) ◆ ▪ Approve register of directors' interests (SGP) ◆ ▪ Approve changes to SOs & SFIs (RW) ◆ ▪ Board self assessment, including a review of committees and working groups (KD) ▪ Single Equality Scheme update (RO)	▪ Infection control quarterly report (BAO) ▪ Infection control assurance framework (RO) ▪ Matrons' report (RO) ▪ Cleanliness report (RO) ▪ Agree 2010/11 Assurance Framework (SGP) ◆ ▪ Freedom of Information annual report (SGP) ▪ Audit Committee annual report (GH) ▪ Quality Accounts (DOD)	▪ Patient Experience Action Plan (RO) ▪ Annual risk report (KD) ▪ Annual complaints report (KD) ▪ Annual Health and Safety report (DoW) ▪ Integrated risk, complaints and claims report (Q4) (KD)
STRATEGY AND DEVELOPMENT	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS)	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS) ▪ Communications and engagement strategy update ◆	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS)
PERFORMANCE MANAGEMENT	▪ Financial performance (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW) ▪ Progress against corporate objectives (Q4) (RK)	▪ Financial performance (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW)	▪ Financial performance (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW)
OPERATIONAL MANAGMENNT	▪ Sustainability	▪ Presentation by PCT Director of Public Heath (Sandwell PCT)	▪ Sandwell Mental Heath Governors report (DT)

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

◆ Denotes items for approval

	QUARTER 2		
	JULY	**AUGUST**	**SEPTEMBER**
QUALITY AND GOVERNANCE	▪ Assurance Framework update (Q1) (KD) ▪ Single Equality Scheme update (RO)	▪ Infection control quarterly report (BAO) ▪ Infection control assurance framework (RO) ▪ Matrons' report (RO) ▪ Cleanliness report (RO)	▪ Patient Experience Action Plan (RO) ▪ Safeguarding Adults update (RO) ▪ Safeguarding Children update (RO) ▪ Integrated risk, complaints and claims report (Q1) (KD)
STRATEGY AND DEVELOPMENT	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS)	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS) ▪ Annual plan process for 2011/12	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS) ▪ IM & T strategy ◆
PERFORMANCE MANAGEMENT	▪ Financial performance (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW) ▪ Progress against corporate objectives (Q1) (RK)	▪ Financial performance (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW)	▪ Financial performance (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW)
OPERATIONAL MANAGMENNT	▪ Annual report on Research & Development (DOD) ▪ Sustainability	▪ Presentation by PCT Director of Public Heath (Sandwell PCT)	

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

◆ Denotes items for approval

	QUARTER 3		
	OCTOBER	**NOVEMBER**	**DECEMBER**
QUALITY AND GOVERNANCE	▪ Assurance Framework update (Q2) (KD) ▪ Single Equality Scheme update (RO)	▪ Infection control quarterly report (BAO) ▪ Infection control assurance framework (RO) ▪ Matrons' report (RO) ▪ Cleanliness report (RO)	▪ Patient Experience Action Plan (RO) ▪ Fire safety annual report (GS) ▪ Radiation protection annual report (BT) ▪ Annual cycle of business for Trust Board (SGP) ◆ ▪ Integrated risk, complaints and claims report (Q2) (KD)
STRATEGY AND DEVELOPMENT	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS) ▪ Estates strategy annual review ◆	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS)	▪ 'Right Care, Right Here' programme: progress report (RK) ▪ New acute hospital programme: progress report (GS) ▪ Communications and engagement strategy update ◆
PERFORMANCE MANAGEMENT	▪ Mid year review of annual plan and budget (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW) ▪ Progress against corporate objectives (Q2) (RK) ▪ ALE assessment – Trust performance (RW) ▪ Sign off annual audit letter (RW) ◆	▪ Financial performance (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW)	▪ Financial performance (RW) ▪ Performance monitoring report (RW) ▪ NHS performance framework update (RW)
OPERATIONAL MANAGMENNT	▪ Sustainability		

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

◆ Denotes items for approval

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Implementation of Service Line Management and Quality Management Framework
SPONSORING DIRECTOR:	Donal O'Donoghue, Medical Director
AUTHOR:	Daphne Lewsley, Project Manager and Donal O'Donoghue, Medical Director
DATE OF MEETING:	19 January 2010

SUMMARY OF KEY POINTS:

The report is provided to update the Board on the progress of the implementation of Service Line Management across the Trust.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To note the progress made to date on implementation of Service Line Management and the ongoing nature of the project.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Developing the management structures of the Trust is key to being an effective NHS FT.
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION: Previously discussed by the Executive Team and Financial Management Board

Sandwell and West Birmingham Hospitals NHS Trust

Report to Trust Board January 2010

Implementation of Service Line Management and Quality Management Framework

Introduction

During the course of our preparations for our FT application in 2008, it was recognised that there was a need to move towards the goal of Service Line Management. In the last twelve months, our thinking in respect of the Foundation Trust model has continued to evolve and, although we have not yet committed to a specific time line to move to a new organisational form, it remains the case that, whatever model we adopt, the introduction of Service Line Management will be integral to the success of that model.

To this end, in order to draw together various strands of work that have been in train for the last couple of years, the Service Line Management Steering Group was established in September 2009 (TOR appendix A) under the chairmanship of the Medical Director.

Vision

The Service Line Management Steering Group has developed a common understanding of the purpose of the project:

> *Service Line Management entails the empowerment of individual directorates or service lines and providing them with the instruments and information they need to run and manage their services and to respond rapidly to the changing needs of our patients and commissioners. SLM will also provide the organisation at large with a comprehensive understanding of its activities and evidence-based assurance about the quality and safety of the services we provide. The successful establishment of Service Line Management will enable us to use our resources wisely and to become a true learning organisation.*

Progress

During the course of the last four months, it has become clear that this is a highly complex endeavour with a large number of apparently disparate pieces of work that need to be co-ordinated. These fall into the following broad categories:

- Organisational structures/management/HR
- Financial
- Clinical
- Information systems

A high level project plan has been developed (appendix B), although it should be noted that each line in this plan represents a project in its own right.

The main enabling projects are: developing directorate and patient level costing systems, the development of directorates, the development of the QMF, and the development of budgetary structures.

Organisational structures/management/HR

The identification of specialties and directorates was a relatively straightforward task. Establishing which parts of the organisation were associated with each directorate, however, was rather more challenging. A number of different data sources have been consulted with a view to aligning the directorates with relevant “real estate”, as well as with relevant governance systems and HR functions. The systems consulted include the safeguard database, ESR, audit databases, and the clinical data archive.

We now have a reasonable association between clinical directorates, the people who work in them and the clinical areas such as wards and outpatients that are relevant to each directorate. A comprehensive knowledge, however, will take quite some time to evolve, possibly as long as two years.

Having established directorates, the appointment of appropriate Clinical Directors is now effectively complete. The allocation of General Managers to directorates is also complete, although further work needs to be done to ensure that the available management resource at directorate level is adequate.

Work is underway to align Financial, HR, and Nursing hierarchies with the clinical directorate structure, but a number of critical tensions do need to be resolved. In particular, the development of the Divisional Nurse Role in the major clinical divisions will be critical.

The Service Line Management group is currently undertaking work to establish agreed terms of reference, decision rights, and a process for “earned autonomy” for the directorates, although this, again, is a process that will take some time.

The divisions are currently continuing to work as they always have, but their roles will also need to be addressed as the capability of the directorates increases.

Financial

The Trust has acquired patient level costing software, which will underpin many of the financial systems informing service line management. The group is currently overseeing the alignment of cost centres with the directorate structure. Further work needs to be done, however, on developing an accurate budgetary statement for each directorate and service line.

A process of iterative dialogue with the directorates will inform the development of accurate financial statements.

The Service Line Management group will continue to review issues relating to service line reporting, particularly the suitability of our current software solution.

The intention is that, in due course, regular monthly or even live information will be available both to the directorates and to the corporate systems.

Clinical

The Quality Management Framework, together with front end dashboard systems, will provide the infrastructure for service line management. The QMF is intended to integrate the Financial, Performance, and Quality information streams into a single system that provides relevant data and assurance at every level of the organisation. The documentation exists although many of the data flows needed to populate it are still being developed. It is intended to provide the board with more detail on the implementation of the QMF in February 2010.

The introduction of clinical directorates has been an essential first step, but there is an enormous amount of work to be done before the directorates are capable of managing multi-million pound budgets. The capability of Clinical Directors and the directorate teams will need to be pro-actively developed. To this end, we have launched a development programme for clinical directors and directorate teams. This commenced on 7th January 2010 and the first cohort programme is expected to take approximately 2 years to complete.

As part of the evolution of the service line management system, a review process of dialogue with the directorates has commenced on a quarterly basis. The discussions, at present, are based on raw QMF data. Ultimately, however, this will be refined into a dialogue based on dashboards of relevant key performance indicators as agreed by the Executive Team.

Other Information Systems

The Trust has an enormous number of disparate systems that are capable of providing data. The Service Line Management group has commissioned an audit of these systems together with an estimate of how many of them are compatible with our ambitions in respect of service line management. In addition to this, the information department is exploring various software solutions that will produce visual representation of the relevant information. It is anticipated that some prototype “dashboards” will be available from Q1 2010/11, but it will probably take a further 1 – 2 years before the information tools reach the desired level of sophistication.

Conclusions

It should be noted that the project is highly ambitious, not least because it involves substantial developments in the organisational culture, systems, information flows, and the “rules of engagement” throughout the organisation. However given these constraints the Trusts has been making steady process towards the goal of being able to delegate responsibility for decision making to the appropriate levels.

During 2010/11 , the information tools needed to manage at directorate level will be further developed , the training program for directorate teams will be continued and the trust will debate and agree what responsibilities can be devolved and when.

Recommendations

The Trust Board asked to **NOTE** the progress made to date on implementation of Service Line Management and the ongoing nature of the project.

Donal O’Donoghue

Medical Director

Appendix A

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

SERVICE LEVEL IMPLEMENTATION STEERING GROUP TERMS OF REFERENCE

Constitution

The Service Level Implementation Steering Group will report to Trust Management Board.

Membership

The Group membership will consist of:

- Donal O'Donoghue (chair)
- Richard Kirby
- Robert White
- Kam Dhami
- Ian Kendall
- Amanda Wharton
- Mike Harding
- Paul Stanaway
- Matthew Maguire
- Andrew Harding
- Lesley Barnett
- Sue Murray
- Mike Beveridge
- Daphne Lewsley
- Rachel Overfield
- Fiona Shorney
- Neil Cruikshank
- Rajai Ahmed

Attendance at meetings

Trust staff or advisers from outside the Trust will be required to attend relevant sections of meetings as appropriate.

Daphne Lewsley will act as secretary to the Group and will maintain minutes of the meetings.

Chair of the Meeting

At any meeting of the Group, the Chair if present shall preside. If the Chair is absent from the meeting then another Executive Director shall preside.

Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

Frequency of meetings

Meetings will be held monthly until the Trust has fully implemented Service Level Management.

Authority

The Group is authorised to investigate any activity within its Terms of Reference.

Duties

The purpose of the Group is to:

- Provide strategic leadership and co-ordination for the different Workstreams which comprise the project.
- Develop a clear Project Plan with key tasks and timescales agreed with the Workstream leads.
- Undertake regular monitoring of progress towards key milestones and agree recommendations for change, where appropriate.
- Support project-specific resolution of issues and actions to mitigate risk.
- Ensure clear communication about the implementation of Service Line Management within the Trust.

Reporting

The minutes of the Service Level Implementation Steering Group shall be recorded and submitted to Trust Management Board.

Reviewed: **September 2009**
Next Review: **September 2010**

Appendix B

Workstreams		Lead	Dates	Progress
Management	Review Service Line Hierarchy	RK	Sep/Oct 09	Complete
	Appointment of Clinical Directors	RK	by 31/12/09	Complete
	Agree Final List of Service Lines	SLIMG	by 31/12/09	Final list to be circulated and agreed
	Establish Clinical Executive Team	DOG	by 31/8/09	Complete
	Integrated governance system to be developed at directorate level	DOD/KD	2010/11	KD developing integrated governance strategy
	Divisional Performance Review to be based on summation of QMF	?		Timescales for full implementation to be discussed. Partial implementation for 2010/11 possible
	Brief Organisation on SLM	SLIMG	by 31/3/10	
	Agree arrangements for nursing , finance, governance ,IMT and HR support	DOD	by 31/3/10	
	Map physical estate, resources and people to service lines	MH	ongoing	The first systems have been mapped, the map will need to be improved over time. As individual systems are incorporated into the reporting they will need to be mapped too
	Framework for Devolution to and accountability of specialties developed and agreed (rules of engagement)	RK	2010/11	Need definition of directorate which will form basis of responsibilities document
	Review impact of SLM on divisional structures and roles	RK	2010/11	
Financial	Procure New Costing Software	IK		Complete
	Implementation of New Costing Software	IK	ongoing	Awaiting next update. Will then review software to confirm whether fit for purpose
	Introduce Quarterly Service Line Reporting	IK	from 1/4/10	utilise QMF review process
	Introduce Monthly Service Line Reporting	IK	tba	
	Introduce Patient Level Costing	IK	tba	
	Align Budgetary Structures	PS	31/03/2010	Work is ongoing to align the 2010/11 budgets to directorates
Clinical	Initiate monthly review of service line performance by divisions (initially led by medical director)	DOD	01/10/2009	Complete

Workstreams		**Lead**	**Dates**	**Progress**
	Launch Development Programme for Clinical Directors	DOD	ongoing	The first all day events took place on 7/1/10. Fortnightly evening events are planned to June.
	Quality Management Framework populated for main specialties	MH	ongoing	The QMF is about 60% populated and should be 80% populated by 1/4/10
	Learn from other providers	SLIMG	ongoing	SLIMG has received a presentation from Salford and plans other interactions during first half 2010
Other Information Systems	ESR /Payroll	LB		Workforce dashboard to be developed at directorate level
	Pas	MM		
	Pharmacy			
	Medical Staffing	KD		
	Clinical resource System	KD		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Mortality Steering Group Update
SPONSORING DIRECTOR:	Donal O'Donoghue, Medical Director
AUTHOR:	Daphne Lewsley, Project Manager
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

The report is provided to update the Board on the progress of the Mortality Steering Group since the last update in September 2009.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

Trust Board is asked to NOTE the progress of the Mortality Steering Group since September 2009.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

Sandwell and West Birmingham Hospitals NHS Trust
Report to Trust Board January 2010
Mortality Update

Introduction

The Trust has established a Mortality Steering Group oversee the improvements in the system for assurance around hospital mortality.

The purpose of this paper is to update the Trust Board on progress by the group. In the period since the last update to the Board in September of 2009, the group has

- Overseen the commencement of a pilot for reviewing all deaths occurring in hospital
- Reviewed the Trust's policy for death certification and referral to the coroners office
- Reviewed deaths and standardised mortality rates by specialty
- Overseen the response to the trusts first CQC alert on mortality ('Peripheral and visceral atherosclerosis'.)
- Reviewed work produced by the SHA on deaths in hospital throughout the working week
- Considered a number of conditions which appear to be raising mortality alerts on the Trusts internal systems and proposed actions to prospectively audit these areas

The updated workplan for the Steering Group is attached at appendix A.

Current position

The data behind the HSMR are analysed in a variety of ways by the Clinical Effectiveness Department and the output of this work is considered by the Mortality Steering Group. The HSMR for this Trust appears to have followed a downward trend in recent years. For the most recent reported month (August 2009) the 12 month rolling HSMR for the Trust was 98.0. This compares favourably with an average HSMR for our peer hospitals in this region of 99.3 for the same period.
Rates in all trusts increased in July 2009 due to a change in the way the baseline calculation is performed by Dr Foster. Individual specialty HSMR rates are reviewed by the MSG and with specialties as part of the QMF.

Mortality Pilot

A key part of the workplan of the Mortality Steering Group has been to oversee the introduction of a consistent cross trust methodology for review of all deaths in hospital.

A three month pilot commenced on 7/12/2009.
This involves the scanning of all deceased notes after issue of the death certificate. Notes are sent off site to a medical records provider to be scanned.
The scans can be accessed through the clinical data archive.

The clinical director of the directorate where the last doctor in charge of the case in the notes works is sent a notification that a review is needed when the scan is received.
A mortality proforma in a form approved by the Mortality steering group has been set up on the CDA for CDs to complete.

The individual directorates have flexibility to arrange for the reviews to be completed in whatever way they deem appropriate but the CD will be reminded if it has not been completed in two weeks. Subsequent escalation to the DD and MD have also been built in.

The pilot will take some time to get working smoothly. Initial issues have been practical ones about the inability of some of the trusts older PCs to access the scans and the direction of the notification to the right CD.
There have also been issues of resource in medical records to prepare the notes which will need to be addressed.

We hope to sort these issues out during January 2010 and to start generating useful information from the system in February 2010.

Recommendation

Trust Board is asked to NOTE the progress of the Mortality Steering Group since September 2009.

Donal O'Donoghue
Medical Director

Appendix 1 – Mortality Steering Group Updated Workplan

Mortality Steering Group – Work Plan (final)
Update – January 2010

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

	Objectives for mortality steering Group	Action required	Lead	Timescale	Position statement	Status
1	*To develop the infrastructure required to support the systematic review by relevant specialties of deaths in hospital and those occurring with 30 days of admission to hospital.*	• Establish Steering Group, agree its terms of reference and work plan.	Chair of Steering Group (DOD)	June 09	Steering Group has been established. Terms of reference have been agreed. Work plan to be approved at June's meeting	4
		• To determine the process for reviewing deaths in hospital	DOD	September 2009	To determine process Minimum data set etc	4
		• To implement the process to ensure the systematic review of mortality across all specialties	Clinical Directors	November 2009	Pilot commenced on 7/12/09. Started with both City and Sandwell all deaths but not maintained at Sandwell due to resource problems. First month has been difficult because of Christmas and problems in getting review letters to correct CDs. Unlikely to start getting comprehensive cover until February.	3
2	*To establish best practice in reviewing mortality data both internally and externally and to ensure that the lessons learnt from national reports are considered when developing local systems.*	• To establish current arrangements in specialties for reviewing deaths against the minimum requirements.	DOD	Sept 2009	Discussion with CDs during QMF round Q3 2010.	3
		• To review and assess current local arrangements against the minimum requirements.	Steering Group	October 2009	Not discussed specifically at steering group – taken into account when agreeing pilot.	

	Objectives for mortality steering Group	Action required	Lead	Timescale	Position statement	Status
		• To search for evidence of good practice in terms of reviewing mortality	Steering Group	September 2009	Evidence available from the states, but not a lot around about this issue GD to investigate practice from the US (Kaiser)	2
		• To use the information gained to inform the development of local arrangements	Steering Group	September 2009	o/s	
3	*To oversee the piloting of the agreed approach for reviewing mortality data in the Trust. .*	• Where mortality review meetings are taking place to evaluate whether they meet minimum requirements and if not to pilot the agreed approach.	Clinical Directors	November 2009	Pilot review methodology introduced December 2009. CDs to feed into results of pilot	3
4	*To ensure that there are effective systems in place for providing information on deaths to the appropriate specialties.*	• To determine the most appropriate assignment of deaths to a given specialty.	Clinical Directors		It will be for CD's to determine who is in charge at the time of death. Every set of case notes gets some review. Scan last admission for first sweep assessment. Most clues are in the last admission.	
5	*To develop guidance on how mortality reviews should be conducted, including on feeding back and responding to findings arising from the case reviews.*	• To produce an information pack to assist/support clinicians conducting reviews.	Steering Group	September 2009	O/S	2
		• To produce standard templates for the reporting outputs and the action required.	Steering Group	September 2009	Template produced for pilot	4
		• To ensure that processes are integrated with risk management and governance arrangements.	Ongoing			
6	*To review deaths against benchmarked data e.g. Dr Foster*	• To ensure that specialties review relevant diagnoses or	Ongoing			

	Objectives for mortality steering Group	Action required	Lead	Timescale	Position statement	Status
		procedures 'flagged up' for attention against benchmarks against local data sources				
7	*To receive and evaluate aggregated data arising from the specialty mortality reviews and initiating further review and other action as required.*	• To establish a central databases for collating and reporting on data from mortality reviews.	Steering Group		Database developed Reporting to be developed	3
		• To receive reports on investigations on alerts and provide assurance to the Governance Board that appropriate action has been taken	Head of Clin. Eff	Ongoing		4

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Taking it on Trust (self assessment)
SPONSORING DIRECTOR:	Robert White, Director of Finance & Performance Mgt
AUTHOR:	Robert White, Director of Finance & Performance Mgt
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

As part of a study of 15 Health Service Trusts, the Audit Commission observed varying degrees of board assurance regarding the information used in managing the risks and operations of the organisations concerned. It made a number of recommendations, one of which was for health bodies to review their arrangements for gaining assurance in areas such as risk management reporting systems and information reliability.

The recommendations for Trusts are set out in a checklist document that suggests a diagnostic approach to the systems, controls and risk management arrangements in place. To this end, the Trust's internal auditor has taken this checklist and devised a survey format for assessing the current position. The management team has prepared a draft response to this questionnaire **(see attached)** that has been reviewed and signed off by the Governance and Risk Management Committee of the Board. Areas highlighted for additional work and an action plan has been developed in response to the Audit Commission findings.

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:

4.1 REVIEW the internal assessment questionnaire and agree any necessary changes
4.2 HIGHLIGHT those areas where any further information is required
4.3 NOTE and support the action plan developed
4.3 AGREE to receive an update paper at its meeting in March

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Systems for managing risk
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	Internal Control dimension

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

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

PREVIOUS CONSIDERATION:

Discussed by the Executive Team at its meeting on 5 January 2010 and by the Governance and Risk Management Committee at its meeting on 21 January 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Board

28 January 2010

Taking it on Trust – self assessment

1.0 Introduction

As part of a study of 15 Health Service Trusts, the Audit Commission observed varying degrees of board assurance regarding the information used in managing the risks and operations of the organisations concerned. It made a number of recommendations, one of which was for health bodies to review their arrangements for gaining assurance in areas such as risk management reporting systems and information reliability.

The full document can be accessed at www.audit-commission.gov.uk

2.0 Taking it on Trust – report summary

In their summary report, the Audit Commission wrote:

We reviewed relevant literature and guidance; carried out a detailed examination of the key processes, controls and assurances at 15 acute and mental health trusts; and held further interviews with individuals and organisations with an interest and experience in the area. We found some good practice. And there is no doubt that the introduction of FTs has generally reinvigorated governance processes and resulted in the recruitment of non-executives with a greater knowledge of effective risk management and board challenge drawn from private sector experience. However, overall, there was room for much improvement. In the worst cases, the assurance process had become a paper chase rather than a critical examination of the effectiveness of the trust's internal controls and risk management arrangements. The NHS has, in many cases, been run on trust.

We also reviewed how boards assured themselves that the data they use are of good quality, drawing on the findings from the Commission's Payment by Results data quality assurance framework. The development of quality metrics, payment for quality schemes and quality accounts all increase the importance of boards using and providing trustworthy data. Recent events in Haringey have demonstrated the importance of good data quality, particularly when such data are being used for key management and regulatory purposes.

Few trusts had a manageable number of clear strategic objectives that would enable risks to be readily identified and managed. One trust we visited could not produce its strategic objectives. Risks were also often poorly specified. Some

trusts found it difficult to embed risk management in the day-to-day running of the organisation and had not linked it effectively to performance management and performance information. Where they had, it had depended on strong leadership and management ownership of action plans, backed by scrutiny, challenge and effective performance management.

In the NHS, the Board Assurance Framework (BAF) is a tool that sets out the risks for each strategic objective, along with the controls in place and assurances available on their operation. The BAFs we reviewed were often very large documents that users found unhelpful and, in some trusts, had effectively stagnated until reviewed as part of a bespoke exercise. It was also clear that the BAF was seen as disassociated from operational management, although there is a link between the two.

Effective assurance requires a number of elements to be present together:

- the right governance framework and risk culture and a clear understanding of strategic objectives and risks;
- good internal controls;
- evidence that internal controls are operating effectively; and
- good data quality.

Our review showed that:

- controls and assurances were often poorly defined, making it difficult to see how boards could be clear that the controls were working effectively and that assurances were sound. Risks and controls were not always aligned to strategic objectives;
- greater attention needed to be paid to compliance mechanisms and these needed to be more clearly distinguished from internal audit, which should review the effectiveness of the compliance framework, not be a substitute for it;
- use of internal audit could be improved, with greater emphasis given to the quality of the assurance derived from it rather than cost minimisation. Its use should also be placed in a wider framework of review as there are alternatives to internal audit in many cases;
- use of clinical audit as part of the BAF was poorly developed. This is a significant weakness. Few trusts could set out how clinical audit was being used in a systematic way to address risks with the results reported to the board through the BAF;
- many trusts had elements of assurance processes in place for data quality but very few were comprehensive and very few boards saw this as a significant issue. There was limited evidence of formally planned audit or review programmes to verify the accuracy of data reported;
- greater effort was made to review and assess assurances provided in respect of self-assessments for compliance with Standards for Better Health. Even so, these efforts were not wholly successful, as judged by the results of follow-up inspections by the Healthcare Commission;

- trusts' approach to the SIC was variable and in some cases appears to have become a matter of lip service. Greater emphasis could be given to the SIC as a key component of the regulatory framework, rather than introduce new, parallel mechanisms. It could also be made less process oriented and more forward looking, thereby encouraging boards to reflect on their identification of risk and success in managing their risks through effective internal controls; and
- there may also be merit in cascading the SIC through the organisation by sub-certification by managers. However, to avoid this becoming a meaningless bureaucratic exercise it would need to be allied with a more effective compliance function, performance information and performance management.

Board assurance can be seen as a dull, dry subject dominated by process. The Healthcare Commission's report on its investigation into Mid Staffordshire NHS Foundation Trust shows that processes without intelligent and rigorous scrutiny are not enough. Governance arrangements that are persuasive on paper must work in practice. The aim of board assurance is to give confidence that the trust is providing high quality care in a safe environment for patients by staff who have received the appropriate training; that it is complying with legal and regulatory requirements; and that it is meeting its strategic objectives. On the evidence we have seen, many board members would not be able to have that confidence. Trusts may indeed be meeting all these requirements but it is not evident from the material presented to the board. This is an important issue for regulators as the regulatory framework is increasingly dependent on self-assessments and self-certification. Mid Staffordshire NHS Foundation Trust certified that it was compliant with all core standards except that relating to waste disposal, but it subsequently became clear that it was very far from providing safe, high quality care.

Internal controls and board assurances are often not up to the weight now being placed on them by the regulatory framework. NHS trusts have the processes and arrangements in place. Indeed, the Commission's own Auditors' Local Evaluation (ALE) confirms this, but greater attention now needs to be paid to the rigour and effectiveness with which the processes and arrangements are applied. Below we make a number of recommendations that we consider will help to bring this about. We will also review our ALE methodology to ensure it has the right balance between processes and outcomes.

Trusts should:

- ensure that their strategic aims and objectives are clearly defined and few in number so they can be widely understood and clearly cascaded throughout the organisation, and that their strategic risks are identified and aligned to their strategic objectives;
- review their risk management arrangements – including the way in which risks are reported to the board – in line with the findings of this report and consider how best to promote and demonstrate the value of risk management work to staff;

- ensure they have systems in place to comply with all statutory, regulatory, clinical and contractual requirements;
- consider cascading the SIC through the organisation by sub-certification by managers. To avoid this becoming simply a bureaucratic exercise it should be allied with a more effective compliance function, performance information and performance management;
- review how they identify and then evidence assurances on the operation of controls and how these are then evaluated;
- review and increase the assurances they receive from sources other than internal audit, including clinical audit, and in doing so ensure that their full portfolio of risk is covered;
- maximise the assurance obtained from internal audit by reviewing the scope of internal audit plans and improving its commissioning;
- better align clinical audit programmes to key strategic and operational risks to maximise the assurance provided by the clinical audit function;
- them more clearly from internal audit, which should review the effectiveness of the compliance framework;
- ensure they have robust arrangements for assuring the quality of their data by assessing themselves against the standards for better data quality set out in the Commission's *Figures You Can Trust* briefing**l** and by developing systematic and formalised review programmes for their data, including checking accuracy back to records; and
- develop policies and guidance on data quality and assurance processes, including defining and allocating responsibility for data quality, to promote consistency and improve awareness of board members.

The summary report then goes on to make recommendations to the Department of Health, Appointments Commission and Regulators.

3.0 Internal Assessment

The recommendations for Trusts are set out in a checklist document that suggests a diagnostic approach to the systems, controls and risk management arrangements in place. To this end, the Trust's internal auditor has taken this checklist and devised a survey format for assessing the current position. The management team has prepared a draft response to this questionnaire **(see attached)** with the following areas highlighted for additional work:

Que 8 Our strategic aims and objectives are effectively cascade through to divisional/directorates/departments and personal objectives

The management team decided that a response of "We need to work on this" was applicable, given that although there are significant measures undertaken to communicate and promote the Trust's strategic aims and objectives, there is

further work to undertake to ensure that there is a clear link between these and personal objectives set as part of the staff PDR process

***Que 13 We delegate responsibility effectively and appropriately*.**

The management team felt that a response of "We need to work on this" was appropriate given the agenda to devolve management responsibility to clinical directorates under the Quality Management Framework, governance structures and SLM (service line management).

Que 24 We have successfully devolved an embedded risk management at an appropriate operational level and risk is escalated from this level when necessary.

This item requires work for the same reason as Que 13, i.e. clinical directorates are in their infancy.

Que 38 We are maximising the assurances we can gain from our clinical audit function

Interestingly this is an area the Audit Commission found to be weak in a number of Trusts. The draft assessment suggests work is required so that greater emphasis is placed on publicising findings, learning outputs are formulated and changes are linked to a forward plan.

Que 48 Our Board reports explain the assurance process for the data contained in them and highlight any issues regarding data quality

Reference to case studies and best practice will assist in this area, but at present the Trust does not routinely record the basis of the assurance process as part of each report.

4.0 Summary and Next Steps

The attached questionnaire uses the Audit Commission checklist to suggest a position statement for the Trust against recommended practice. Areas in need of further work are highlighted in the section above and an action plan has been developed to ensure that the identified shortfalls are addressed (see attached).

It is proposed that an update paper be brought to the Governance and Risk Management and Trust Board meeting in March.

For now, the Trust Board is asked to:

4.1 REVIEW the internal assessment questionnaire and agree any necessary changes

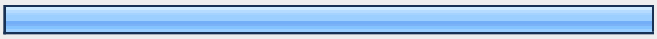
4.2 HIGHLIGHT those areas where any further information is required

4.3 NOTE and support the action plan developed

4.4 AGREE to receive an update paper at the meeting in March

Robert White
Director of Finance & Performance Management

1. Please indicate your role within the Board

		Response Percent	Response Count
Non Executive Director		0.0%	0
Executive Director		**100.0%**	**1**
	answered question		**1**
	skipped question		**0**

2. If an Executive Director please describe role here (this will remain anonymous in the survey results)

	Response Count
	1
answered question	**1**
skipped question	**0**

3. We have set a clear long term vision for the trust

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have set a clear long term vision for the trust	**100.0% (1)**	0.0% (0)	0.0% (0)	0.0% (0)	1.00	1
	answered question					**1**
	skipped question					**0**

4. We have defined a clear set of strategic aims and objectives

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have defined a clear set of strategic aims and objectives	**100.0% (1)**	0.0% (0)	0.0% (0)	0.0% (0)	1.00	1
					answered question	**1**
					skipped question	**0**

5. Our strategic aims and objectives have been sufficiently communicated to staff

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
Our strategic aims and objectives have been sufficiently communicated to staff	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

6. We refer to our strategic aims and objectives when taking significant decisions

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We refer to our strategic aims and objectives when taking significant decisions	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

7. We provide adequate leadership to staff to motivate them to deliver our strategy

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We provide adequate leadership to staff to motivate them to deliver our strategy	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

8. Our strategic aims and objectives are effectively cascaded through to divisional/directorates/departments and personal objectives

	We do this really well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
Our strategic aims and objectives are effectively cascaded through to divisional/directorates/departments and personal objectives	0.0% (0)	0.0% (0)	**100.0% (1)**	0.0% (0)	3.00	1
				answered question		**1**
				skipped question		**0**

9. If you replied that “we need to work on this” to any of the questions, can you please give your reason(s) for this below (clearly identifying the question number(s) you are referring to) ……..

	Response Count
	0
answered question	**0**
skipped question	**1**

10. We have established appropriate and effective governance structures within the trust						
	We do this very well	**We do this well enough**	**We need to work on this**	**Not really sure**	**Rating Average**	**Response Count**
We have established appropriate and effective governance structures within the trust	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

11. We have the relevant skills and experience we need as a board to operate effectively						
	We do this very well	**We do this well enough**	**We need to work on this**	**Not really sure**	**Rating Average**	**Response Count**
We have the relevant skills and experience we need as a board to operate effectively	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

12. We have the relevant skills and experience we need to operate our sub-committees effectively						
	We do this very well	**We do this well enough**	**We need to work on this**	**Not really sure**	**Rating Average**	**Response Count**
We have the relevant skills and experience we need to operate our sub-committees effectively	**100.0% (1)**	0.0% (0)	0.0% (0)	0.0% (0)	1.00	1
				answered question		**1**
				skipped question		**0**

13. We delegate responsibility effectively and appropriately

	We do this really well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We delegate responsibility effectively and appropriately	0.0% (0)	0.0% (0)	**100.0% (1)**	0.0% (0)	3.00	1
					answered question	**1**
					skipped question	**0**

14. We receive suitable reports from our sub-committees to satisfy ourselves that they are operating effectively

	We do this really well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We receive suitable reports from our sub-committees to satisfy ourselves that they are operating effectively	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

15. If you replied that “we need to work on this” to any of the questions, can you please give your reason(s) for this below (clearly identifying the question number(s) you are referring to) ……

	Response Count
	0
answered question	**0**
skipped question	**1**

16. Our board agenda is sufficiently focused upon the achievement of strategy and objectives

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
Our board agenda is sufficiently focused upon the achievement of strategy and objectives	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

17. We have an established mechanism for reporting and monitoring achievement against our strategy and associated plans

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have an established mechanism for reporting and monitoring achievement against our strategy and associated plans	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

18. We receive adequate and sufficient information for us to be confident about the strategic decisions we take

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We receive adequate and sufficient information for us to be confident about the strategic decisions we take	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

19. If you replied that "we need to work on this" to any of the questions, can you please give your reason(s) for this below (clearly identifying the question number(s) you are referring to) ……..

	Response Count
	0
answered question	**0**
skipped question	**1**

20. We provide appropriate leadership on risk management

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We provide appropriate leadership on risk management	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

21. Our risk culture and appetite has been communicated to and is understood by staff

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
Our risk culture and appetite has been communicated to and is understood by staff	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

22. We have established an accountability framework that sets out the levels of risk that is expected to be managed at each level within the trust

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have established an accountability framework that sets out the levels of risk that is expected to be managed at each level within the trust	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

23. We have successfully integrated our risk management procedures within strategic planning, performance management and compliance arrangements

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have successfully integrated our risk management procedures within strategic planning, performance management and compliance arrangements	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

24. We have successfully devolved and embedded risk management at an appropriate operational level and risk is escalated from this level when necessary

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have successfully devolved and embedded risk management at an appropriate operational level and risk is escalated from this level when necessary	0.0% (0)	0.0% (0)	**100.0% (1)**	0.0% (0)	3.00	1
					answered question	**1**
					skipped question	**0**

25. We have arrangements in place that provide evidence of the effectiveness of our risk management arrangements

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have arrangements in place that provide evidence of the effectiveness of our risk management arrangements	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

26. If you replied that “we need to work on this” to any of the questions, can you please give your reason(s) for this below (clearly identifying the question number(s) you are referring to) ……..

	Response Count
	0
answered question	**0**
skipped question	**1**

27. We have robust arrangements in place to ensure we identify all our strategic risks

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have robust arrangements in place to ensure we identify all our strategic risks	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

28. We have established robust risk reporting arrangements in place

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have established robust risk reporting arrangements in place	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

29. There is sufficient scrutiny and challenge to ensure that strategic risks are properly managed and monitored

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
There is sufficient scrutiny and challenge to ensure that strategic risks are properly managed and monitored	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

30. If you replied that “we need to work on this” to any of the questions, can you please give your reason(s) for this below (clearly identifying the question number(s) you are referring to) ……..

	Response Count
	0
answered question	**0**
skipped question	**1**

31. We have a clear understanding of the potential sources of assurance available to us and have proactively planned for them to be received by the board

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have a clear understanding of the potential sources of assurance available to us and have proactively planned for them to be received by the board	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

32. We systematically test and evaluate the potential sources of assurance, identify any assurance gaps we may have and address these

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We systematically test and evaluate the potential sources of assurance, identify any assurance gaps we may have and address these	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

33. We are assured across the full range of our strategic risks (including clinical, financial, reporting, operations and compliance

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We are assured across the full range of our strategic risks (including clinical, financial, reporting, operations and compliance	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

34. We have a process in place to ensure that systems of internal control are operating robustly

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have a process in place to ensure that systems of internal control are operating robustly	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

35. We ensure that our Statement on Internal Control is robust and consistent with other declarations and self-certifications

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We ensure that our Statement on Internal Control is robust and consistent with other declarations and self-certifications	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

36. If you replied that "we need to work on this" to any of the questions, can you please give your reason(s) for this below (clearly identifying the question number(s) you are referring to) ……..

	Response Count
	0
answered question	**0**
skipped question	**1**

37. We are maximising the assurances we can gain from internal audit

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We are maximising the assurances we can gain from internal audit	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

38. We are maximising the assurances we can gain from our clinical audit function

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We are maximising the assurances we can gain from our clinical audit function	0.0% (0)	0.0% (0)	**100.0% (1)**	0.0% (0)	3.00	1
				answered question		**1**
				skipped question		**0**

39. Our clinical audit function provides a comprehensive view of the quality of clinical services across the trust's portfolio

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
Our clinical audit function provides a comprehensive view of the quality of clinical services across the trust's portfolio	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

40. We have appropriate arrangements in place to ensure that operations comply with laws, rules, regulatory requirements and our policies

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have appropriate arrangements in place to ensure that operations comply with laws, rules, regulatory requirements and our policies	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

41. If you replied that "we need to work on this" to any of the questions, can you please give your reason(s) for this below (clearly identifying the question number(s) you are referring to) ……..

	Response Count
	0
answered question	**0**
skipped question	**1**

42. We have a framework in place for the management and accountability of data quality that makes clear respective responsibilities at all levels throughout the trust

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have a framework in place for the management and accountability of data quality that makes clear respective responsibilities at all levels throughout the trust	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

43. We have appropriate policies and procedures in place to secure the quality of data used for reporting

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have appropriate policies and procedures in place to secure the quality of data used for reporting	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

44. Our staff have the right knowledge, competencies and capacity in relation to data quality

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
Our staff have the right knowledge, competencies and capacity in relation to data quality	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
				answered question		**1**
				skipped question		**0**

45. We make best use of available data to inform our decision making

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We make best use of available data to inform our decision making	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

46. If you replied that "we need to work on this" to any of the questions, can you please give your reason(s) for this below (clearly identifying the question number(s) you are referring to) ……..

	Response Count
	0
answered question	**0**
skipped question	**1**

47. We have sufficient controls to ensure that the quality of data used for decision making is good enough

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have sufficient controls to ensure that the quality of data used for decision making is good enough	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

48. Our board reports explain the assurance process for the data contained in them and highlight any issues regarding data quality

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
Our board reports explain the assurance process for the data contained in them and highlight any issues regarding data quality	0.0% (0)	0.0% (0)	**100.0% (1)**	0.0% (0)	3.00	1
					answered question	**1**
					skipped question	**0**

49. We have the knowledge and expertise on the board to understand and challenge effectively on data quality issues

	We do this very well	We do this well enough	We need to work on this	Not really sure	Rating Average	Response Count
We have the knowledge and expertise on the board to understand and challenge effectively on data quality issues	0.0% (0)	**100.0% (1)**	0.0% (0)	0.0% (0)	2.00	1
					answered question	**1**
					skipped question	**0**

50. If you replied that “we need to work on this” to any of the questions, can you please give your reason(s) for this below (clearly identifying the question number(s) you are referring to) ……..

	Response Count
	1
answered question	**1**
skipped question	**0**

Sandwell & West Birmingham Hospitals NHS Trust

Trust Board

28 January 2010

Draft Action Plan

Taking it on Trust (self assessment)

The Taking it on Trust (self assessment) paper highlights those areas where further work is needed. To this end, the table below assigns key actions and Director responsibilities for improving the status of areas assessed as "we need to work on this".

1.0 The first area identified under this category falls under statement 8. ***Our strategic aims and objectives are effectively cascaded through to divisional/directorates/departments and personal objectives.***

There is good evidence that our strategic aims are cascaded owing to the way in which annual plans are constructed (common format, divisional objectives linked to key themes). However, there is less evidence (on a wider scale) that divisional, directorate or department plans feature prominently within personal objectives. This is not to say that they don't, but that no systematic assessment has been undertaken to determine this.

2.0 The next area relates to statement 15. ***We delegate responsibility effectively and appropriately.***

The reason for concluding that there is work to be done reflects initiatives underway in developing the clinical directorate structures together with the resource management and information to support their work, examples of this include the quality management framework and service line management. These initiatives are being developed and have recognised project timescales.

3.0 The next area relates to statement 24. ***We have successfully devolved and embedded risk management at an appropriate operational level and risk is escalated from this level when necessary.***

Risk management is vital for ensuring the quality and safety of patient care as well as planning for potential adverse events be they strategic, regulatory or operational. The systems for alerting the board are comprehensive, red alerts, SUIs, RCRH risk register, Dr Foster alerts and the like. Given that perpetual risk management training is required under ALE, it was felt that this constituted the need for ongoing work.

4.0 The next area relates to statement 38. ***We are maximising the assurances we can gain from our clinical audit function.***

The findings from clinical audits are not routinely made available and should be drawn together for reporting to Governance Board such that findings are made available, planned changes in clinical practice are implemented and a process is identified for subsequent re-audit. A periodic summary report should be presented to the G&R committee.

5.0 The next area relates to statement 48. ***Our board reports explain the assurance process for the data contained in them and highlight any issues regarding data quality.***

The Board reporting templates allow for this information but greater rigour is needed when considering and completing this information.

Based on these areas where “we need to work on this” is the conclusion of the assessment, the following actions are proposed.

Area	Action Proposed	Lead Director	Completion Date	Notes
8 Cacading objectives	Determination of key objectives capable of insertion across broad range of staff members, e.g. mandatory training, dignity & privacy	JA – for action by Directors	March ’10 – to ensure preparation for forthcoming year	
8 Cascading objectives	Revise PDR policy at paragraph 2.1d, that asks that individual objectives are set for short, medium and long term goals (currently does not emphasise consistency with organisational objectives)	Acting Directors of Workforce – GD/LB	May ’10 – to allow for any other aspects to be reviewed and consulted on	
8 Cascading objectives	Issue guidance to managers to ensure that PDRs to B7 reflect strategic and operational goals consistent with Trust, divisional and directorate objectives	Directors (for their teams)	March ’10 – to ensure preparation for forthcoming year	
15 Delegating responsibility	Actions currently covered by work programmes for QMF, development of clinical directorate structures, SLM. Continue with reporting mechanisms. Ensure board kept up to date.	Lead Directors for each programme.	January ’10 SLM update to Board Regular FMB/TMB updates for monitoring progress with devolving clinical and resource management responsibilities.	The programmes of change extend beyond 09/10.

Area	Action Proposed	Lead Director	Completion Date	Notes
24 Embedding Risk Management	Ensure development of clinical directorate level risk registers up and running	Dir of Governance	By end of Q1	
24 Embedding Risk Management	Ensure non clinical risk registers are up to date	Dir of Governance	March '10	
38 Clinical Audit Function	Ensure clinical audit findings are periodically reported to both Governance Board and G&R committee	Dir of Governance	By end of Q1	
48 Data assurance	Ensure that all additions to corporate performance reports highlight data sources and the verfication process in place. Review and amend report cover sheets.	Dir of F&PM (Head of Performance Mgt support) Lead Directors of the specific report	March '10	
48 Data assurance	Undertake annual exercise to assess information to Trust Board across governance, risk, and safety dimensions to determine information assurance drawing on learning points from	Dir of Governance	March '10	

	Mid Staffs investigation.			
48 Data assurance	Ensure Internal Audit annual plan includes provision for corporate report data verfication. Most likely to be a rolling programme of random sampling.	Dir of F&PM	End of Q1	

6.0 Summary & Recommendations

The Trust Board is asked to:

RECEIVE the draft action plan to accompany the assessment of the findings from 'Taking it on Trust'

RECOMMEND any changes to either the assessment or action plan

Robert White
Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Single Equality Scheme (SES) Annual Report
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Sheila Peacock, Assistant Director of Nursing
DATE OF MEETING:	28 January 2010

KEY POINTS:

The report is intended to share with the Trust Board the progress achieved against the Single Equality Scheme for the previous year.

The SES document has been updated to reflect both legislative and local changes to ensure that it remains as accurate and timely as possible.

Progress continues to be good against the action plan but will continue to require focussed effort if the Trust is to achieve all of its aspirations with regard to equality and diversity.

Particular work streams for the coming year relate to improving IT systems to ensure relevant data is captured especially around "hard to reach groups", eg asylum seekers and migrant communities. In addition, we need to give attention to the translation of patient information into alternative media formats and language for non- English reading patients and individuals with learning disabilities.

PURPOSE OF THE REPORT:

To provide the Trust Board with an annual report of progress in relation to achieving its obligations under the equality legislation and objectives and changes to the Single Equality Scheme.

◉ **Noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to note the progress to date and the revised Single Equality Scheme.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

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

IMPACT ASSESSMENT:

FINANCIAL	☑	None known currently although there may be some as the action plan is implemented
ALE	☐	
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☑	Equality Legislation
EQUALITY & DIVERSITY	☑	Single Equality Scheme (SES)
COMMUNICATIONS	☑	Public dates for publishing and access to information under equality legislation
PPI	☑	Consultation and engagement active as required under public duties of equality legislation.
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

EQUALITY & DIVERSITY ANNUAL REPORT

Pauline Richards
Head of Equality & Diversity
December 2009

Equality & Diversity department

CONTENTS

Equality and Diversity Annual Report
July 2008 – December 2009

1.0 Summary

The past year has been a productive and successful one for the Trust in terms of Equality and Diversity; from the launch of its Single Equality Scheme to the declaration of compliance with the Equality and Diversity elements of the Healthcare Commission (presently known as the Care Quality Commission - CQC) core standards. This achievement has been possible with the collective effort of staff, who have embraced the changes required and adopted new ways of working.

As one of the leading NHS organisation the Trust has demonstrated its commitment to make a difference by embracing the principles of Equality and Diversity as part of its core value system. For individuals to achieve their full potential, the trust understands and strives to create environments where recognising and valuing individuals, celebrating the similarities and embracing the difference is becoming an integral component of everyday practice. This has been evident in the success of its 'Listening Into Action' programme founded on the belief that through listening and understanding, people will take ownership, feel valued and have pride in what they do, enabling a positive experience for all those who deliver and use our services.

2.0 Background

Equality and diversity are central to the NHS, both in terms of employment and service delivery. **Equality** is about 'creating a fairer society, where everyone can participate and has the opportunity to fulfil their potential' (DH, 2004). **Diversity** literally means 'difference' and when used in relation to equality, it is about recognising individual as well as group differences, treating people as individuals, and placing positive value on diversity in the community and in the workforce

The current Equality legislation places a legal duty on all public bodies to promote equality and eliminate discrimination. It also requires organisations to foster positive relationships between different groups of people, eliminate harassment, and involve people in decisions regarding their health, social care and access to services.

In April of this year a new Equality Bill was introduced into Parliament, which will distil all nine existing pieces of Equality legislation into one to simplify and strengthen the law on equality. The Bill will outlaw age discrimination in the provision of services and in the exercise of public functions. It also creates a new general public sector equality duty - to have due regard to the need to promote equality of opportunity, in relation to race, disability, gender, gender reassignment, age, religion or belief, and sexual orientation. This new duty replaces what are currently separate duties, covering race, disability and gender. All public bodies, such as SHAs and PCTs, are also bound by Specific Equality Duties to help them meet the requirements of the general duty. Therefore, in anticipation of new law the Trust will be increasing the equality groups to include Carers and will take in to account Human Rights and the significance of socio-economics.

The Equality Bill will strengthen our equality law by:

- Introducing a new public sector duty to consider reducing socioeconomic inequalities;
- Putting a new Equality Duty on public bodies;
- Using public procurement to improve equality;
- Banning age discrimination outside the workplace;
- Introducing gender pay and equality reports;
- Extending the scope to use positive action;
- Strengthening the powers of employment tribunals;
- Protecting carers from discrimination;
- Protecting breastfeeding mothers;
- Banning discrimination in private members' clubs; and
- Strengthening protection from discrimination for disabled people.

3.0 Trust Equality Framework – Single Equality Scheme

Following the merger of the three existing Equality Commissions to become the new Equality and Human Rights Commission (EHRC), organisations were encouraged to develop a Single Equality Scheme which would bring together all of their previous Equality schemes (Race, Disability & Gender).

Sandwell and West Birmingham Hospitals NHS Trust developed and published its first Single Equality Scheme (SES) in July 2008. This dynamic strategy encompass the current equality duties of Race, Disability and Gender equality schemes, whilst addressing duties in relation to age, religion and sexual orientation. The SES sets out how the Trust will meet its obligations under the equality legislation over the next three years and how it intends to make a real and positive difference to the lives of all who are affected by what it does. It also set out the Trust commitment to achieving equality and its determination to ensure that policies and practices meet the needs of all service users and staff. It provides the Trust with a formal framework to support the implementation and delivery of the Equality and Diversity action plan.

The monitoring and reporting structure for Equality and Diversity originally comprised of four subgroups; Workforce, Service & Polices, Patient Experience and Independent Living.

In March 2009 it was decided that the Patient Experience Group has significant importance to the overall patient experience agenda that it warranted having a separate reporting mechanism. Therefore Patient Experience Subgroup has been removed from the existing E&D structure.

The current reporting framework provides and ensures that communication and information sharing is a key function between the overarching E&D Steering group, subgroups and the Trust board. All groups within the Equality & Diversity monitoring and reporting structure is chaired by an Executive Director or Deputy/Assistant Director. The chairs and members of the Equality and Diversity Subgroups are key and committed to driving forward the SES action plan which forms the work plan for each of the groups.

3.1 Equality & Diversity Steering Group

The Equality and Diversity agenda has been given a high profile by the commitment of several executive directors joining the E&D Steering group. This group provides strong leadership to all the E&D subgroups through its monitoring role; ensuring accountability and dissemination of the principles of Equality and Diversity remains an essential focus of all the groupsTo set the strategic direction for equality and diversity in line with the Trust's Single Equality Scheme.

The group receives quarterly updates from all subgroups and provides the Executive Board with assurance in relation to the progress of the SES. Since its introduction it has been instrumental in ensuring that Equality and Diversity training and awareness has been commissioned and delivered to all committee members and key stakeholders through a specialist external company. It supported the recruitment of a Head of Equality and Diversity and Equality Advisors to provide strategic and operational focus on Equality & Diversity within the Organisation.

3.1.1 Workforce Monitoring Subgroup

The Workforce subgroup is established to manage the data collection and analysis of the associated action plans relating to all elements of workforce employment and training. Ensuring their findings are published and easily accessible to the public. This group is also responsible for monitoring the training and development of all Trust employees and new inductees in both equality and diversity awareness and undertaking impact assessments. The subgroup will be host agents to evidence folders to demonstrate good practices.

During the year the group has been influential in a number of achievements, including;

- The Trust compliance with its Equality Legislation publication duties.
- The SES is built into the staff annual appraisal procedure based on KSF.
- Robust monitoring information is available for staff annual appraisals and course attendances.
- Equality and Diversity is part of the Trust Mandatory programmes.
- Equality and Diversity E-learning course available to all staff.
- The Trust induction Programme has been revised and now includes E&D as does the Trust Conflict Resolution and Bully and Harassment programmes.

The group remains proactive and features regularly in the Trust staff magazine as part of its marketing and staff awareness campaign. It recognises and supports existing staff groups in line with the equality strands.

3.1.2 Service and Policy Assessment Group

The Service and Policy Assessment subgroup monitors the completion of all Equality Impact Assessment [EIA] of policies, services and functions in accordance with the legal duties. They ensure the publication of all completed Equality Impact Assessments in line with the Equality legislation.

The group supports and promotes dissemination of good equality and diversity practices by ensuring effective monitoring and reporting systems in place are complied with across the organisation. They review the priority order of assessments and review associated SES action plans, including having a central register for the EIA process.

The Equality Impact Assessment process allows you to assess whether your policies, services and functions are discriminating directly or indirectly. Using the EIA process allows staff to identify the policies, functions and services which adversely or have to potential to adversely affect the equality groups which stem from existing legislation that covers discrimination;

- Ethnic communities
- Age groups
- Gender groups (including transgender)
- Religious groups
- People of varying sexual orientations (heterosexual, homosexual, bisexual)
- Disabled people

During the year the subgroup has been influential in a number of achievements including;

- A review of all existing policies to monitor compliance with EIA standards.
- Processes are in place to review all new policies, functions and services EIAs.
- Development of new EIA toolkit and assessment forms.
- Development of a central Trust EIA register for all completed assessments.
- Commission Equality and Diversity training for all members of the E&D framework groups and other key stakeholders.

The group's membership has progressed steadily throughout the year and has now established core members who are committed in their role.

3.1.3 Independent Living Group [ILG]

The ILG core function is to monitor the environmental elements of hospitalization, access to services and quality of care delivery for disabled and disadvantaged groups, in line with DDA and the Trust's Single Equality Scheme. It provides a public and user involvement and engagement role through its membership and work plan as well as contribute to raising the profile of equality and diversity across the Trust, in line with the Single Equality Scheme. The group provides the Steering group with quarterly update reports as part of it core function.

Despite a slow growth in membership this group has remained committed and has been very productive and influential across the Trust. In the last year the group has ensured that the following actions have been undertaken;

- The completion of a Demography Report to provide accurate data which is reflective of the Trust local population.
- Members of the subgroup joined the Diversity advisors and carried out a comprehensive Way finder Audit. The outcome and recommendations now informs the work being undertaken to improve signage and access within the organisation.
- Equality and Diversity Resource Pack has been completed which includes relevant and up to date information on the equality strands and local community support groups, to enable staff to be knowledgeable and sensitive in their every day practice.
- To improve and gain compliance with Ethnic data collection and monitoring within the Trust. A successful poster campaign was launched aimed at staff and patients. Early reports have indicated improvements within this area. A detailed audit is scheduled to be undertaken to evaluate the full impact of the campaign.
- Following a presentation to the E&D Steering group further work has been undertaken to commission Disabled –Go to undertake an independent review of the premises access, reception and environment to identify areas for improvement. This information will culminate in the production of a SWBH website for disabled access.

4.0 The Equality and Diversity Team

The E&D team falls within the Patient Experience work stream of the Nursing Division under the strategic leadership of an Assistant Director of Nursing. The team became fully established with the appointment of the Head of Equality & Diversity in March 2009, who joined two Equality advisors to form the full compliment of the team.

4.1 Publication Duties

The Head of E&D provides leadership and operational management of the team, as well as working closely with the Equality and Diversity groups within the framework and other key leaders in the implementation and delivery of the SES.

It has been an exciting year for the team which has seen each member of the team working in partnership with staff and stakeholders both internally and externally to the Trust. An Equality and Diversity website is available on the Trust Intranet and Internet sites, although it is at its embryonic stage it is a resource for staff which provides public access to information, in order to meet our publication duties.

4.1.2 Training

Raising staff awareness and completing Equality Impact Assessments have been a major part of the teams' focus to date culminating in 66 Executive and senior managers attending a cohort of Equality and Diversity master classes; 127 frontline clinical staff receiving E&D awareness sessions in the clinical areas, 16 managers attending a formal EIA workshop followed by 1:1 and team EIA training sessions held in divisions across the organisation. A formal training program for both EIA and E&D awareness sessions have been developed to commence in October 2009.

It has been very encouraging to have Managers and frontline staff central to the Equality Impact Assessment process which have significantly increased in numbers of completed EIAs. The identification of adverse impacts has resulted in the development of realistic actions to either eliminate and/or minimise the impact. Actions include the following:

- Information produced in easy-read versions
- Lowering of ticket machines for wheelchair users
- Improved signage and maps
- Increased access routes for disabled people
- Information produced in larger fonts for visually impaired
- Review of the recruitment process
- Increased and accurate data available (demography)
- Pictorial patient satisfaction surveys for learning disability patients

The team is being recognised for its expert advice and support and is becoming more involved in activities across the Trust to enable and support Equality and Diversity becoming mainstreamed within the organisation.

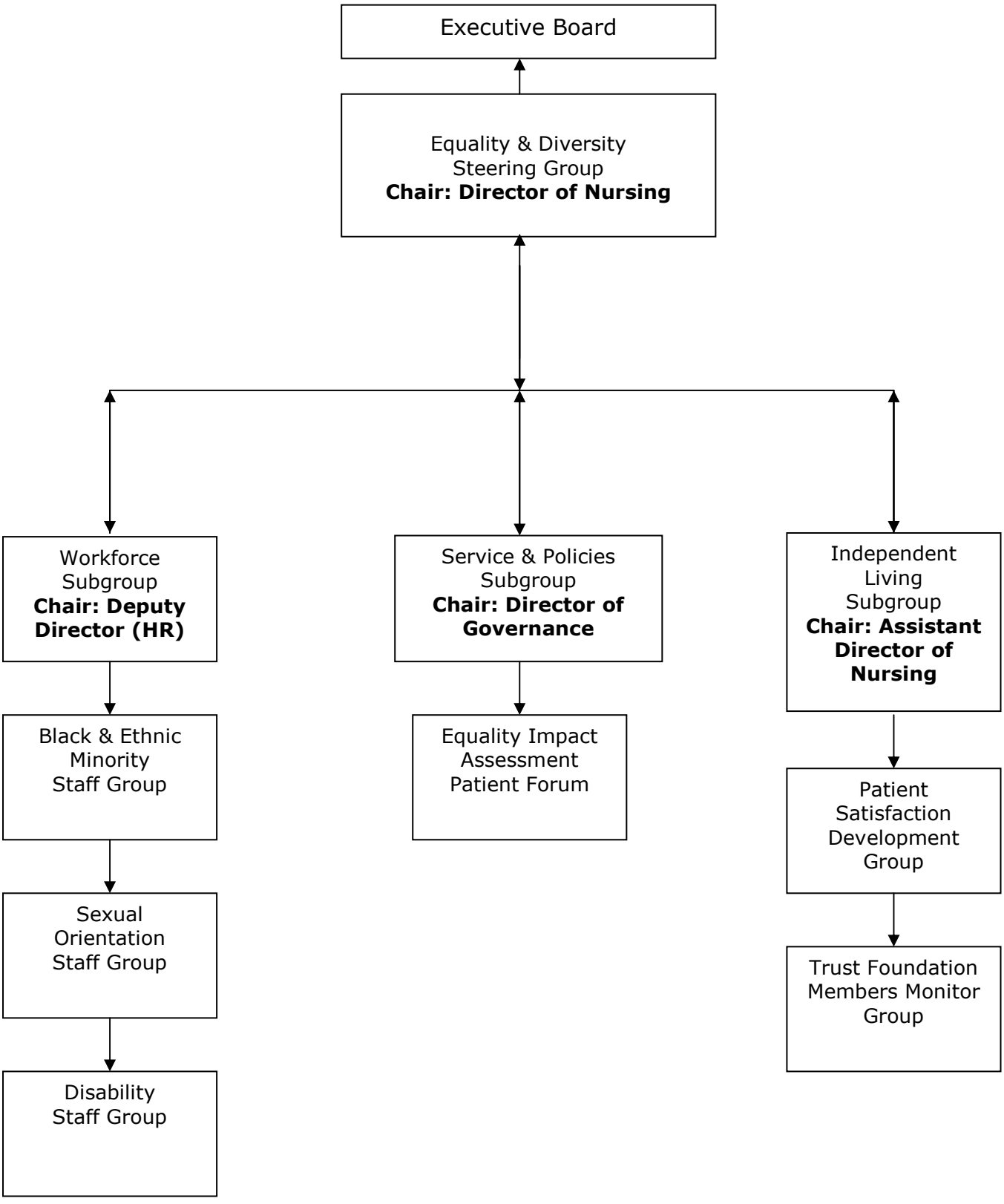
5.0 Conclusion

In the last twelve months significant strides have been made and changes brought about within the Trust as part of its Equality and Diversity agenda. However, it is important to note that we still have a long and sometimes challenging road ahead in order for us to become a role model organisation in terms of its equality and diversity practices.

We have much to learn from our local communities, our public sector peers, our staff and patients that will enhance and enrich us as a service provider. As long as we continue to create environments where lessons can be learnt, opportunities are promoted and differences embraced, we will at least be taking the right steps towards becoming a centre of excellence where the principles of equality and diversity is not rhetoric but is embedded in whatever we do.

APPENDIX 1

MONITORING AND REPORTING STRUCTURE



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Embracing Our Diverse Communities
Single Equality Scheme
JANUARY 2010

Where EVERYONE Matters

Embracing Our Diverse Communities
Single Equality Scheme

PROFILE	
REFERENCE NUMBER:	
VERSION:	Final
STATUS:	Approved
ACCOUNTABLE DIRECTOR:	Chief Nurse
AUTHOR:	Assistant Director of Nursing – Patient Experience
DATE OF LAST REVIEW/ ORIGIN DATE:	
DATE OF THIS REVIEW:	January 2010
APPROVED BY:	Trust Board
DATE OF APPROVAL:	July 2008
IMPLEMENTATION DATE:	July 2008
DATE NEXT REVIEW DUE:	January 2013
REVIEW BODY:	
CATEGORISATION:	
DATE OF EQUALITY IMPACT ASSESSMENT:	October 2009
APPLICATION:	
PRINCIPAL TARGET AUDIENCE:	Staff & Public
ASSOCIATED TRUST DOCUMENTS:	Current Equality & Diversity Policies Policy on Policy Development new version

Embracing Our Diverse Communities
Single Equality Scheme

Contents **Page No.**

FOREWORD BY TRUST CHIEF EXECUTIVE

I welcome the introduction of our 2010 Single Equality Scheme into Sandwell and West Birmingham Hospitals NHS Trust. We serve a diverse population over a large area and have extensive experience of promoting equality for patients and staff across the organisation. The Trust is committed to providing equal employment and advancement for all individuals.

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

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

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

John Adler
Chief Executive

WIDESPREAD CONSULTATION

This document is a result of our existing Equality and Diversity Schemes to produce a Single Equality Scheme. It contains the Trust's response to the statutory general and specific duties enshrined in the Equality Act (2006), the Disability Discrimination Act (2005) and the Race Relations (Amendment) Act (2000). It also embraces other equal opportunities legislation outlined in the New Equality Bill, including sexual orientation, religion and belief, age, race, disability and gender. This document supersedes our original 2008 SES because it reflects new legislation, staff and user feedback.

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

We would welcome comments on all aspects of this document, in particular your opinions on the action plans. Should you want to join any of our sub groups or contribute to elements of our work then please contact our Equality and Diversity Team on 021 507 5561 or 0121 507 5169.

DOCUMENT TRANSLATION AVAILABILITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mirpuri اگر تساں بے معلومات کسے بوری زبان وچ چاہنڑیں او، تے میربانی کری تے ساڑے نال رابطہ کرو. ساڑیاں تفصیلاں تلے دیتاں نیں.

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

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

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

TRUST VISION

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

OUR VALUES

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

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

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

1.0 INTRODUCTION

1.1 This Single Equality Scheme has been updated to reflect changes in Equality Legislation and alternations in the reporting framework. In April of this year the Equality Bill was introduced into Parliament, and will streamline all nine existing pieces of Equality legislation into one to simplify and strengthen the law on equality. The Bill will outlaw age discrimination in the provision of services and functions. It also creates a new general public sector equality duty - to have due regard to the need to promote equality of opportunity, in relation to race, disability, gender, gender reassignment, age, religion or belief, and sexual orientation. This new duty replaces what are currently separate duties, covering race, disability and gender. Certain listed public bodies, such as SHAs and PCTs, are also bound by Specific Equality Duties to help them meet the requirements of the general duty. Therefore, in anticipation of new law the Trust will be increasing the equality groups to include Carers and will take in to account Human Rights and the significance of socio-economics.

1.2 The original monitoring and reporting framework for Equality and Diversity comprised of four subgroups; Workforce, Service & Policy Assessment, Patient Experience and Independent Living Group. In March 2009 it was decided that the Patient Experience Group had significant importance to the overall patient experience agenda that it warranted a separate reporting mechanism. Therefore the Patient Experience Subgroup has been removed from the existing E&D structure. The equality framework continues to monitor progress of the action plans which are designed to ensure compliance to the Equality legislation.

1.3 Sandwell & West Birmingham Hospitals NHS Trust (SWBH) is currently operating across three hospital sites, City Hospital, Sandwell Hospital and Rowley Regis Hospital. The Trust has a workforce of 6,400 staff, with an income in excess of £365 million. The Trust is recognised as an excellent employer.

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

2.0 Single Equality Scheme

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

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

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

The Trust continues to consult with disabled people and with employee networks in the development of the SES in relation to individual protected characteristics e.g DDA compliance, Race Relations issues.

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

3.0 Aims of the Single Equality Scheme

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

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

3.3 To ensure that patients and their families have equality of access and can voice their opinions on how we can develop our services. This can be done through the equality impact assessment process to reduce health inequalities and improve health outcomes for all patients.

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

3.5 Ensure that consideration of diversity and equality issues are mainstream and embedded in day to day practices across the Trust. Educate all staff to understand respect for the individual and their family.

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

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

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

4.0 How the Trust will implement the Single Equality Scheme

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

5.0 The Framework for Delivery

5.1 Equality and Diversity Steering Group: Leadership is crucial to the success of the Single Equality Scheme, therefore an Equality and Diversity Steering Group chaired by The Chief Nurse has been established, to ensure that overall standards, targets and objectives are met. Senior managers and clinicians join with user representatives, trade union delegates and voluntary sector nominees, to work in partnership in monitoring the overall effectiveness of the scheme.

The purpose of the Steering group is:

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

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

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

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

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

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

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

5.5 The Independent Living Group: To address the legal requirements of public involvement in line with Disability Discrimination Act 2005 and Section 11 of the Health and Social Care Act, the ILG group has been established. This group will monitor the environmental elements of hospitalization, access to services and quality of care delivery for disabled and diverse groups. The membership of this group will be made up of disabled people with an interest in the Trust's work. They will be linking with the Patient Environmental Action Team (PEAT) inspection teams to ensure a coordinated approach to service improvement.

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

6.0 Involvement & Consultation of Stakeholders

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

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

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

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

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

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

7.0 Public Access to Information

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

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

7.3 The Trust is committed to ensuring that information provided is user friendly, and is available at the right time and accessible. We are currently updating an Equality and Diversity ward resource pack, and exploring many forms of media to deliver information. We continuously monitor and improve communication through user groups and reading panels; working with communities to gain knowledge and exchange ideas.

8.0 Meeting our specific duties as an employer

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

The Trust introduced the Electronic Staff Record system from April 2007. This system collects personal data on all of its employees, the purpose of which is to monitor whether the Trust's jobs and development opportunities are equally open to staff and that we encourage applicants from the community that we serve.

Monitoring will also enable the trust to see whether there are any differences in employment practice, training, disciplinary and grievance etc. and to take action (including positive action) to address any inequalities or discrimination, as appropriate.

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

Monitors the age, disability, ethnicity and gender of:

- staff in post and
- applicants for jobs, promotion and training
- training activity
- grievances
- disciplinary procedures
- performance appraisal
- dismissals and other reasons for leaving, including redundancy and retirement

This information will be published on the Trust's website and updated accordingly.

The Trust has completed an equal pay audit, which has been reported to the Trust Board in February 2010.

9.0 Equality Impact Assessments

9.1 The Trust provides an extensive number of services to the people of West Birmingham and Sandwell. It is a legal requirement to conduct equality impact assessments of those services/functions and associated operational policies/procedures; in order to determine that we are meeting the public duties to promote equality.

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

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

Equality impact assessments may be carried out sooner than 3 years where there are significant changes, (including reviews, restructures, withdrawal or introduction

of services) or where there is evidence of inequality e.g. from complaints, public concern or equality monitoring information.

9.4 The Trust has developed a new user friendly assessment tool to assist managers in being consistent in their assessments – the Trust's EIA Toolkit which is available in electronic format from the Equality & Diversity website.

The Service and Policy Assessment Group and Equality Lead will advise and support managers whilst overseeing progress on EIA and report to the Equality and Diversity Steering Group and the Trust Board.

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

9.5 The Equality and Diversity Team in conjunction with the Learning and Development teams will ensure the rollout and continuation of Equality and Diversity training, EIA workshops in order to complete the EIA process. All Trust Managers should ensure they undertake the EIA training provided. However, in the first instance, the priority for such training will be given to identified leads.

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

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

9.8 Where negative impact is identified, or where policies or functions may not be appropriately ensuring equality, an action plan will be drawn up and any remedial action prioritised to address any adverse impact. Where there is limited information available to assess for negative impact, action plans may be drawn up to put equality monitoring systems in place to monitor the impact of the policy or function on different groups.

9.9 For new policies, an equality impact assessment must be carried out by the policy author, as part of the policy development process. The procedure for this is set out in the Trust's Policy on Policy Development and in the Trust's EIA Toolkit. All new policies and functions should also include arrangements for equality monitoring the effectiveness of the policy.

9.10 The Trust will consult on the likely impact of its new and proposed policies and its existing functions, strategies and services, as part of the EIA process. This may

involve consultation with employee networks and/or external stakeholders such as the Independent Living Group or user focus groups.

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

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

10.0 Procurement

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

10.2 Contractors (or partners) carrying out public functions on behalf of the Trust are, by extension, required to work in accordance with the public duties placed on the Trust. The Trust will take steps to ensure that its equality and diversity commitments are carried out by organisations that are engaged through a contract or service level agreement. An equality compliance clause will be written into all our contracts.

10.3 Through the Divisional Finance Teams we will seek to ensure compliance with equality legislation with the procurement process. Positive action needs to be taken to promote equality. This will be reflected in the Trust's Procurement Strategy.

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

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

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

11.0 Equality Monitoring in services

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

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

11.2 It is essential that service improvements and progress achieved within the SES action plan is captured, co-ordinated and published to demonstrate our organisational commitment to progressing the equality agenda at SWBH.

12.0 Training staff in equality and diversity

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

12.2 The Trust has made EIA training available for all managers of services and introduced monitoring through the Divisional performance review system to ensure its implementation.

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

13.0 Reviewing and monitoring the Single Equality Scheme

13.1 As described in Section 5.0 an Equality and Diversity Steering Group has been formed with specific subgroups related to addressing the action plans of the scheme.

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

14.0 Conclusion

14.1 The Equality Bill introduced in 2009 replaces nine major pieces of legislation (Appendix 1) and around a hundred other measures with a single statue. In general, each of the predecessor pieces of legislation deals with only one protected characteristic. The Equality Bill streamlines and strengthens existing discrimination by:-

- harmonizing definitions and exceptions
- removing unnecessary variations in the lead of protection given to different characteristics
- extending the scope to take positive action
- banning age discrimination in the provision of services and exercise of public functions

It is essential that whilst SWBH has created a Single Equality Scheme to condense all these elements if does not dilute the general and specific duties for equality groups. Clear monitoring and report for elements such as DDA compliance, is vital to demonstrate our commitment to closing the equality gap amongst disadvantages groups.

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

APPENDIX 1

Legal Framework

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

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

Equal Opportunity Legislation

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

European Directives

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

NHS Guidance

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

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

PUBLIC DUTIES

The Race Relations Act 1976 and Amendment Act 2000

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

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

General duty

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

Specific duty

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

Specific Employment Duty

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

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

Disability Discrimination Act 1995 and 2005

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

- recruitment and retention policies and procedures
- learning and development

- planning and development of services
- services outsourced to private contractors

General duty (section 49a)

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

Specific duty

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

Equality Act 2006 and Gender Equality Scheme

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

General duty

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

- promote equality of opportunity between men and women

Specific Duty

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

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

New Equality Bill

A new Equality Bill was introduced in the House of Commons on 24th April 2009. Subject to the approval of the Commons Committee and the House of Lords, we expect the Bill to receive Royal Assent in spring 2010, the Bill to come into force at this time. It is expected

that certain parts of the Bill, such as the socio-economic duty on public bodies, and the public sector Equality Duty are likely to come into force in 2011. The Bill will distil all nine existing pieces of Equality legislation into one to simplify and strengthen the law on equality.

What will the Bill mean for the Public Sector?

The new Equality Bill will mean some important changes for the way the public sector operates as an employer and a provider of services: Public bodies already have a duty to consider how their spending decisions, employment practices, and service delivery can affect people according to their race, disability, or gender. The Equality Bill will replace this with a new streamlined and strengthened Equality Duty, which will be extended to cover sexual orientation, gender reassignment, age, and religion or belief.

The Bill will:

- Introduce a new duty on public authorities to consider reducing socioeconomic inequalities. It will apply to Government Ministers, departments and key public bodies such as local authorities and NHS bodies. The duty will affect how public bodies make strategic decisions about spending and service delivery.

- Bring in equality reports. The Equality Bill includes powers for Ministers to require public bodies to report on equality issues. We anticipate that public bodies with over 150 employees will be required to publish annually details of their ethnic minority and disability employment rate, and their gender pay gap.

- Make it clear that public bodies can use procurement to drive equality. For example, in a contract to manage its recruitment, a department, to ensure that its work is available to all groups of people, requires that all jobs must be advertised on either a part-time basis or with flexible working unless there is a business reason why this is not possible.

- Ban age discrimination. It is already unlawful to discriminate against people at work because of their age. The Equality Bill will make it unlawful to discriminate against someone aged 18 or over when providing services or carrying out public functions. For example, this could mean a Primary Care Trust ensuring they give an older person the same care and attention for a medical condition as they do a much younger person with the same condition.

- Put a new Equality Duty on public bodies. The Duty will mean public bodies need to think about the needs of everyone who uses their services or works for them. The new Duty will be easier for the public sector to understand and comply with.

- Extend the use of positive action in the workplace so public bodies will be able to address under-representation when, for example, recruiting staff. This will help to create a more diverse workforce in the public sector.

- Extend the use of positive action in service delivery so public bodies will be able to take positive action measures to meet the particular needs of disadvantaged groups.

APPENDIX 2

TRUST POLICIES ON INTRANET

October 2009

TOTAL = 209

Initial Equality Impact assessed = 136

Priority for Full Equality Impact Assessment as identified by Executive Directors	
High	11
Medium	11
Low	47

TITLE	PRIORITY FOR FULL EQUALITY IMPACT ASSESSMENT	INITIAL EQUALITY IMPACT COMPLETED	EXECUTIVE DIRECTOR	REVIEW DATE
1. Protected Mealtime Policy	Medium	Yes	Chief Nurse	30/11/2011
2. Red Tray and Blue Beaker Policy	Medium	Yes	Chief Nurse	30/11/2011
3. Bed Rails; policy for safe use	Medium	Yes	Chief Nurse	31/01/2011
4. PALS Operational Guidelines	Medium	Yes	Chief Nurse	31/01/2011
5. Patient Information Policy	Medium	No	Chief Nurse	31/01/2011
6. Tuberculosis; infection control	Medium	Yes	Chief Nurse	31/01/2011
7. Visitors Policy	Medium	No	Chief Nurse	31/10/2009
8. Infection Control Service	Medium	Yes	Chief Nurse	30/09/2009
9. Infection Control; Outbreak Plan	Medium	Yes	Chief Nurse	30/09/2009
10. Infection Control; Suspected Communicable infections	Medium	Yes	Chief Nurse	30/09/2009
11. Infection Control; Viral Haemorrhagic Fevers; infection control	Medium	Yes	Chief Nurse	30/09/2009
12. Infection Control; Creutzfeldt-Jacob Disease (CJD); infection control	Low	Yes	Chief Nurse	31/07/2012
13. Patient identification Wristband Policy	Low	Yes	Chief Nurse	31/07/2012
14. Oxygen Therapy at Home; Children's	Low	No	Chief Operating Officer	31/03/2012
15. Infection Control; C Difficile	Low	Yes	Chief Nurse	31/07/2011
16. Infection Control; Diarrhoea	Low	Yes	Chief Nurse	31/07/2011
17. Infection Control; Isolation	Low	Yes	Chief Nurse	31/07/2011
18. Infection Control; MRSA	Low	Yes	Chief Nurse	31/07/2011
19. Infection Control; Decontamination-Environment; infection control	Low	Yes	Chief Nurse	31/03/2011
20. Infection Control; Decontamination-Equipment; infection control	Low	Yes	Chief Nurse	31/03/2011
21. Infection Control; Flexible endoscope	Low	Yes	Chief Nurse	31/01/2011

TITLE	PRIORITY FOR FULL EQUALITY IMPACT ASSESSMENT	INITIAL EQUALITY IMPACT COMPLETED	EXECUTIVE DIRECTOR	REVIEW DATE
22. Infection Control; Gram Positive; infection control	Low	Yes	Chief Nurse	31/01/2011
23. Information Sharing (Overarching) Policy	Low	Yes	Director of IM&T	30/12/2010
24. Staffing levels nursing	Low	Yes	Chief Nurse	30/11/2010
25. Information Governance policy	Low	Yes	Director of IM&T	30/09/2010
26. Missing Patient Policy	Low	Yes	Chief Nurse	31/05/2010
27. Hospital Cleaning Policy	Low	Yes	Chief Nurse	25/04/2010
28. Infection control; Taking peripheral blood culture guidelines	Low	Yes	Chief Nurse	31/01/2010
29. Infection Control; Asepsis; Infection control principles	Low	Yes	Chief Nurse	30/09/2009
30. Infection Control; A-Z Communicable Infections	Low	Yes	Chief Nurse	30/09/2009
31. Infection Control; Blood and Body Fluid Spillage Policy	Low	Yes	Chief Nurse	30/09/2009
32. Infection Control; Blood borne Viruses, Infection control	Low	Yes	Chief Nurse	30/09/2009
33. Infection Control; Building/Upgrade works, infection control	Low	Yes	Chief Nurse	30/09/2009
34. Infection Control; Central venous catheters; infection control	Low	Yes	Chief Nurse	30/09/2009
35. Infection Control; Gram Negative; infection control	Low	Yes	Chief Nurse	30/09/2009
36. Infection Control; Hand Hygiene Guidelines for Staff	Low	Yes	Chief Nurse	30/09/2009
37. Infection Control; Infected Bodies; infection control	Low	Yes	Chief Nurse	30/09/2009
38. Infection Control; Infection Control Committee	Low	Yes	Chief Nurse	30/09/2009
39. Infection Control; Infection Control in Paediatrics	Low	Yes	Chief Nurse	30/09/2009
40. Infection Control; Infection Control in Theatres	Low	Yes	Chief Nurse	30/09/2009
41. Infection Control; Infestations; Human and Environmental; Infection control	Low	Yes	Chief Nurse	30/09/2009
42. Infection Control; Linen Segregation; infection control	Low	Yes	Chief Nurse	30/09/2009
43. Infection Control; Meningococcal; Infection Control Guidelines	Low	Yes	Chief Nurse	30/09/2009
44. Infection Control; Pathology specimens; infection control	Low	Yes	Chief Nurse	30/09/2009
45. Infection Control; Protective Clothing	Low	Yes	Chief Nurse	30/09/2009
46. Infection Control; SARS, Severe Acute Respiratory Syndrome; Infection control	Low	Yes	Chief Nurse	30/09/2009

TITLE	PRIORITY FOR FULL EQUALITY IMPACT ASSESSMENT	INITIAL EQUALITY IMPACT COMPLETED	EXECUTIVE DIRECTOR	REVIEW DATE
47. Infection Control; Sharps, clinical and infectious waste; infection control	Low	Yes	Chief Nurse	30/09/2009
48. Infection Control; Specimen collection	Low	Yes	Chief Nurse	30/09/2009
49. Infection Control; Splenectomy; Policy for prevention of infection	Low	Yes	Chief Nurse	30/09/2009
50. Infection Control; Varicella zoster virus; chickenpox, shingles; infection control	Low	Yes	Chief Nurse	30/09/2009
51. COSHH Policy	Low	No	Director of Workforce	31/12/2008
52. Domestic Abuse	Low	Yes	Chief Operating Officer	31/12/2008
53. Glove Policy	Low	No	Director of Workforce	01/09/2008
54. Identification of Responsible Professional	Low	No	Chief Operating Officer	15/07/2008
55. First Aid Policy	Low	Yes	Director of Workforce	01/06/2008
56. Transfer Policy for Children and young adults	Low	Yes	Chief Operating Officer	28/02/2008
57. Child Abuse; Guidelines for Medical and Nursing Management	Low	No	Chief Operating Officer	01/02/2008
58. Children's Community Care Nursing Operational Policy	Low	No	Chief Operating Officer	31/01/2008
59. Counselling Policy	High	Yes	Director of Workforce	31/03/2012
60. Leavers Policy	High	Yes	Director of Workforce	31/03/2012
61. Vulnerable adults	High	Yes	Chief Nurse	31/01/2011
62. Falls policy	High	Yes	Chief Nurse	30/09/2010
63. Uniform and Dress Code Policy	High	Yes	Chief Nurse	28/02/2010
64. Safeguarding/Child Protection-Guidelines for staff	High	Yes	Chief Nurse	31/01/2010
65. Infection Control; Infection Control Policy	High	Yes	Chief Nurse	28/01/2010
66. Mental Capacity Policy	High	Yes	Chief Nurse	30/09/2009
67. Family Leave Policy	High	No	Director of Workforce	01/09/2008
68. Capability Procedure	High	No	Director of Workforce	25/01/2007

TITLE	PRIORITY FOR FULL EQUALITY IMPACT ASSESSMENT	INITIAL EQUALITY IMPACT COMPLETED	EXECUTIVE DIRECTOR	REVIEW DATE
69. Agenda for Change, Review and Appeals Procedure	High	No	Director of Workforce	31/12/2006
70. Missing Child/Baby abduction		Yes	Chief Nurse	31/08/2012
71. Bed management Policy		Yes	Chief Operating Officer	31/07/2012
72. Transfer of patients		Yes	Chief Operating Officer	31/05/2012
73. Fire Policy		Yes	Chief Operating Officer	30/04/2012
74. Death of neonate or child policy		Yes	Chief Operating Officer	31/03/2012
75. Employee Personal Information		Yes	Director of Workforce	31/03/2012
76. Risk Assessment and Register Policy		Yes	Director of Governance	31/03/2012
77. Contractors; Management Policy		Yes	Director of Estates	28/02/2012
78. Healthcare Assistants Development		Yes	Chief Nurse	28/02/2012
79. Recruitment and Selection of Ex-Offenders		Yes	Director of Workforce	31/01/2012
80. Armed Police; Policy on Deployment		Yes	Director of Workforce	31/12/2011
81. Blood Contamination / Needlesticks Incidents		Yes	Director of Workforce	31/12/2011
82. Security Policy		Yes	Director of Estates	31/12/2011
83. Immunisation Guidelines Occ Health		Yes	Director of Workforce	30/11/2011
84. Medicines Reconciliation Policy		Yes	Chief Operating Officer	31/10/2011
85. Healthcare Records Management		Yes	Chief Operating Officer	30/10/2011
86. Consent for postmortem		Yes	Medical Director	30/09/2011
87. Display Screen Equipment (DSE)		Yes	Director of Workforce	30/09/2011
88. IV Medicines Policy		Yes	Chief Operating Officer	31/08/2011
89. Policies; Development, Approval and Management		Yes	Director of Governance	31/08/2011

TITLE	PRIORITY FOR FULL EQUALITY IMPACT ASSESSMENT	INITIAL EQUALITY IMPACT COMPLETED	EXECUTIVE DIRECTOR	REVIEW DATE
90. Waiting list policy Admitted		Yes	Chief Operating Officer	31/08/2011
91. Waiting List Policy Non admitted		Yes	Chief Operating Officer	31/08/2011
92. Whistleblowing Policy		No	Director of Workforce	31/08/2011
93. Discharge Policy		Yes	Chief Operating Officer	31/07/2011
94. New and expectant mothers (Health & Safety for staff)		Yes	Director of Workforce	31/07/2011
95. Major Incident Procedure-Trustwide		No	Chief Operating Officer	30/06/2011
96. Induction and Mandatory training Policy		Yes	Director of Workforce	31/05/2011
97. Subject Access Requests		Yes	Chief Operating Officer	31/05/2011
98. Blood Components (Products) in Adults		Yes	Chief Operating Officer	31/03/2011
99. Clinical Supervision Policy		Yes	Chief Nurse	28/02/2011
100. Adverse Events, investigation		Yes	Director of Governance	31/01/2011
101. Being Open		Yes	Director of Governance	31/01/2011
102. Claims Policy		No	Director of Governance	31/01/2011
103. Complaint, claim support for staff		Yes	Director of Governance	31/01/2011
104. Data Quality Policy		No	Director of IM&T	31/01/2011
105. Influenza Policy		Yes	Chief Nurse	31/01/2011
106. Recruitment Medical Staff		Yes	Director of Governance	31/01/2011
107. Safety Mittens		Yes	Chief Nurse	31/01/2011
108. Consent for Examination or Treatment Policy		Yes	Director of Governance	31/12/2010
109. Controlled Drugs Policy		Yes	Chief Operating Officer	31/12/2010
110. NICE Guidance Policy		No	Director of Governance	31/12/2010
111. Results Validation Imaging		Yes	Consultant Radiologist	31/12/2010

	TITLE	PRIORITY FOR FULL EQUALITY IMPACT ASSESSMENT	INITIAL EQUALITY IMPACT COMPLETED	EXECUTIVE DIRECTOR	REVIEW DATE
112.	Stress at Work Policy		No	Director of Workforce	31/12/2010
113.	Resuscitation Policy		Yes	Director of Governance	30/11/2010
114.	Blood Transfusion		Yes	Medical Director	31/10/2010
115.	Emergency Care Plan in children (DNAR)		Yes	Chief Operating Officer	31/10/2010
116.	Expenses Policy		Yes	Director of Workforce	30/09/2010
117.	Health and Safety Policy		No	Director of Workforce	27/09/2010
118.	Sickness Absence Policy		Yes	Director of Workforce	31/08/2010
119.	Hospital at night (out of hours policy)		Yes	Chief Nurse / Medical Director	21/08/2010
120.	Photographic and video consent policy		No	Chief Operating Officer	31/07/2010
121.	Waste Management Policy		Yes	Director of Estates	31/07/2010
122.	Young worker Policy		Yes	Director of Workforce	31/07/2010
123.	Cervical Cancer Audit and Disclosure Policy		Yes	Medical Director	30/06/2010
124.	Heatwave Plan		No	Chief Operating Officer	30/06/2010
125.	Long Service Awards Policy		Yes	Director of Workforce	30/06/2010
126.	Business Continuity Plan		Yes	Chief Operating Officer	31/05/2010
127.	Non Medical Prescribing Policy new number Pt Care/019		Yes	Medical Director	31/05/2010
128.	Bed Capacity Plan		No	Chief Operating Officer	30/04/2010
129.	Restraint and control policy		Yes	Chief Nurse	30/04/2010
130.	Risk Management Strategy		No	Director of Governance	30/04/2010
131.	Clinical Audit Policy		Yes	Director of Governance	31/03/2010

	TITLE	PRIORITY FOR FULL EQUALITY IMPACT ASSESSMENT	INITIAL EQUALITY IMPACT COMPLETED	EXECUTIVE DIRECTOR	REVIEW DATE
132.	Influenza Pandemic Contingency Plan		Yes	Chief Operating Officer	31/03/2010
133.	Retirement Policy		Yes	Director of Workforce	31/03/2010
134.	Antimicrobial Therapy		Yes	Consultant Microbiologist DIPC	31/01/2010
135.	Complaints Handling Policy		Yes	Director of Governance	31/01/2010
136.	Massive Blood loss (Major Haemorrhage)		Yes	Clinical Director	31/01/2010
137.	Medical Devices Competency		Yes	Director of Governance	31/01/2010
138.	Research & Development Policy		Yes	Medical Director	31/01/2010
139.	Lone Worker Policy		Yes	Director of Workforce	31/12/2009
140.	Medicines Management Policy		Yes	Director of Workforce	31/12/2009
141.	Moving and Handling Policy		Yes	Director of Workforce	31/12/2009
142.	National Reports		No	Director of Governance	31/12/2009
143.	Disciplinary Policy		Yes	Director of Workforce	30/11/2009
144.	External Visits Policy		No	Director of Governance	30/11/2009
145.	Professional Registration Procedure		Yes	Director of Workforce	30/11/2009
146.	Recruitment and Selection Procedure		Yes	Director of Workforce	30/11/2009
147.	Slips, Trips and Falls		Yes	Director of Workforce	30/11/2009
148.	Violence and Aggression Policy		Yes	Director of Workforce	30/11/2009
149.	Criminal Records Disclosure Policy		Yes	Director of Workforce	31/10/2009
150.	Food Hygiene Policy		Yes	Director of Estates	31/10/2009
151.	Grievance and Disputes Procedure		Yes	Director of Workforce	31/10/2009
152.	Information Security Policy		Yes	Chief Operating Officer	31/10/2009
153.	Personal Development Review (PDR)		Yes	Director of Workforce	31/10/2009
154.	Dignity at Work Policy		Yes	Director of Workforce	30/10/2009

	TITLE	PRIORITY FOR FULL EQUALITY IMPACT ASSESSMENT	INITIAL EQUALITY IMPACT COMPLETED	EXECUTIVE DIRECTOR	REVIEW DATE
155.	Investigatory Guidance		Yes	Director of Workforce	30/10/2009
156.	Pt Held Community Childrens Nursing Records Policy		No	Chief Operating Officer	30/10/2009
157.	Alcohol/Drug Misuse Policy		Yes	Director of Workforce	30/06/2009
158.	Complementary Therapy in Cancer Services		Yes	Richard Kirby	30/06/2009
159.	Disciplinary Procedure for Medical Staff		No	Director of Workforce	30/06/2009
160.	Smoking Policy		No	Director of Workforce	01/06/2009
161.	Resuscitation; DNAR		No	Director of Governance	30/04/2009
162.	Overseas Visitor Policy		No	Chief Operating Officer	31/03/2009
163.	Oxygen Policy		Yes		31/03/2009
164.	Medical Devices Policy		No	Director of Governance	01/03/2009
165.	Pest Control Policy		No	Director of Estates	28/02/2009
166.	Lost and Found Property		No	Director of Estates	31/01/2009
167.	Personal Protective Equipment		No	Director of Workforce	31/12/2008
168.	Doctors' Absence Policy		No	Director of Governance	31/10/2008
169.	Supply of Temporary Staff		No	Chief Nurse	31/10/2008
170.	Incident and Hazard Reporting Policy		Yes	Director of Governance	30/10/2008
171.	Recruitment and Retention Premia		No	Director of Workforce	01/10/2008
172.	Copyright Policy		No	Director of Governance	30/09/2008
173.	Bomb Threat Procedure		No	Chief Operating Officer	01/06/2008
174.	Discharge Policy consultant mandated nurse led		No	Chief Nurse	01/06/2008
175.	Evacuation Plan		No	Chief Operating Officer	01/06/2008
176.	Mass Casualty Plan		No	Chief Operating Officer	01/06/2008

TITLE	PRIORITY FOR FULL EQUALITY IMPACT ASSESSMENT	INITIAL EQUALITY IMPACT COMPLETED	EXECUTIVE DIRECTOR	REVIEW DATE
177. STEP Procedure		No	Director of Workforce	01/05/2008
178. Confiscation of Illegal Drugs		No	Director of Estates	31/01/2008
179. Dignity and Privacy for Patients		No	Chief Nurse	31/01/2008
180. Prison Winson Green and City Hospital; Standing arrangements		No	Director of Estates	31/01/2008
181. Visually Impaired; Registration Form		No	Chief Nurse	31/12/2007
182. Company Representatives on Trust Premises		No	Chief Operating Officer	30/11/2007
183. Point of Care Testing Guidelines		No	Director of Estates	30/11/2007
184. Prescribing unlicensed medicines		No	Chair DTC; Head Pharmacy	01/11/2007
185. Intellectual Property; Managing Protocol		No	Director of Governance	31/10/2007
186. Fraud and Corruption Policy		No	Director of Finance	31/07/2007
187. Interpreting Services		No	Chief Nurse	31/07/2007
188. Mental Health Act Policy		No	Chief Nurse	31/07/2007
189. Red Identification Bracelet Policy		No	Chief Operating Officer	31/07/2007
190. Bathing; policy on management of safe bathing		No	Chief Nurse	01/07/2007
191. Casenotes; alerting clinicians		No	Chief Operating Officer	01/07/2007
192. Casenotes; organisation and maintenance		No	Chief Operating Officer	01/07/2007
193. Coroner Requests; Policy for dealing with Requests from HM Coroner		No	Director of Governance	01/07/2007
194. Clinical Guideline Development Policy		No	Director of Governance	30/06/2007
195. Macmillan Palliative Care Referral Form		No	Richard Kirby	01/05/2007
196. Environmental Management Policy		No	Director of Estates	01/04/2007
197. Bleep Policy for Junior Doctors		No	Director of Governance	31/03/2007
198. Clinical interventional procedures		Yes	Director of Governance	31/12/2006

	TITLE	PRIORITY FOR FULL EQUALITY IMPACT ASSESSMENT	INITIAL EQUALITY IMPACT COMPLETED	EXECUTIVE DIRECTOR	REVIEW DATE
199.	Mobile Telephone Policy		No	Chief Operating Officer	31/12/2006
200.	Work Permit Policy		No	Director of Facilities	31/12/2006
201.	Hospitality Policy		No	Director of Governance	01/12/2006
202.	Study Leave Policy; non medical		No	Director of Workforce	30/11/2006
203.	Theatre Utilisation Policy		No	Chief Nurse	30/11/2006
204.	Elective Clinical Sessions - Cancellation or Reduction		No	Chief Operating Officer	31/08/2006
205.	Safety Reporting in Research		No	Director of Governance	30/04/2006
206.	Late Cancellation Policy		No	Chief Operating Officer	31/03/2006
207.	IT User Policy		No	Chief Operating Officer	01/03/2006
208.	Secondment Policy		No	Director of Workforce	31/01/2006
209.	Removal and Associated Expenses Procedure		No	Director of Workforce	04/01/2006

APPENDIX 3

Service & Functions Impact Assessment Programme

Updated September 2009

2008 -2011

The Trust acknowledges that considerable work has been scheduled in 2008-2011, to undertake a corporate review of functions and services over the next 3 years. This will ensure existing and proposed impact assessments are up to date and action plans implemented and monitored.

Using the guidance notes the service lead and Divisional manager needs to identify all services/functions within the Division is listed.

Then a rating in priority order of high, medium, and low equality impact relevance amend the assessment work programme illustrated below. It is intended that a website page will be developed to publish EIA ongoing action plans and details of the public involvement in the process.

Functions	High	Medium	Low	Completed	Registered EqIAs
Communication & Public Affairs					
Medicine Management	*				
Marketing	*				
Patient Information	*				
Internal Communication	*				
Public and Patient Engagement	*				
Communicate advice strategy development	*				
Strategy & Commissioning					
2010 Programme	*				
New Hospital Building	*				
Service redesigning / reconfigurations	*				
Commissioning	*				
Strategic Partnership			*		
Health Strategy	*				
Governance					
Policy Development	*				
Complaints Procedure	*				
Research & Development		*			
Healthcare Standards	*				
Clinical Effectiveness	*				

Functions	High	Medium	Low	Completed	Registered EqIAs
Medical Staffing	*				
Workforce Development					
Human Resources		*			
Recruitment Services	*				
Occupational Health		*			
Chaplaincy Services	*				
Learning & Development	*				
Finance & Performance					
Procurement / Purchasing	*				
Financial Strategy			*		
Financial Control			*		
Local Development Plan			*		
Capital Investment			*		
Nursing Division					
Therapy Services	*				
Facilities Services	*				
Continence			*		
TVS		*	*		
IV Team Service		*		√	
Palliative Care		*			
Patient Support Centre	*			√	
Women & Child Health Division					
Paediatric Services	*			√	
Neonatal	*				
Maternity Services	*			√	
GU Medicine	*				
Gynaecology Services		*		√	
Medicine & Emergency Care Division Medicine A					
Emergency Care	*				
Diabetes & Endocrinology		*			
Renal		*			
Neurophysiology		*			
Clinical Immunology		*			
Dermatology			*		
Clinical Pharmacology & Toxicology			*		
Gastroenterology		*			
Neurology	*				
Rheumatology			*		

Functions	High	Medium	Low	Completed	Registered EqlAs
Elderly Care/Rehabilitation	*				
Endoscopy (City)	*				
Medicine & Emergency Care Division Medicine B					
Emergency Care	*				
Elderly Care/Rehabilitation	*				
Respiratory	*				
Sickle Cell & Thalassaemia (SCAT)				√	
Haematology & Oncology	*				
Cardiology	*				
Stroke	*				
Surgical Division					
General Surgery	*				
Surgical Assessment Unit	*				
Trauma & Orthopaedics	*				
Vascular Services	*				
Colorectal		*			
Endoscopy		*			
Urology	*				
Ambulatory Care BTC	*				
Surgical Day Unit	*				
Urodynamics		*			
Orthotics	*				
Plastics		*			
Breast Surgery	*				
Theatre		*			
Fracture Clinic		*			
Oral, Maxillo Facial & Dental			*		
ENT	*				
Audiology		*			
Ophthalmology	*				
Pathology					
Haematology	*				
Microbiology	*				
Toxicology	*				
Infection Control	*			√	
Histopathology	*				
Clinical Chemistry	*				
Immunology	*				
Phlebotomy	*			√	

Functions	High	Medium	Low	Completed	Registered EqlAs
Virology	*				
Imaging					
Plain Radiography	*			√	
CT	*				
MRI	*				
Breast Screening	*			√	
Neurophysiology - Sandwell	*				
Nuclear Medicine		*			
Medical Illustration			*		
Specialist Radiology	*				
Ultrasound	*				
Interventional Radiology	*				
Dexa Scanning	*				
Medical Physics		*			
Radiopharmacy		*			
Anaesthetics & Critical Care					
Outreach Services		*		√	
Pain Management (Chronic or Acute)		*			
Critical Care Units		*		√	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Adult Inpatient Satisfaction Survey November 2009
SPONSORING DIRECTOR:	Rachel Overfield – Chief Nurse
AUTHOR:	Sheila Peacock, Assistant Director of Nursing
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

OVERVIEW:

The Trust's Adult Inpatient Satisfaction Survey was launched in May 2009 to monitor the perceived quality of our services by patients. The surveys are now conducted continuously and reports can therefore be generated as required for ward reviews, divisional reviews, and Trust Board reports.

ABOUT THE SURVEY

This survey includes 35 adult inpatient wards. Every patient aged 16 years or above who have had at least one overnight stay on a ward, is offered the opportunity to provide feedback about their experiences on the ward.

The results of this survey will be integrated into the Trust's Patient Experience Action Plan and Ward Review Action Plans.

The Trust has achieved its CQUIN target with respect to inpatient surveys.

Patient Satisfaction Working Group

This group was set up following feedback received from the previous survey results and other sources, to look at how we can survey hard to reach patient groups, such as those that are vulnerable or have communication difficulties or are non-English speaking. A Pictorial Easy Read version of the survey has been produced and is now available on the wards.

It has been agreed that when the current questionnaire is modified early in 2010, the surveys will be translated into the six main languages used in our Trust. Modifications will be necessary to include more focus on privacy and dignity and key areas from the new CQC outcome measures.

The Medical Assessment Unit (MAU) and Emergency Assessment Unit (EAU) have been included in the survey process but not in the results for this report. Questions were customised for these areas and reports are available if Trust Board members wish to see. The same approach will be taken for other specialist areas within the Trust this year. A further development early in 2010 will be a carers/relatives survey and real time patient survey reporting.

Audit Methodology

The original survey questionnaire and methodology has not been altered to provide a baseline for comparison between the surveys.

RESULTS OF THE SURVEY

Achievements compared with the last survey of May 2009

- Provision of single sex accommodation rose from 91%to 93%.
- Patients saying that they were kept involved and informed about their treatment and care remained static at 93%.
- Cleanliness of the wards rose from 80% to 86%.
- Discussion regarding dietary needs rose from 61% to 65%.
- 94% Patients were satisfied with their hygiene arrangements while on the wards.
- 92% of our patients thought that the overall care was excellent or good.

Areas for Improvement

- Respect and dignity on the wards slightly decreased from 98% to 96%.
- Information provision on the wards remained unchanged at 74%.

Key Actions

To address some of these issues, the Trust has formed a DSSA project group to monitor and improve the organisational compliance to single sex accommodation.

A Privacy & Dignity Month was launched in December 2009 where a variety of activities were delivered across the three hospital sites, these included:

- P&D Market stalls-Stands and leaflets.
- Senior nurses have undertaken ward observations of care across the organisation linked to the 8 key nursing P&D actions.
- The Nutrition &Dietetic Team are conducting Meal Observations and repeating the Malnutrition Universal Screening Tool Audit.

Information Provision – The Communication department has developed a new Patient Information Policy which when implemented, will improve the quality and quantity of information provided to patients.

Development of the Trust Patient Experience Group
The Trust Board will be aware from a previous report that the Chief Nursing Officer has published 8 key actions for nurses nationally. These include:
Reducing hospital falls,
Improving nutrition and hydration of patients,
Reducing hospital acquired tissue damage,
Reducing hospital acquired catheter sepsis,
Improving choice of place to die.
The patient experience group has been altered to include nursing quality issues and therefore the above actions.
In future the Trust Board will therefore receive Patient Experience and Nursing Quality Reports.

PURPOSE OF THE REPORT:

To provide a progress report on the Adult Inpatient Satisfaction Survey showing comparison between May and Nov 09.

✓ Noting

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the findings.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

The action plan aligns with the Trust Strategic Objectives

- No 4 Respond to our patients
- No 5 Improve quality and standards of care
- No 7 Promote education, training and research
- HCC core standards
- Essence of Care standards
- Privacy and Dignity National Standards

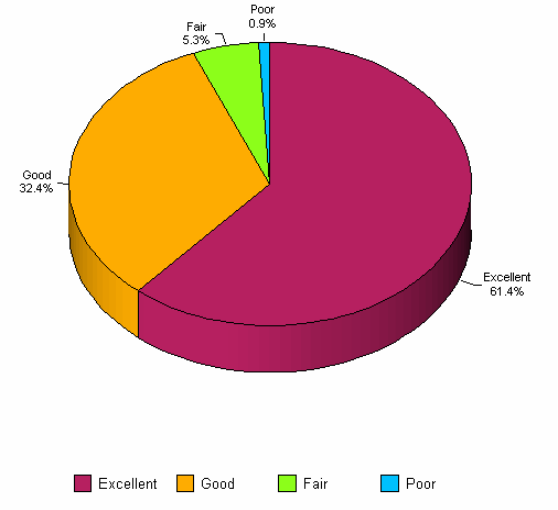
IMPACT ASSESSMENT:

FINANCIAL	√	None known currently although may be some as the action plan is implemented.
ALE		
CLINICAL		
WORKFORCE		
LEGAL		
EQUALITY & DIVERSITY	√	Single Equality Scheme (SES)
COMMUNICATIONS	√	Further work has been done on developing a questionnaire for hard to reach groups the new 2010 questionnaire will be translated into the 6 top language that are used in the Trust.
PPI		User feedback has been obtained in order to design the questions contained within the survey
RISKS		

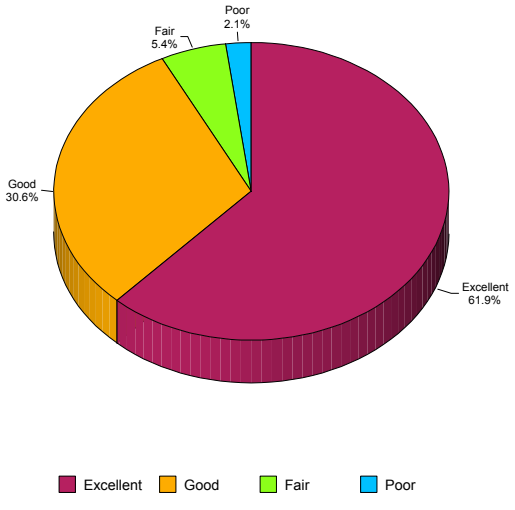
ADULT INPATIENT SATISFACTION SURVEY OCT 2009
Trust Results (Base: 1100 respondents)

OVERALL CARE AS RATED BY THE PATIENTS

May 2009



Oct 2009



PATIENT PROFILE		
	May 09	**Oct 09**
Are you		
Male……..	49.5%	50.0%
Female…….	50.5%	50.0%
What is your age?		
Under 18…...	0.7%	0.6%
18 to 24…….	6.0%	4.2%
25 to 44…….	18.7%	17.5%
45 to 60…….	20.6%	24.9%
Over 60…….	54.0%	52.8%
Which of the following best describes your ethnic background?		
White - British……..	66.4%	63.1%
White - Irish……....	3.8%	2.9%
White - any other White background (b/g)	1.0%	1.2%
Mixed-White & Black Caribbean…….	2.8%	2.3%
Mixed-White & Black African	0.8%	0.5%
Mixed-White & Asian	1.3%	0.3%
Mixed- any other mixed b/g..	0.3%	0.2%
Asian/Asian Brit – Indian……...	7.8%	9.7%
Asian/Asian Brit – Pakistani……...	3.3%	6.1%
Asian/Asian Brit – Bangladeshi……...	2.2%	2.3%
Asian/Asian Brit-any oth Asian b/g…...	0.6%	0.6%
Black/Blk Brit-Caribbean……	5.5%	7.5%
Black/Blk Brit-African	1.3%	1.0%
Black/Blk Brit – Any other Blk b/g	0.5%	0.3%
Other Ethnic Group - Chinese	0.3%	0.3%
Other Ethnic group	0.8%	0.3%
Not stated	1.3%	1.4%

THE WARD AND STAFF		
	May 09	**Oct 09**
On admission to this ward, was your bed next to a member of the opposite sex?		
Yes	8.5%	6.7%
No	91.5%	93.3%
When you arrived at this unit/ward, were you made to feel welcome by the staff?		
Yes	97.0%	94.7%
No	3.0%	5.3%
Were you treated with respect and dignity while you were in this ward?		
Yes	98.7%	96.4%
No	1.3%	3.6%
Were you kept well informed & involved in your treatment and care by the staff?		
Yes	93.0%	92.9%
No	7.0%	7.1%
Was the amount of information (leaflets, etc) about your condition or treatment given to you.....		
The right amount	74.3%	73.9%
Not enough	24.2%	25.1%
Too much	1.5%	1.0%
WARD ENVIRONMENT AND PATIENT NEEDS		
How clean was the ward/room that you were in?		
Very clean	79.3%	86.2%
Fairly clean	20.0%	13.3%
Not at all clean	0.7%	0.5%
Were you satisfied with your hygiene (washing & toileting) arrangements as a patient on this ward?		
Yes	94.8%	94.7%
No	5.2%	5.3%
Did a nurse discuss your dietary needs (food & drink) when you were admitted to this ward?		
Yes	61.1%	64.5%
No	38.9%	35.5%
Were you provided assistance with feeding when required?		
Yes	20.9%	26.5%
No	4.1%	3.1%
Not needed	75.0%	70.5%
Overall, how would you rate the care you received:		
Excellent	61.4%	61.9%
Good	32.4%	30.6%
Fair	5.3%	5.4%
Poor	0.9%	2.1%

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Results of OFSTED inspection of Sandwell Council Children's Services
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Care Quality Commission
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

The purpose of this report is to inform the Trust Board of the outcome of the above inspection. The Trust is a partner organisation of Sandwell Council Local Children's Safeguarding Board and therefore was included in the inspection.

The inspection found Sandwell Council Children's Services to be for:
Looked after children – adequate overall
Safeguarding – inadequate

There is very little comment made within the inspection report regarding NHS organisations. We submitted a vast amount of evidence to OFSTED ahead of their visit and played a fairly minor part in the inspection visit.

The report comments positively on health around:

- Safeguarding training
- Medical Assessment in A&E
- Communication with Community services
- Maternity working well with mental health and drug and alcohol services
- Mothers and babies have two visits from midwives before being transferred to health visitors
- Performance management

Areas that are identified as requiring attention are:

- Training in and use of the domestic violence assessment tool (common assessment framework)
- Assurance that children with child protection plans are suitably 'flagged' in A&E departments

Both improvement areas are already incorporated within our safeguarding action plans and we will see improvement over the next few months.

PURPOSE OF THE REPORT:

To inform the Board of the outcome of the above inspection.

✓ Noting

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the findings.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically, although some alignment to the objective to deliver significant improvements in the Trust's maternity services.

IMPACT ASSESSMENT:

FINANCIAL		
ALE		
CLINICAL	**x**	
WORKFORCE		
LEGAL AND POLICY	**x**	
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

Inspection of safeguarding and looked after children services

Sandwell Metropolitan Borough Council

Inspection Reference Number
Inspection dates **30 November – 11 December**
Reporting inspector **Martin Ayres HMI**

Age group: All

Published: 13 January 2010

Contents

About this inspection

1. The purpose of the inspection is to evaluate the contribution made by relevant services in the local area towards ensuring that children and young people are properly safeguarded and to determine the quality of service provision for looked after children and care leavers. The inspection team consisted of three of Her Majesty's Inspectors (HMI) and one inspector from the Care Quality Commission. The inspection was carried out under the Children Act 2004.

2. The evidence evaluated by inspectors included:

- discussions with children and young people receiving services, front line managers, senior officers including the Director of Children's Services and the Chair of the Local Safeguarding Children Board, elected members and a range of community representatives
- analysing and evaluating reports from a variety of sources including a review of the Children and Young People's Plan, performance data, information from the inspection of local settings, such as schools and day care provision, and the evaluations of three serious case reviews undertaken by Ofsted in accordance with 'Working Together To Safeguard Children' 2006
- a review of 31 case files for children and young people with a range of need. This provided a view of services provided over time and the quality of reporting, recording and decision-making undertaken
- the outcomes of the most recent annual unannounced inspection of local authority contact, assessment and referral centres, undertaken in July 2009.

The inspection judgements and what they mean

3. All inspection judgements are made using the following four point scale.

Outstanding (Grade 1)	A service that significantly exceeds minimum requirements
Good (Grade 2)	A service that exceeds minimum requirements
Adequate (Grade 3)	A service that only meets minimum requirements
Inadequate (Grade 4)	A service that does not meet minimum requirements

Service information

4. Sandwell, comprising of the towns of West Bromwich, Oldbury, Rowley Regis, Smethwick, Tipton and Wednesbury, was formed in 1974 and is one of seven children's services areas in the West Midlands conurbation. Children and young people aged 0 to 18 years represent almost 25% of the total population of 289,100 (2008 census). The population is diverse and includes children and young people from a wide range of ethnic, cultural and religious backgrounds. Deprivation levels in Sandwell are relatively high and the area is ranked 14th most deprived in England with 53% of the population living in areas designated very deprived.

5. Strategic partnerships have been established in the area including the Sandwell Local Safeguarding Children Board and the Sandwell Local Strategic Partnership which co-ordinate six thematic partnerships, one of which is the Children's Trust Board. The Children's Trust membership includes representation from the local council, Sandwell Primary Care Trust (PCT), the third Sector, Connexions, Sandwell College, the Learning and Skills Council, West Midlands Police, Sandwell Local Safeguarding Children Board and the Probation Service.

6. In October 2009, there were 483 children and young people in the care of the local authority and 185 children and young people were subject of child protection plans. The council directly provides 279 foster care placements, 14 respite and 38 family link placements and commissions 66 more fostering placements through independent agencies.

7. A network of 19 children's centres has been established in the six towns in Sandwell, with an additional two centres due to be opened. These are managed by a range of organisations including the council, the PCT and the third sector. The use of the Common Assessment Framework (CAF) has been incrementally developed and is now available across the whole borough.

8. Sandwell has nine infant, eight junior and 77 primary schools, eight secondary and two foundation schools, six academies, two trusts and four special schools. There are also seven pupil referral units providing 201 places. Sandwell's strategy for extended schools and children's centres is based on collaboration in seven learning communities. Some 109 schools are delivering the extended school offer.

9. Commissioning and planning of health services is carried out by Sandwell PCT. Sandwell and West Birmingham Hospitals NHS Trust provide acute hospital care for children. Specialist children's health care is provided through Birmingham Children's Hospital which was not included in this inspection. Child and adolescent mental health services (CAMHS) are provided by Sandwell Mental Health NHS and Social Care NHS Foundation Trust. Community services, including health visiting, nursing and therapy services, are provided by Sandwell Community Healthcare Services.

The inspection outcomes: Safeguarding services

Overall effectiveness Grade 4 (Inadequate)

10. The overall effectiveness of safeguarding services in Sandwell is inadequate. The Sandwell Local Safeguarding Children Board is not fully functional and safeguarding priorities across the partnership are not clearly defined. The Board's business plan is not robust and joint audit arrangements are not embedded. Communication between the Sandwell Local Safeguarding Children Board and the Children's Trust is inconsistent and neither are providing sufficient strategic leadership for children's services as a whole, and safeguarding in particular. The analysis of safeguarding need within the diverse children's population in Sandwell is inadequate and lacks comprehensive awareness of potential risk to some vulnerable groups within the community. The third sector provides a good range of family support and direct services to children in need and is appropriately included in strategic planning arrangements including the Children's Trust and Sandwell Local Safeguarding Children Board.

11. Although most cases of children deemed to be at immediate risk of physical harm are pursued quickly by duty workers, other cases do not receive such attention. The response from children's social care to some referrals is inadequate, with reported inconsistencies in the timeliness and effectiveness of action. Feedback to referrers is not routine. Safe recruitment and joint workforce planning arrangements are adequate, including robust strategies for new recruitment and training. However, referral and assessment pressures and fluctuating staffing levels have led to a degree of turbulence in front line services and responses. The quality of initial and core assessments is inadequate overall and management oversight of casework does not ensure that unsatisfactory assessments and reports are routinely identified and improved.

12. Performance management arrangements are not consistently applied across the partnership. There is too great an emphasis on headline indicators rather than service quality and outcomes. A proportion of initial and core assessments are signed off as completed by managers when the quality remains inadequate. The arrangements for joint audit and performance management within the Sandwell Local Safeguarding Children Board are also inadequate. Assessments of need and risk lack necessary detail and do not lead to clear plans for safeguarding. Case recording is of poor quality and made more difficult by the use of the Integrated Children's System (ICS) which does not focus sufficiently on risk. The views of children are not routinely sought or fully recorded. From performance information provided by the local authority, in 8% of cases of children subject to child protection plans in September 2009, the ethnicity, culture and language were not recorded.

Capacity for improvement Grade 4 (Inadequate)

13. Capacity for improvement is inadequate. Improvements that were achieved after the joint area review (JAR) in 2006 have not been sustained and the current structures and strategies for safeguarding are not delivering the changes needed in key areas of service. Quality assurance arrangements are inadequate. The council's own performance report for the period April to September 2009 relating to children with child protection plans highlights the fact that the outcome of 9% of strategy discussions, the outcome of 30% of enquiries and the outcome of 4% of case conferences were not recorded. The Sandwell Local Safeguarding Children Board is unable to assure itself of the quality and outcomes of agreed joint safeguarding policies. The lack of a clearly defined relationship between the Sandwell Local Safeguarding Children Board and the Children's Trust results in a risk of procedural confusion and lack of clear accountability.

14. Staffing capacity in referral and assessment services is inadequate. Frequent staff turnover and use of agency social workers has lead to front line managers in social care too frequently having to act down in order to fill practice gaps. This in turn has reduced their own capacity to oversee the quality of work and outcomes for children. Midwifery and health visiting services are managing growing workloads and staffing pressures exist with a current health visitor vacancy rate of 10%. There has been improved training in the health sector in relation to safeguarding and an improvement in the number of staff undertaking training at all levels related to their role. All Family Practitioners have received the safeguarding manual and have a named safeguarding lead. At the time of inspection, the Executive Director of Children's Services was on long-term sick leave and the statutory duties associated with this role had been assumed by the Chief Executive. A new Director of children's social care had recently taken up his post and is starting to develop an analysis of social care performance. The Chief Executive and Director provided a detailed action plan in response to issues raised through inspection in order to strengthen management in key areas of safeguarding.

15. The council has made a considerable investment in children's centres, with 19 operational centres and two more under development. The impact of the centres in reducing the pressures on higher level services is yet to be fully evaluated.

Areas for improvement

16. In order to improve the quality of provision and services for safeguarding children and young people in Sandwell, the local authority and its partners should take the following action:

Immediately:

- Secure agreement across the partnership for thresholds and criteria for service access at different levels and for an urgent implementation plan.
- Improve the quality of initial and core assessments and ensure that managers monitor their quality to agreed standards before 'sign off'.
- Closely monitor that children are being seen alone during assessment processes and that their views are fully ascertained and recorded.

Within three months:

- Make the Sandwell Local Safeguarding Children Board fully operational, including the development of a robust business plan and secured effective communication with the Children's Trust.
- Review staff workloads and pressures in referral and assessment services and take action to ensure these are consistently delivered to the required standards and are supported by regular supervision and managerial oversight.
- Take action to ensure children who have, or have had, child protection plans are suitably identified if admitted to Accident and Emergency (A&E) departments, General Practitioner walk-in centres or local hospitals.
- Ensure ethnicity, culture, religion and linguistic needs are fully recorded and acted upon for all children and young people.
- Conduct a joint audit of assessment and planning processes across the partnership to ensure that practice and management oversight complies fully with statutory requirements.
- Establish agreed models for performance management and reporting arrangements to the Sandwell Local Safeguarding Children Board, Children's Trust and scrutiny committees.

Within six months:

- Evaluate the current impact of CAF and the consistency of joint working in preventing the need to accommodate children and young people or to

invoke child protection processes when not appropriate according to the needs of the child and family.

- Undertake a comprehensive needs assessment of the area to develop priorities for joint support and intervention by agency partners for all groups of children and young people.

- Implement a joint information-sharing protocol between agencies.

Outcomes for children and young people

The effectiveness of services in taking reasonable steps to ensure that children and young people are safe. Grade 4 (Inadequate)

17. The effectiveness of services in taking reasonable steps to ensure that children and young people in Sandwell are safe is inadequate. Sandwell Local Safeguarding Children Board is not providing a sufficiently strong strategic lead in raising safeguarding awareness or ensuring that joint policies and procedures are effective. Although prompt action is taken to respond to the protection needs of those at immediate risk of physical harm, the needs of some vulnerable groups do not receive sufficient attention. For example, children who had entered Sandwell from overseas had been wrongly categorised as private foster children. As a result they were exposed to potential risks and were not fully safeguarded. Safeguarding action across the partnership is not rigorously targeted within community safety and multi-agency public protection arrangements for some vulnerable groups, including the small but significant number of young people who are the potential victims of sexual exploitation.

18. The contact centre which was established to provide a greater consistency of response across the borough is not fully meeting this objective. Referring agencies reported variations in response from social care and a lack of clarity in respect of thresholds. Feedback is not routinely provided to referring agencies, which is contrary to national guidance. The referral and assessment team has been under considerable staffing pressures and several posts have been filled by a succession of short-term agency staff. As a result, thresholds for intervention remain too high and assessments are not routinely completed and lack detailed analyses of need and risk. Assessment and planning processes are inadequate. The use of CAF is not yet fully embedded across the borough, although there are examples of positive use within some schools and by some health professionals. Assessment and planning arrangements for children with disabilities are more robust although some parents and carers of children with disabilities felt their views were not always taken into consideration and they were not always kept informed of developments.

19. Multi-agency work to address domestic violence is good. However, the planned introduction of the domestic violence abuse assessment tool has not been supported by training. Safeguarding is suitably embedded in school improvement partnership processes and all children and young people admitted

to hospital because of self harm are assessed for need and risk. The lack of an effective flagging system in A&E services and in the General Practitioner walk-in centre has reduced the ability of staff to check whether children have, or have had, child protection plans. Good arrangements are in place to ensure that children admitted to A&E or hospitals are not discharged without a full medical assessment and that community services are suitably informed. Maternity services work closely with mental health and drugs and alcohol services to ensure that mothers are supported well during pregnancy. Mothers and babies receive two midwife visits before being transferred to a health visitor and this arrangement is adequate.

20. Performance management is improving in health services but few joint measures are utilised across the partnership to monitor the quality and impact of interventions at different points within the overarching strategy for children's services. Sandwell Local Safeguarding Children Board has not developed a business model to ensure that strategic performance is routinely assessed and the relationship between the Board and the Children's Trust is not well defined. There has been too great an emphasis on high level performance indicators which do not provide managers, the Board or the Trust with a clear enough view of service quality, impact or outcomes. Too many assessments are prematurely signed off as completed by local managers and when these data are aggregated for performance monitoring purposes they provide a potentially misleading account of achievement, as the actual quality of assessments is poor overall.

The effectiveness of services in taking reasonable steps to ensure that children and young people feel safe. Grade 3 (Adequate)

21. The effectiveness of services in taking reasonable steps to ensure that children and young people feel safe is adequate. Surveys indicate that most children and young people in Sandwell say they feel safe. Schools are providing good programmes to raise awareness of safeguarding and to ensure staff remain alert to possible concerns about the welfare of children. Safeguarding is routinely on the agenda of all school meetings with children and young people and they are able to contribute well to discussions about aspects of their life including bullying, health care and promotion, and lifestyle and vulnerability within the community. There is good progress in reducing bullying and school exclusions have been comparatively low for several years. Health services contribute well to the provision of information and support to enable children to feel safe.

22. Race, ethnicity, religion and language are not recorded consistently in children's social care files. Recent performance information produced by the council shows that the ethnicity of 8% of children with child protection plans was not recorded. Direct work with children and families in ascertaining their wishes and feelings is also inadequately recorded and is not given sufficient priority within individual plans. This is a significant omission given the fact that some vulnerable groups in Sandwell are not sufficiently well identified through

joint processes. ICS and other recording systems in use in Sandwell do not readily assist in gathering data on inclusion or the views of children and young people. This is reducing the efficacy of individual assessments and plans and the capacity to aggregate data for strategic planning purposes.

The quality of provision Grade 4 (Inadequate)

23. The quality of safeguarding provision in Sandwell is inadequate. A good framework setting out the criteria for access to services has been developed but this is interpreted differentially across the partnership and thresholds are not universally understood. The response from children's social care to some referrals is also inadequate. The timeliness and effectiveness of action are inconsistent and appropriate feedback to referrers on the decisions and actions taken is often lacking. Most cases of children deemed to be at immediate risk of physical harm are pursued quickly by duty workers but other cases of less obviously immediate concern do not receive timely attention. From a sample of cases self audited by children's services shortly before the inspection, issues were identified which warranted immediate attention. Although this showed good self awareness, it also highlighted the fact that some safeguarding needs were missed by managers and during the internal monitoring processes. Additionally, other aspects of safeguarding were identified in the course of the inspection which had not been appropriately pursued within the area. Contact and referral arrangements are not robust and agencies reported inconsistencies in contact or referral definition, responsiveness and feedback. Arrangements for collaboration across the partnership in the completion of comprehensive assessments of need and risk are not embedded and the overall quality of assessments and plans is inadequate. The quality of recording is also inadequate and not aided by the lack of integration in recording systems. Some records are held electronically within ICS and others are stored in other systems making cross referencing difficult.

24. In many instances, thresholds for access have been set too high and, as a result, some forms of harm to children and young people are not fully identified. Children and young people are not routinely involved in assessments and planning and recording systems do not reflect the voice of the children in sufficient depth or understanding. Managerial oversight is not always evident on files and, in some cases seen during the inspection, written management direction had not been actively followed and this had not been identified. Processes to respond to children missing from home, school and care are in place and operating adequately.

25. CAMHS have an input into youth offending and drugs and alcohol services, but there are gaps in services and the average waiting time is 16 weeks which is slightly below the national minimum target of 18 weeks. Some lower level services, such as counselling, social and emotional aspects of learning and educational psychologist support, are available during the waiting time for specialist services but access to specialist services for some vulnerable young people is not sufficiently timely or fully responsive to their immediate needs.

Leadership and management Grade 4 (Inadequate)

26. The leadership and management of safeguarding services in Sandwell are inadequate. The strong ambition held by all agencies to safeguard vulnerable children and young people is not translated into concerted strategies or action, nor is this reflected in the day to day practice in key areas of safeguarding, including awareness, assessment and individual planning. There are too many projects in place which have spread capacity too thinly in key areas. Elected members and senior managers have clearly worked hard to improve safeguarding since the JAR in 2006 but the effort and improvements made have not been fully sustained. The processes for information sharing between agencies remain under developed and priorities for action are not gleaned from aggregated data or sufficiently well defined by the Sandwell Local Safeguarding Children Board or the Children's Trust. Communication between the Trust and Sandwell Local Safeguarding Children Board is not clear and respective accountability requirements have not been achieved. The Sandwell Local Safeguarding Children Board is not fulfilling the full range of responsibilities set out in national guidance. The Sandwell Local Safeguarding Children Board struggles to fund and provide the full range of activities to the required level, including the well received joint training programme. Three serious case reviews have been commissioned by the Sandwell Local Safeguarding Children Board and evaluated by Ofsted as adequate. Agencies report that learning from these reviews has been disseminated and included in training programmes.

27. The council has been responsive to staffing pressures in front-line safeguarding through the use of agency staff and a number of acting-up arrangements. However, this has contributed to a degree of turbulence in the workforce which has resulted in variability in the quality of planning for vulnerable children. Adequate systems are in place for financial control but performance management arrangements across the partnership in respect of safeguarding are inadequate and do not lead to sustained improvements in outcomes. Joint workforce planning processes, including safe recruitment, are satisfactory but struggle to keep pace with increased work pressures and rapid staff turnover. Supervision in social care and health services is available to staff but there is limited evidence that this is regular and helping to support improvements in the quality of practice. Training of staff across the partnership is adequate with good feedback on the range of training made available However some staff commented that owing to day to day work pressures they were not always able to avail themselves of the training they feel they need.

28. Systems to enable users of services to complain and to comment on services are adequate and this is reflected in the surveys on participation and involvement. However, user views are not routinely recorded on electronic records and it is therefore impossible to ascertain whether views have influenced individual and strategic plans. Case recording does not demonstrate that children are being seen alone and their views taken into full consideration.

29. Partnership working at practice level on some cases is adequate but inconsistent across the area. CAF is used well by some groups of professionals but is not yet fully embedded across the borough. Partnership working at a strategic level to ensure services are integrated, embedded and fully evaluated is inadequate. Service planning and delivery do not take effective account of the outcome from equality impact assessments, and diversity and equality are not integrated in assessment and intervention. Recording of culture, religion and identity is inconsistent and does not show that the individual needs of all children are assessed and taken into account.

30. Value for money is adequate. The costs of services are known and are suitably monitored. Additional resources, particularly in response to staffing pressures, are allocated where necessary. There has been considerable investment in preventative services including children's centres. There is evidence that this has had impact in reducing the numbers of children who enter care although formal evaluation of the impact on safeguarding and child protection has not been undertaken by the Sandwell Local Safeguarding Children Board or the Children's Trust. Contracting and commissioning arrangements are adequate and ensure that safeguarding requirements are included.

The inspection outcomes: services for looked after children

Overall effectiveness Grade 3 (Adequate)

31. The overall effectiveness of services for looked after children and young people is adequate. Statutory requirements for visiting and case review are met, although in some cases only to a minimal level. The corporate parenting board is working well and providing a driving force to improvement, which is reflected in improving trends of performance against key indicators. However, the Children's Trust is not ensuring that looked after children services are sufficiently well targeted and mechanisms for performance management relating to quality, user engagement and outcomes are under developed.

32. Outcomes for looked after children are adequate overall with some good examples of effective health and education support, including the proactive role of the looked after children nurse, the impact of health improvement programmes and the provision of targeted education support through virtual school arrangements. Offending rates amongst looked after children have reduced significantly with effective work by the Youth Offending Service in conjunction with Connexions, the police, housing and schools. There is an increasing trend of young people leaving care entering higher education and there has been commendable progress, in a high unemployment area, to ensure young people are in employment, education or training.

33. The quality of case planning is adequate but the rigour of planning is variable. Some individual planning aims and objectives, which appear to have been well considered, are subsequently changed without sufficient explanation or recording of evidence. Management oversight of planning is not always obvious and in the sample of cases seen by inspectors, there was evidence of planning drift. This included the timeliness of plans, changes in original objectives without suitable commentary and lack of engagement of stakeholders. A permanency planning policy is in place but this is not ensuring in all cases that robust plans for young children are adhered to and that all stakeholders, including parents, are absolutely clear about their roles and responsibilities within the plans.

34. Adequate user engagement and participation procedures have been developed but are not consistently ensuring that the voices of looked after children are heard and acted upon. Independent reviewing processes meet statutory requirements but have not established a planning culture whereby children and young people and other stakeholders are empowered in their own planning. Strategies to promote equality and diversity are in place but monitoring arrangements are not effective in ensuring records contain relevant information on individual children and families and that full weight and consideration are given to these aspects in the delivery of services across the partnership.

35. Staffing resources to support looked after children are adequate although some children and young people have commented on the frequent turnover of social workers. There is good commitment to meeting the holistic needs of children and young people at practice level with good examples of collaboration by health, education, social care and third sector representatives. Nevertheless, some aspects of service remain stretched and increasing demands and pressures are having an impact on the quality of assessments and planning.

Capacity for improvement Grade 3 (Adequate)

36. The capacity for improvement is adequate. The quality of looked after children services and partnership working is improving and this trend, overall, is being sustained. Elected members and senior managers are ambitious for the service and committed to improvement and there are good examples of effective partnership working in practice. These include education, health and youth offending services. The corporate parenting board functions well and is backed up by a committed scrutiny panel of elected members. The joint workforce strategy group is working adequately to ensure that staffing capacity and skill are available to meet the needs of looked after chidren across the partnership.

37. Quality assurance and performance management systems are substantially and inappropriately focused only on high level indicators. The Children's Trust, the corporate parenting board and scrutiny panels do not receive sufficient information on service quality, user engagement, the impact of local strategies

and key outcomes. Adequate systems and structures are in place to commission services for looked after children. However, there is a lack of clarity regarding the balance of agency placement use, including fostering and residential care. Residential care commissioning is less developed and an existing large and costly contract with an independent provider of service is being re-negotiated. Overall, value for money is adequate and there is sufficiently tight monitoring of service costs.

Areas for improvement

38. In order to improve the quality of provision and services for looked after children and care leavers in Sandwell, the local authority and its partners should take the following action:

Immediately:

- Record the ethnicity, race, culture, religion and language of all looked after children and young people accurately and fully.
- Include an up to date photograph on the records of all looked after children.

Within three months:

- Review the functioning of the independent reviewing service to ensure that it is providing the impetus for effective user participation and that it is robust in reviewing and monitoring the implementation of care plans.
- Review the use of the 'Social Work Pilot' project for looked after children and young people and ensure they have a full voice in any service changes or developments.
- Develop a quality assurance framework which provides performance information to the Children's Trust, Sandwell Local Safeguarding Children Board, the corporate parenting board and scrutiny panels on assessments and plans, user engagement and outcomes for looked after children and young people.
- Improve access to support services for children and young people with lower levels of mental health and emotional need.

Within six months:

- The Children's Trust, in collaboration with the corporate parenting board, to jointly agree monitoring and evaluation arrangements of the impact of looked after children services to reduce the need to receive children into care and to promote their long-term welfare.

Outcomes for children and young people

39. Services to promote good health amongst children in care are adequate. Performance on targeted health support has significantly improved over the last year. Health support is now received by 88% of children and young people. Improvements in access to behavioural and support services has been slower and is currently only 55%. Looked after children are appropriately 'fast tracked' into CAMHS where a specific need is identified. Access to CAMHS through educational psychologists in Sandwell schools is good but is significantly reduced for children and young people placed out of the borough. Some care leavers indicated that the provision of mental health services at the transition stage from children to adult services is less effective, with delays in service provision and problems in contacting appropriate support professionals at times of need. The designated nurse for looked after children provides a responsive service to children and young people placed out of borough. Care leavers report good satisfaction with the health support they receive, including optical and dental care. The co-location of drugs and sexual health workers within the leaving care service is seen by young people and their carers as a positive development and providing good access to key health services. Looked after young people who are pregnant or caring for their child receive good support through the family nurse partnership until their babies are over two years old. The virtual teenage pregnancy team works in a cohesive and enthusiastic manner and is good. It has taken effective steps to ensure it has a good profile amongst the teenage population. Communication is good amongst staff members and they have identified and taken opportunities to engage young people through school and specialist nurses and maintained a presence at various outreach and consultation activities such as residential trips and specific looked after children events.

40. Children and young people in care are adequately safeguarded. Placement stability is comparatively good and services are in place to reduce disruption and breakdown. The Barnford project provides focused therapeutic services to looked after children and young people to support placement stability. Joint protocols, to identify and track children and young people who go missing from care, are adequate. However, not all looked after children and young people have their photographs on record as procedures require. Children and young people report that they feel safe in their placements and all looked after children have an allocated social worker and care plan. The quality of care plans is variable, with some good examples but there are also others which lack detail in respect of needs and services to improve outcomes. Decision making in care planning is not always clear. Some plans are changed without the rationale fully recorded, despite the original objectives having been agreed in the best interests of the children concerned. This includes permanency plans where adoption had been seen as a priority for young children. Although arrangements for looked after children are reviewed in accordance with statutory requirements, the quality of reviews and participation of children, family and other stakeholders is inconsistent. Independent Reviewing Officers (IROs) do not provide the impetus to planning envisaged in this role or act

together to aggregate important data for strategic planning purposes. This aspect of the service is therefore inadequate. There is a lack of clarity regarding decision making and ownership of care plans leading to drift in the achievement of agreed planning actions in some cases. IROs have not developed the service to empower children and young people to have a major voice in their own planning.

41. Services to enable looked after children and young people to enjoy and achieve are adequate. The ambition and prioritisation of educational achievement of looked after children by partners are adequate. The Looked After Children in Education (LACE) service functions adequately as a virtual school. The strategic placement of the LACE service within the multi-agency looked after children service is satisfactory although the development of an integrated, multi-agency looked after children service has not yet fulfilled the potential envisaged by the Children's Trust. Evaluation of LACE, including performance management, quality assurance and workforce development, is adequate. Performance targets for the educational attainment of looked after children and care leavers are mostly met and achievement is at least in line with statistical neighbours. There are sufficient posts in the looked after children team but, due to vacancies, work has to be continually re-prioritised to ensure that children and young people in greatest need of support are helped promptly.

42. Satisfactory support and guidance are in place for looked after children to promote their engagement in learning. Carers and social workers receive sound help and guidance when considering school placement for looked after children. There is sufficient guidance to carers of looked after children in the early years age group. Looked after children are given suitable priority for admissions to Sandwell schools and with good guidance from the LACE service. LACE does not provide the same level of guidance about school placement and education quality when children and young people are placed out of the area, although adequate support and monitoring are given to individuals once admitted to schools out of the area. Good attention is given to stability of education for looked after children by the LACE service, social workers and partners in Sandwell and when children and young people are placed out of the area. The targets for achievement, attainment and the progress made by looked after children are monitored effectively. Most looked after children make adequate or better progress across most key stages and subject areas, considering their starting points. Looked after children achieve very well at Key Stage 2, doing better than in other comparable areas and nearly as well as their peer age group in Sandwell schools. The attainment of looked after pupils at the end of Key Stage 4 (at age 16) is adequate.

43. Up to date personal education plans are in place and are monitored adequately. Children and young people are routinely involved in the preparation of plans. Audit processes are at an early stage of development and the outcomes of the plans are not yet used to inform wider planning for each individual. The attendance of looked after children has been given very close

attention. Disruptions to education for appointments outside school are kept to a minimum and attendance rates are very good in comparison with the national average. The rates of fixed term and permanent exclusions for looked after pupils are very low compared with similar areas and are good. Arrangements for continuing education are effective in ensuring that looked after children receive their entitlement.

44. Recording of uptake of leisure, recreation and voluntary learning opportunities taken up by looked after children is unsatisfactory. Inadequate use is made of the recording headings for achievement and qualifications on individual records and insufficient use is made of the information by social workers in wider case planning. Looked after children benefit from a good range of activities in the borough and children and their foster carers are entitled to receive a card to enable them to access affordable leisure activities in the borough. Satisfactory numbers of children and young people take up the activities. Children and young people placed outside the borough have more limited access to activities. Case records do not routinely show in which leisure activities and pursuits children and young people participate, except where these activities are highlighted in personal educational plans.

45. Opportunities for looked after children and young people to make a positive contribution are adequate overall. Good action is taken to enable children and young people to build positive relationships with adults and their peers. Children and young people in care have good access to advocacy services and information on making representations or complaints about services is accessible. The Youth Offending Service and schools have worked well together to help reduce the rate of offending amongst looked after children and young people and rates are comparatively low. The contribution of other agencies to reduce offending is less obvious and the focus on antecedents is not given sufficient joint attention in respect of the impact of wider community safety strategies affecting vulnerable young people, including the risk of sexual exploitation. Looked after children and young people have some good opportunities to comment on matters affecting them, although a large group of looked after children potentially affected by the planned social work pilot project has not been fully consulted about the project. The information derived from these processes is not always used to best effect to develop strategies. Scrutiny reviews on services for looked after children have been well managed and have led to good decisions and recommendations. However these have not been consistently enacted or monitored.

46. The impact of services in enabling looked after children and young people to achieve economic well-being is adequate. There is a sustained improvement in the number of care leavers placed in suitable accommodation from 80.6% to 94.9% in three years. However, a small number of care leavers are still placed in bed and breakfast accommodation although these placements are suitably supervised. The leaving care team works systematically and proactively to track and support care leavers. There is good and effective communication between the team, Connexions, Youth Offending Services, Housing and colleges.

47. Transition plans for looked after young people with disabilities are in place and are timely. Care leavers aspire to achieve and an increasing number go on to higher education. However, the quality of pathway plans is variable and in too many cases processes for planning have not been timely. Insufficient attention is given to targeted support for employment. The number of care leavers in education, employment or training at age 19 has increased and is now at 73.5% which compares positively to similar areas.

The quality of provision Grade 3 (Adequate)

48. Service responsiveness is adequate with active effort made to understand the needs of the looked after children population. The corporate parenting board works well and is helping to drive some improvements in outcomes for looked after children, as demonstrated in performance trends against key national targets. However, insufficient attention is given to data quality, measuring outcomes for individual children and the engagement of users in planning processes. Overall, outcomes for looked after children and young people against the five Every Child Matters dimensions are adequate although levels of aspiration remain too low in some aspects. Health and education partners are making sustained contributions to meet the needs of looked after children but commissioning arrangements are generally under developed and not sufficiently well informed by outcomes and quality information on service impact. Access to advocacy is good and statutory guidance in respect of representation and complaints systems is met. The Children's Trust board is not monitoring the quality and impact of different services which contribute to improved outcomes for looked after children and does not have systems in place to evaluate the quality of provision.

49. Placement contracting arrangements are generally well managed with adequate attention to the quality of out of borough placements for vulnerable looked after children and young people. However, the council is engaged in re-negotiations with a voluntary organisation providing residential care in the borough in order to ensure that the service is sufficiently focused on current need and is delivered to the highest standard.

50. Assessment and direct work with looked after children are improving although the quality of case recording is too variable. Management oversight is not consistently evident and the role of IROs is not effective in raising standards and ensuring plans are sufficiently robust and are fully delivered in timescales pertinent to the ages of the children concerned. Permanency planning procedures are in place but the rigour of plans and practice remains only adequate.

Leadership and management Grade 3 (Adequate)

51. The Children's Trust and corporate parenting board have high ambitions for looked after children but this is not consistently translated into joint action in practice. Outcomes for looked after children in the borough are adequate

overall and there is evidence of improving performance in health and education. However, the Children's Trust does not have a clear enough view of the impact of all the services for looked after children within the wider children's strategy and joint resources are not utilised in the most effective ways. The corporate parenting board and scrutiny panels work well and are pushing hard for sustained improvement but their recommendations for action are not systematically followed and monitored.

52. Foster care services are adequate and are appropriately commissioned. Residential care provision is less well developed and commissioning in this field is not well focused on the needs of groups of young people in the borough, including young women who may be exposed to sexual exploitation. Work is currently being undertaken at a senior level to strengthen placement options and choice.

53. Performance management processes are in place but these are too focused on data-based high level indicators and too little attention is given to quality, user engagement and outcomes. Performance reports for the boards provide useful trend information, including the increasing rate of young children entering care, but this is not leading to concerted action to examine the services available to children and families on the cusp of care. Joint workforce planning arrangements are in place and good training support to all staff is provided. All looked after children are allocated to social workers, although some looked after children and young people expressed concerns about high turnover of social workers.

54. The culture of engagement and direct work to ascertain wishes and feelings of looked after children and carers are under developed, including within the Independent Reviewing Service. Recording of direct work with children remains inconsistent and it is often difficult to see from case records how the wishes and feelings of looked after children and young people are contributing to planning. A scrutiny review required the use of a good information pack for all looked after children in the borough but the low use of this is not closely monitored. IROs have been commissioned to develop new consultation tools but these are currently not available.

55. Partnership working at a case level is generally effective; practitioners show a strong commitment to co-operate in the interest of children. Third sector organisations provide a valuable input to services and are able to offer innovative solutions to individual cases. Third sector partners commented that local commissioning seems to be too rigid and risks a reduction in opportunities for innovation. There are some good examples of shared budgeting to meet the needs of individual children and service costs are known. Value for money overall is adequate.

56. The promotion of equality and diversity for children and young people who are looked after is adequate. However, this aspect is not given sufficient attention by IROs and case recording of ethnicity, race, culture and language is

inconsistent. This is pertinent in the context of the diverse community in Sandwell and fast changing demography. Good work is being undertaken within children's centres to respond to the needs of local communities and to ensure that all children and families have equal access to services including prevention and care. Health and education services respond appropriately to individual need but their contribution to care planning is not always clearly defined.

Record of main findings: Sandwell

Safeguarding services	
Overall effectiveness	Inadequate
Capacity for improvement	Inadequate
Outcomes for children and young people	
Children and young people are safe: effectiveness of services in taking reasonable steps to ensure that children and young people are safe	Inadequate
Children and young people feel safe: effectiveness of services in helping to ensure that children and young people feel safe	Adequate
Quality of provision	Inadequate
Service responsiveness including complaints	Inadequate
Assessment and direct work with children and families	Inadequate
Case planning, review and recording	Inadequate
Leadership and management	Inadequate
Ambition and prioritisation	Inadequate
Evaluation, including performance management, quality assurance and workforce development	Inadequate
User engagement	Inadequate
Partnerships	Inadequate
Equality and diversity	Inadequate
Value for money	Adequate

Services for looked after children	
Overall effectiveness	Adequate
Capacity for improvement	Adequate
Outcomes for looked after children and care leavers	
Being healthy	Adequate
Staying safe	Adequate
Enjoying and achieving	Adequate
Making a positive contribution	Adequate
Economic well-being	Adequate
Quality of provision	Adequate
Service responsiveness	Adequate
Assessment and direct work with children	Adequate
Case planning, review and recording	Adequate
Leadership and management	Adequate
Ambition and prioritisation	Adequate
Evaluation, including performance management, quality assurance and workforce development	Adequate
User engagement	Inadequate
Partnerships	Adequate
Equality and diversity	Adequate
Value for money	Adequate

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Assurance Framework 2009/10: Quarter 3
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	28 January 2010

KEY POINTS:

This report is provided to update the Trust Board 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	1.1 (b), 1.3 (b), 2.3, 2.6, 2.7, 2.8, 5.1, 6.2, 6.3	RED	2.8, 6.3
AMBER	1.1 (a), 1.3 (a), 1.5, 2.1, 2.2, 2.4, 2.5, 2.9, 2.10, 3.1, 3.2, 3.3, 4.2, 4.3, 4.4, 5.2, 5.3, 6.1, 6.4	AMBER	1.1 (b), 1.3 (b), 1.5, 2.1, 2.4, 2.5, 2.9, 3.2, 4.1, 4.2, 4.3, 5.1, 5.3, 6.1, 6.2
YELLOW	1.2, 1.4 (a), 1.4 (b), 4.1, 6.5, 6.6, 6.7	YELLOW	1.1 (a), 1.2, 1.4 (a), 2.3, 2.6, 2.7, 3.3, 4.1, 4.4, 5.2, 5.3, 6.5, 6.6, 6.7
GREEN	None	GREEN	1.3 (a), 1.4 (b), 2.2, 2.10, 3.1, 6.4

Following proposed mitigating treatment, risks around the delivery of objectives 2.8 (achievement of NHS LA standards) and 6.3 (delivery of Mandatory Training) remain as red.

Feedback from discussions at the Governance and Risk Management Committee on 21 January 2010 have been incorporated.

Progress against delivery of the corporate objectives is to be discussed separately at the Trust Board.

PURPOSE OF THE REPORT:

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

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.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Relevant to all corporate objectives

IMPACT ASSESSMENT:

FINANCIAL	☑	
ALE	☑	
CLINICAL	☑	
WORKFORCE	☑	
LEGAL	☑	
EQUALITY & DIVERSITY	☑	
COMMUNICATIONS	☑	
PPI	☐	
RISKS		The update identified the principal risks to the achievement of the Trust's corporate objectives

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ASSURANCE FRAMEWORK 2009-10 – QUARTER 3

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.

January 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
DW	Director of Workforce
MD	Medical Director

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

ASSURANCE FRAMEWORK 2009/10

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						
What could or is preventing this objective from being achieved?	*Pre-mitigation*			*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*	*Post-mitigation*		
	Probability	Severity	Risk score									Probability	Severity	Risk score
1. Accessible and Responsive care														
1.1 Ensure continued achievement of national access targets (A&E, cancer, inpatient, outpatient and diagnostics and GUM)														
• Trust not able to adapt care pathways to respond to impact of new cancer targets for 2009.	3	3	9	Well established cancer patient tracking systems supported by new IT system and routine reporting,	Performance on cancer targets reported monthly to TMB, F&PC and Trust Board.	No gaps in control.	Performance to date is above expected thresholds.	No significant gaps in assurance.	None required	COO	• Cancer Mgr now part of DGMs weekly meeting. • Cancer waiting times now included in weekly WL meeting • Meeting new national standards and working with PCTs to improve timeliness of referrals from GPs.	2	3	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						
• Major increase in activity due to swine flu / heatwave or winter pressures presents major capacity problems	4	5	20	Business Continuity / Flu Pandemic and Major Incident Plans in place.	Trust plans meet NHS standards for business continuity,	No gaps in control – currently responding to flu pandemic in line with plan.	Trust has responded well to flu pandemic to date. Board has been briefed verbally.	More formal briefing for Trust Board required.	• Report to Trust Board in July on action taken to date and expectations for the summer. • September Trust Board receives formal assessment of state of readiness for autumn / winter.	Dep COO	• Influenza pandemic plan presented to the Trust Board in September • Vaccination programmes for seasonal and H1N1 flu were started in October and are ongoing (currently 31% of patient facing staff have been given the H1N1 vaccine) • Trust has adequate PPE to deal with increased numbers of patients with Swine 'Flu • Additional capacity has been identified to deal with seasonal (Winter) activity pressures	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			
1. 2 Deliver commitments in Single Equality Scheme for 2009/10														
Failure to meet statutory standards could result in Trust prosecution under Equality and Diversity legislation.	2	4	8	Meeting structure. E&D team. E&D training. E&D website. Action plan.	TB reports. E&D Steering group. Action Plan. Monitoring impact assessments.	Still need to train more staff. Greater interrogation of HR info. Impact assess all services.	TB reports.	None.	More training. Impact assessments.	CN	Infrastructure in place. E&D team in place. Compliant with publication duties. Exec Team training session held 12 October 2009 and revised action plan as a result.	2	4	8 ▶
1.3 Improve patient privacy and dignity by increasing compliance with single sex accommodation standards														
• That activity pressures prevent access to undertake the necessary capital work to meet the standards.	4	3	12	Trust capacity plan revised to enable capital works to be undertaken. Plan agreed by TMB.	Progress reported to Trust Board in July and expected again in September. Trust provides regular reports to SHA and has been pilot site for national support team visit.	No significant gaps in control.	Ongoing review of Trust plans by SHA and national support team.	No significant gaps in assurance.	None required	COO	• P&D work on wards at Sandwell completed. • Privacy and dignity work on Sheldon wards at City Hospital completed.	1	3	3 ▶

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 the age and layout of the wards at City make it impossible to comply with the new standards.	4	4	16	Plan for City being produced for review by Trust Board in September	Ongoing review of Trust plans by SHA and national support team.	Need to establish monthly single-sex accommodation standards project team.	Ongoing review of Trust plans by SHA and national support team.	No significant gaps in assurance.	Four key areas of action agreed by Trust Board. • Awareness, bed management and escalation; • Ward P&D work (Sandwell & Sheldon) • Specialist areas at City; • Single-Sex wards at City.	COO	Progress to date reported to Trust Board in December. Future monitoring to be included in corporate performance report. Detailed option appraisal of arrangements for City presented to Board in December.	4	3	12 ▶
1.4 Continue to improve communication with patients about their care														
1) Failure to seek views of patients about their care.	2	4	8	Twice year patient surveys. Patient views Committee and Action Plan.	Twice a year TB reports. Reports to Patient Views Committee.	Currently non recurrent funding for this activity.	Trust Board reports.	None identified	Recurrent funding identified for post and software licence	CN	1st round of surveys and reports complete. CQUIN target achieved. Surveys are now being conducted on A continual basis. Surveys for vulnerable groups and those whose first language is not English are currently being revised.	2	4	8 ▶
2) Failure to achieve CQUIN target.	2	4	8									1	4	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			
1.5 Work with Sandwell and HoBtPCTs to identify key hospital actions that will contribute to improvements in public health														
Financial difficulties could get so challenging that each party tries to defend their own position at the expense of the others	2	5	10	Right Care Partnership promotes deepening of the relationships necessary for the delivery of the objective	Financial, quality and performance data and systems.	None identified	Minutes of Partnership meetings, Quality review meetings with PCTs.	None identified	None required	MD	Monitoring framework established through a number of key committees and groups. Systems have been established around the collection of data for smoking referrals. There has been difficulty arranging follow up meetings with the Directors of Public Health.	2	5	10 ▶
2. High Quality Care														
2.1 Ensure continued improvement in infection control and achievement of national and local targets														
1) Failure to meet Trust IC targets.	3	4	12	IC infrastructure. Monitoring reports. PEAT cleanliness plan.	TB reports. IC Committee reports.	None identified.	Trust Board reports.	None identified.	Continue with IC action plans.	CN	Incentive to meet targets.	3	4	12 ▶
2.2 Complete implementation of surgical reconfiguration														
• That failure to agree appropriate arrangements for the medical staffing prevent successful implementation of reconfiguration.	3	4	12	Established project structure for delivering reconfiguration including steering group and project board.	Interim Reconfiguration project board oversees implementation on behalf of board.	No significant gaps in control.	Project board has strong NED representation.	No significant gaps in assurance.	None required	COO	Reconfiguration now implemented.	1	3	3 ▶

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			
2.3 Deliver significant improvements in quality of care for patients with stroke/TIA														
Failure to implement 24/7 scanning and treatment. Failure to ensure that beds available throughout the pathway.	4	4	16	Stroke Action Team responsible for monitoring Pathways	Regular audits	Systems for monitoring performance not yet developed or in place	CQUIN data	Systems for monitoring performance not yet developed or in place	Stroke Action Team needs to develop appropriate systems and ensure that performance data flows to board level	MD	Stroke Action Team set up to implement Stroke Plan developed in 08/09 24/7 scanning implemented September 2009. Systems now much improved. Pathway performance remains a challenge.	2	4	8 ▶
2.4 Deliver significant improvements in the Trust's maternity services														
Resource constraints Leadership capacity Difficultly in recruiting new staff Failure to monitor progress Lack of data to evaluate progress Stakeholder objections re configuration review	3	4	12	Maternity Taskforce, Maternity Action Team, Dashboard	Dashboard reports, Taskforce Minutes, Risk Mitigation Plan progress reports, Integrated Development Plan progress reports	None identified	Recent progress reports indicate bulk of actions on track and quantifiable improvements	None identified	None required	CE	Risk mitigation pan continues to be monitored. Principal outstanding risk is community staffing levels – reorganisation planned. Configuration review progressing as planned. Further clinical review commissioned to assess progress.	3	3	9 ▶
2.5 Deliver the Trust's "Optimal Wards" programme														
Failure to improve patient and staff experience.	3	4	12	Optimal Ward Programme. Productive Ward tools. LiA toolkit. Nursing infrastructure.	Patient surveys. Staff surveys. Ward Reviews.	None identified	Trust Board reports.	None identified.	None required	CN	21 wards in programme. Further 7 joining September 09. Ward Reviews show improvement. Customer care promises launched and Privacy and Dignity devised for implementation during the latter part of 2009/10	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			
2.6 Develop the Trust's approach to measuring and managing clinical quality														
Complexity of task and the multitude of departments and systems that need to be integrated	4	4	16	Basic quality data in F&P reports. Risk reports.	Minutes of Board meetings, Adverse events committee.	Integrated quality reports and systems not yet developed	Quality management framework basic data is available	QMF is still not fully developed or implemented	QMF development needs to be completed. Clinical Executive Team established to oversee QMF	MD	QMF already developed in basic form. CET meetings scheduled from 9/09 CET established September 2009 QMF review first quarterly cycle commenced 1 October 2009	1	4	4 ▶
2.7 Deliver CQUIN targets: ▸ Time to surgery for fractures neck of femur; ▸ Access to CT scan for stroke patients; ▸ Reduced caesarean section rate; ▸ Improved outpatient data quality (referral source); ▸ Introduction of patient surveys; ▸ Referral of patients to smoking cessation services;														
Not all targets have systematic collection of relevant data	4	4	16	CQUIN data in performance reports	Minutes of Board and F&P meetings	Data collection is not yet robust	Existing data is reviewed monthly	Systems are not fully developed	Integrate CQUIN data into QMF and monitor regularly	MD	QMF already developed in basic form. Clinical Executive Team meetings commenced 9/09 First QMF cycle commenced 10/09. Systems now providing more data. Smoking referral target is now at risk.	1	4	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			
2.8 Achieve NHSLA standards Level 2 (general) by December 2009 and new Level 1 (maternity) by March 2010														
The Trust may fail to achieve level 2 NHSLA risk management standards in December 2009 as a result of: ▪ Lack of awareness of and/or failure of staff to follow policy requirements, ▪ Inadequate/inappropriate requirements within policies and/or processes for them to be operationalised ▪ Inability to collect adequate evidence due to lack of resource within risk and/or unavailability of evidence ▪ Interpretation of policies/ evidence by assessors at assessment The Trust may fail to achieve level 1 CNST maternity standards in March 2010 as a result of: ▪ Failure to develop guidelines containing all minimum requirements ▪ Failure to ensure guidelines are approved appropriately	4	4	16	Monthly project groups chaired by Director of Governance (NHSLA standards) and Clinical Director for Obstetrics (CNST maternity) Regularly reviewed action plans 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	Interim visit January 2009 and September 2009 from NHSLA assessor approved Trust approach in many areas.	Lack of centralised evidence for some standards, resulting in difficulties in assessing status Key Training allocation/reporting systems around induction/mandatory training require development to establish levels of non-compliance with training	▪ Fill vacant posts ▪ Continue collection and assessment of evidence from leads / divisions ▪ Continue targeted "hot spot" work streams (mandatory training, medical devices training, consent, patient information, Being Open) ▪ Criteria leads to present evidence at 'mock assessments' during October/November 2009 to assess level 2 compliance ▪ Awareness raising in organisation by payslip leaflets, Hot Topics and project group	DG	Band 4 in post since August 2009. Band 7 post filled with temporary staff, pending readvertisement (awaiting vacancy approval) Shared drive set up to view evidence. Mock assessments carried out Ward reviews to establish compliance/raise awareness ongoing NHSLA leaflets published with payslips. Maternity Level 1 assessment on track	4	4	16 ▶
2.9 Improve the quality of care provided to vulnerable adults (e.g. patients with Mental Health difficulties or learning disabilities) and children														
Failure to effectively safeguard vulnerable adults and children leading to incident and investigation.	3	4	12	Vulnerable Adults and safeguarding Children Nurse in post. Reporting system in place. Safeguarding Committee. Training for staff level 1+2.	Quarterly reports.	Insufficient resource to investigate and action plan incidents.	None identified at present.	None identified	Further resources need to be identified.	CN	Structures now established. Reporting systems in place. Training established.	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			
2.10 Ensure the Trust fully meets the EWTD standards for junior Doctors by August 2009														
▪ Unfilled deanery posts from August 2009 (particularly in Trauma and Orthopaedics and General Surgery) ▪ Lack of availability of doctors to cover vacant posts with Trust doctors or locums ▪ Unexpected outcome of monitoring exercises of new EWTD compliant working arrangements	4	3	12	Structured action plan (managed by the Deputy Medical Director and Head of Medical Staffing) in place to oversee the process of EWTD compliance. Specialty working groups established to resolve difficulties. Ongoing attention to specialties where new working arrangements may impact on the organisation of training and service delivery and/or where there are unfilled deanery posts. All junior doctor posts to continue to be monitored every 6 months.	Monthly update to the Trust Management Board	No significant gaps in control identified	Monthly reports to the SHA. Monthly updates of RAG status.	No significant gaps in assurance identified.	None required	DG	EWTD compliant working patterns for all junior doctors employed by the Trust (366) were introduced from 15th June 2009. No issue reported concerning EWTD compliance of junior doctor working arrangements in place from 1 August 2009 EWTD compliance achieved and maintained.	1	1	1 ▼

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						
3. Care Closer to Home														
3.1 Ensure full Trust participation in delivery Towards 2010 Programme exemplar projects														
• That the Trust's teams do not participate fully in the work of the Right Care Right Here Programme resulting in delayed progress on new models of care.	3	4	12	Progress with new models of care overseen by Trust RCRH Board and then by health economy wide structures.	Monthly report to Trust Board on progress with projects. External overview from RCRH Programme Director.	No significant gaps in control.	Health economy level oversight through Programme Director provides assurance.	No significant gaps in assurance	None required	COO	• Targets agreed for existing projects in 2009/10. • Progress on individual projects reviewed at RCRH Implementation Board. Most making good progress. • Agreed SWBH input to next set of RCRH projects.	1	3	3 ▼
3.2 Make full use of outpatient facilities in Aston HC, Rowley Regis Hospital														
• That the Trust cannot invest in the necessary levels of infrastructure to deliver increases in outpatient in Aston and Rowley.	4	3	12	RCRH Implement ation team leading the work on these projects. Progress reported monthly to RCRH Imp Bd chaired by CEO.	PCTs ensuring progress made with plans through the RCRH Partnership Bd.	Will need project teams to be established for the capital works once agreed.	RCRH reports to Trust Board provide assurance.	No significant gaps in assurance.	• Finalise agreement on capital required to increase OP capacity at Rowley. • Agree list of specialties who will use new capacity at Rowley. • Agree approach to provision of outpatients outside of hospital for HoB.	COO	• Further discussions with HoB tPCT have shifted emphasis away from Aston and potentially towards Greet Health Centre as a base for Outpatient activity • Outline plan for Rowley agreed at SIRG in September. Detail to be developed. • Continuing to work on provision of ophthalmology outpatients to Rowley.	4	3	12 ►

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						
3.3 Deliver successful community ophthalmology service for South Birmingham PCT														
• That the Trust does not attract sufficient activity to make the clinics viable or that the Trust cannot staff the clinics adequately.	4	3	12	Divisional level project team established, reporting monthly to COO and to RCRH Imp Bd.	Regular mthly mtgs with South Birmingham PCT provide feedback on commissioner view of the service.	No significant gaps in control.	Reported to Board through quarterly corporate objectives report.	Consider further reporting to board and/or F&PC to strengthen oversight of this development.	• Deliver agreed plan for roll out of clinics including: - Hall Green - Edgbaston - Northfield - Selly Oak • Agree whether further board oversight is required.	COO	• Clinics established in Hall Green, Northfield and Edgbaston localities. • Now planning for launch of Selly Oak service. • Exec level review of progress through RCRH Implementation Board	2	3	6 ▶
4. Good Use of Resources														
4.1 Delivery of planned surplus of £2.3m														
Unforeseen financial costs and/or income losses	2	3	6	Routine and ad-hoc monitoring	Non exec scrutiny	None identified	Board receives minutes and periodic updates from Finance Committee, which have highlighted emerging risks	None identified	Dedicated meetings with PCT to discuss and agree a way forward specifically in the area of data and income challenges	DFPM	Mid year income adjustments were effected owing to material changes in the way HRGv4 behaves as compared with HRG v3.5. Senior level meetings planned for January 2009 to resolve current year issues regarding income accruing to the Trust	3	3	9 ▲
4.2 Delivery of CIP of £15m														
Slippage on higher risk schemes not covered by replacement schemes	3	3	9	FMB detailed monitoring	Monthly interrogation of performance	None identified	Variances spotted with replacement schemes identified	None identified	None required	DFPM	CIP slippage reduced and now closer to £100k as at Month 8, reflecting trend of in-year improvement	3	3	9 ▶

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						
4.3 Develop approach to service improvement concentrating on theatres, outpatients and bed management														
• That the Trust is not able to deliver improvements in productivity in the key areas of theatres and outpatients.	3	3	9	Project plans for all areas agreed through FMB, Progress reports monthly to TMB. Project team for theatres meets monthly.	Improvements in productivity should be seen in Trust monthly performance report.	Need to establish project teams for the outpatient and bed mgmt exercises.	Trust performance reports show impact of activity.	No significant gaps in assurance.	• Establish project teams for outpatient and bed management exercises. • Deliver action plans as agreed by FMB.	COO	• Theatres showing improvement in number of lists starting on time. Now focussing on throughput as part of next stage. • Continuing to work to improve outpatient performance through LiA action plan. Will need further work in 2010/11.	3	3	9 ▶
4.4 Introduce routine service line reporting to support development of clinical management structure														
Lack of pathway and/or reserves	3	3	9	Corporate objectives reporting	Steering Group set up	None identified	Recent updates provided to Trust Board, F & PMC and FMB. Will report progress as part of Steering Group.	None identified	None required	DFPM	SLR reporting (routine) incorporated into work programme for SLM (therefore pathway clearer). Working with software provider to resolve implementation issue	3	2	6 ▶
5. 21st Century Facilities														
5.1 Continue to deliver New Hospital Project as planned														
Failure to achieve approval of OBC Failure to launch CPO Failure to maintain affordability of project	5	4	20	Project structure and management processes established. Affordability review taking place.	Project Board minutes made available to Trust board. Green Gateway Review	None identified	Project Board minute available in Project office shows delivery against plan.	None identified	None required	DE/ NHPD	Affordability review initiated. Quarterly risk review completed	4	3	12 ▶

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						
5.2	**Continue to improve current facilities through the delivery of the capital programme including:** ▸ Replacement MRI scanner at City ▸ Upgrade of accommodation at City (MAU and D16) ▸ New facilities for PCCU at Sandwell													
Insufficient resources to deliver programme	3	3	9	Project teams established	Project reported to SIRG (monthly)	Imminent retirement of Capital projects staff	SIRG project reports available	None identified	Staff succession planning required	DE/ NHP D	Succession plan to be developed	2	3	6 ▶
5.3	**Fully engage with PCTs in design of major community facilities (Aston, BTC, Rowley Regis and Sandwell)**													
Insufficient resources to engage fully	3	3	9	Project teams for City and SGH established	Project team minutes and reporting	None identified	Projects progressing as planned	None identified	Secure sufficient resources to deliver projects	DE/ NHP D	None required at present.	2	3	6 ▶
6.	**An Effective NHS Foundation Trust**													
6.1	**Achieve NHS FT Status**													
Requirement to revise IBP and LTFM in light of revised growth assumptions. Interface with review of Right Care Right Here programme Difficulty in meeting Prudential Borrowing Code requirements Variation in national assessment requirements. Objective amended to 'continue to pursue FT status and explore complementary approaches to further increasing patient, public and staff engagement'	4	3	12	FT Project Board, FT Seminars, Ft project Team	Project Plan updates, Project Board minutes	None identified.	Latest progress reports and analysis, although these do not eliminate risks.	None identified.	None required	CE	Operating Framework requires trajectory for FT or other organisational form to be presented by 31-03-10. Capacity needs to be created to achieve this.	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 Continue to achieve Annual Health check Core Standards														
• Failure to implement the action plan for standards 20b (privacy and confidentiality) which was declared as 'not met' in 2008/09 and which should be achieved by December 2009 (see 1.3 above) • Inability to provide evidence to support continued compliance with the core standards	4	4	16	Executive Leads identified for each core standard Executive Team and Governance and Risk Management Committee oversee the declaration process and implementation of action plans.	Reports to the Executive Team and Governance and Risk Management Committee	No significant gaps in control identified	Electronic system that centrally captures evidence to support compliance. Internal Audits Third party commentaries e.g. Overview and scrutiny committee NHSLA accreditation PEAT reports NHS Staff & Patient Surveys	No significant gaps in assurance identified	None required	DG	Work is on-going to implement the action plan developed to address the areas of non-compliance with care standard C20b (single sex accommodation) – see 1.3 above. To avoid confusion with providers' applications for registration for 2010/11, which will start in January 2010, the CQC has requested a core standards declaration mid year. However, Trusts are required to comply with the core standards for the entire assessment year 1 April 2009 to 31 March 2010. Declaration submitted in December 2009, reporting ongoing non-compliance with standard C20b and also for C11b, in reflection of current mandatory training issues.	4	3	12 ▶
6. 3 Deliver improved uptake of mandatory training and implement the LiA "Time to Learn" project														
It is important that managers clearly identify the training needs of their workforce set against the new policy and that they have regular appraisals . If this is done correctly and staff attend the sessions there should be few problems. TTL is being dealt with as the second phase of improving MT and is therefore not dealt with here.	5	4	20	Monthly reporting will allow managers to keep track of individuals status	Corporate level reports will be available	Reporting system needs to bed in.	MT policy reports	System and data quality issues have caused delays with issuing corporate level compliance reports. This should be resolved by the end of October 2009.	Work is ongoing with the IT supplier to ensure the development of accurate compliance reports. The Trust's Information Department is also developing an alternative solution.	DW	Internal web-based IT solution developed and introduced. Work ongoing to validate data and ensure accurate compliance reporting. Additional mandatory training capacity to be	4	4	16 ▲

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			
											provided from January to March 2010, including increased access via e-learning. A 'Learning Passport' for the 'Time to Learn' Project has been designed and a revised implementation plan is being drawn up.			
6. 4 Continue to spread staff engagement through Listening into Action delivery of the LiA "Enabling Our People" projects														
Failure to maintain momentum and spread.	3	3	9	LiA Sponsor Group, project monitoring process	Project progress reports, monthly LiA updates, updates to TMB and Trust Board	Lack of robust project monitoring system	Staff survey results, progress reports (but see gap at left)	Difficulty in accurately assessing project progress	Introduce more robust and cyclical project reporting process. Increase Divisional accountability for LiA projects.	CE	New project management arrangements working well. Big increase in projects and other workstreams using LiA techniques	1	3	3 ▶
6. 5 Establish the next stages of the Trust's clinical research strategy														
Trust R&D systems need to be completely overhauled.	2	3	6	Regular meetings of R&D committee	R&D committee minutes Annual report to Board	No gaps identified	R&D committee minutes Annual report to Board	No gaps identified	None required	MD	R & D strategy circulated for consultation. Remains on track.	2	3	6 ▶
6. 6 Improve the Trust's approach to leadership development														
We do not yet have a leadership development strategy although some early work has been produced on what should be included. It is important to note that LD is high on the DoH agenda and we will be expected to deliver against any targets that they set. As with any staff development issue resourcing will be a problem. We do run a risk of not identifying and developing our best leaders.	4	1	4	None as yet	Not applicable	We need to ensure that the PDR system is working and that it supports the identification of leadership talent.	Not applicable	None identified	Development of a clear strategy and operational policy designed to identify and develop those who have leadership potential from the workforce. This has been commissioned and a first report available for consideration in November 2009	DW	The ethos and principles of the Trust's Staff Engagement approach (LiA) has been included in all existing management development programmes The review of leadership development activity is complete and makes a recommendation for	4	1	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			
											future work to commence to develop an overarching framework to govern leadership development activity and associated organisational processes.			
6. 7 Improve the environmental sustainability of the Trust's operations by responding to the national carbon reduction strategy														
A suitable strategy cannot be developed	3	2	6	Programmed report to Trust Board	Board reporting cycle	None identified	Minutes of Board presentation	None identified	None required	DE/ NHPD	Strategy developed. Action plan developed and under review.	2	2	4 ▶

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Right Care Right Here Progress Report
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Jayne Dunn, Redesign Director – Right Care Right Here
DATE OF MEETING:	28 January 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 December 2009 and includes a copy of the *Right Care Right Here* Programme Director's report to the Right Care Right Here Partnership.

It covers:

- Progress of the Programme including performance data for exemplar projects against targets for April – October 2009.

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 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	
Core Standards	
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: Usual monthly update to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT

JANUARY 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 December 2009.

This report is in three sections:

a) Overview of the work of the Right Care Right Here Programme
b) Programme Director's report as presented to the Right Care Right Here Partnership and the Boards of Sandwell and HoB PCTs (Appendix 1)
c) Right Care Right Here Exemplar Project Performance for April – October 2009 (Appendix 2 – separate spreadsheet)

OVERVIEW

This section provides an overview of the work of the Right Care Right Here Programme. This work is set out in more detail in the Programme Director's report in Appendix 1. 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. The most significant issues arising this month are as follows:

Project Performance – Appendix 2 shows the performance of exemplar projects (first and second wave) for the period April – October 2009.

There are four projects with 'Green' status – Rehab Beds - Sheldon, Urgent Care – Sandwell, Respiratory, Dermatology and ENT, all of which are exceeding targets.

The following four of the projects are rated as 'Amber' :

- *Urgent Care, HoB*: activity 5% below target.
- *Gynaecology:* October performance data unavailable.
- *Rehab Beds, Rowley*: Data has now been provided for the STAR service but is showing an underperformance and the Step Up bed provision continues to under perform.
- *Musculoskeletal*: there are areas of underperformance for Community Orthopaedics and Pain Management and no primary care data for GP led Rheumatology.
- *Diabetes:* October performance data unavailable.

Two projects are rated 'Red':

- *Ophthalmology*: Year to date performance is 13% below target. Data for one location is still not available but not expected to account for the majority of the underperfomance.
- *Cardiology*: Performance data to the end of September is below target and the data submitted from Sandwell PCT fro October needs to be validated.

Issues relating to data collection and reporting continue to be discussed at Programme Delivery Group and actions agreed/undertaken with some improvement.

Service Redesign Activity :

The Strategic Model Of Care Steering (SMOCS) Groups continue to present their three key deliverables (Clinical Strategy, Overall Model of Care and Priorities for Service Redesign) to the Clinical Group. The current position with regard to these is:

Approved:
Maternity and Newborn, Planned Care, Dementia, Long Term Conditions, End of Life, Children's Services. Staying Healthy, Acute Care

For approval in February after amendments:
Mental Health

Within the Trust the approved SMOCS will be considered by the RCRH Implementation Board and also circulated to members of the Clinical Management Executive. They will then be added to the Trust's intranet.

Exemplar Projects – Final Review: The final review process for the exemplar projects has been completed with a clear outcome for each project having been identified and approved by the RCRH Strategy Group. The table below summarises these outcomes:

Project	Recommendation
Urgent Care – HoB tPCT	Completion as a project due to opening in February of the urgent care service within Darzi Practice at Summerfield Health Centre.
Intermediate Care Beds – Rowley	Decision deferred pending a review being undertaken by the project.
Intermediate Care Beds – Sheldon	Completion as a project. Mainstream commissioning of the service.
Musculoskeletal	Completion of parts of the project (Sandwell Community Orthopaedic Service/Consultant-led Outpatient Clinics in the Community) with mainstream commissioning of these services. Transfer of remaining parts of the project to the new RCRH Demand Management – Outpatient and Referrals Workstream.
Dermatology Outpatients	Completion as a project. Mainstream commissioning of the service.
Gynaecology Outpatients	Decision deferred pending agreement of the service specification for community Gynaecology clinics.
Cardiology Outpatients	Completion as a project, but continue service redesign work through Care Pathway Review.
Urgent Care – Sandwell	Transfer of project to the new RCRH Urgent and Emergency Workstream (existing Project Team and redesign work to continue until formal transfer).
Diabetes Outpatients	Completion as a project. Mainstream commissioning of the service.
Respiratory Outpatients	Completion of parts of the project (Asthma and COPD) with mainstream commissioning of these services. Transfer of remaining parts of the project to the new RCRH Demand Management – Outpatient and Referrals Workstream.
ENT Outpatients	Completion as a project in March 2010 (after completion of some outstanding elements). Mainstream commissioning of the service from April 2010.
Ophthalmology Outpatients	Transfer of the project to the new RCRH Demand Management – Outpatient and Referrals Workstream.

The Programme will continue to monitor performance in all of these projects. The new service redesign workstreams are being established.

Review of the Programme – Work continues on the revised Overall Programme Plan. The Programme will present the outcomes of the review to the Joint Health Overview and Scrutiny Committee in February.

Review of Commissioning Arrangements in Birmingham – Following discussion at RCRH Partnership Board meeting a letter was sent to Ian Cumming, SHA Chief Executive. Feedback from the SHA has included very positive reassurance about the support of the SHA for the Programme and its need to reach completion.

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
21st January 2010

APPENDIX 1

Sandwell and the Heart of Birmingham Health and Social Care Community

RIGHT CARE, RIGHT HERE PROGRAMME

Report to:	**Right Care, Right Here Partnership Board**
Report of:	**Les Williams, Programme Director**
Subject:	**Programme Director's Report**
Date:	**Monday, 21st December 2009**

1. Summary and Recommendation

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

The Partnership Board is recommended to:

- Note the content of the report
- Discuss and agree any further action required in the context of the Review of Commissioning Arrangements in Birmingham (Section 5)

2. Project Performance

2.1 April to October 2009

Given at Appendix 1 is the Project Performance report for April to October 2009.

In summary, the RAG status assigned to the projects (with reasons) and signed off by the Programme Delivery Group is as follows:

- **Red (2/12 Projects)**

  Ophthalmology
  Year to date performance is 13% below target and anticipated actual activity at Rowley Regis Medical Centre for August to October (which is not currently available) is not anticipated, based upon previous monthly performance, to be sufficient to account for the underperformance

  Cardiology
  The partial actual performance information to September is below target. Information provided by Sandwell PCT Information Department requires validation as it is not consistent with previously reported consultant led activity and non consultant led activity has not yet been identified

- **Amber (5/12 Projects)**

  Urgent Care – Heart of Birmingham
  5% underperformance against year to date target

  Rehabilitation Beds - Rowley
  Step-up capacity not being fully utilized by GPs and STAR data, now reported for the year-to-date, is below target

  Musculoskeletal
  Areas of underperformance persist and no primary care data for GP-led Rheumatology

  Diabetes
  October performance data unavailable

  Gynaecology
  October performance data unavailable

- **Green (5/12 projects)**

  Urgent Care – Sandwell
  Rehabilitation Beds - Sheldon
  Dermatology
  Respiratory
  ENT

It is worth noting that overall performance has improved, with the number of Green rated projects increasing from four to five since the November report. The projects assigned red status in the October report remain unchanged. Adverse rating changes apply to Gynaecology owing to the unavailability of performance data.

As members will recall, the lack of Cardiology data was escalated to Chief Executive level and while some data has been provided, it is disappointing that some elements of activity data in relation to the Cardiology project remain unavailable for reporting, leaving the performance of this project still unclear. The Programme Manager is working with the Information Department to resolve this.

Progress is continuing in relation to developing a monthly Programme Performance Report which shows activity transferring into community and primary care settings in relation to total SWBH activity. Options for the design of a highly visual dashboard type performance report are being created which will enable the Partnership Board to identify easily trends in performance and the position against target for the period. As previously reported, Information leads at the two PCTs have agreed to establish systems to enable routine reporting of the community activity directly to the Programme following the outcomes from the Final Project Review Process being agreed.

3. Service Redesign Activity

3.1 SMOCS Update

The December Clinical Group received reports for the first time from the Acute Care, Mental Health and Staying Healthy SMOCS groups, and received a second presentation of the Children's Services SMOCS (initially presented 7 October 2009).

The Children's Services document was acknowledged to have been amended to address the issues raised on initial presentation, and was approved. Staying Healthy was well received, and approved subject to one addition to its content. The Clinical Group were largely supportive of the direction in the Acute Care and Mental Health reports but raised several questions and suggested a number of areas for further clarification, development and/or inclusion.

The Programme Manager has met with the Chair and a number of members from the Acute Care SMOCS Group and agreed the amendments required to enable this report to be approved by the Clinical Group in January. With regard to the Mental Health report, since the December Clinical Group meeting further issues have been raised from commissioners that were not previously raised during the work of the SMOCS group, and these are now the subject of further discussions between Sandwell PCT, Sandwell Mental Health Foundation Trust and the Programme. It is anticipated that the Mental Health SMOCS will be re-presented to the Clinical Group when it convenes in February. It should be noted that the Clinical Group felt that the approach to user engagement by the Mental Health SMOCS was considered to be exemplary.

The revised reports for Long Term Conditions, End of Life and Dementia were received, and approved.

The current status is therefore:

Approved:

Maternity and Newborn, Planned Care, Dementia, Long Term Conditions, End of Life, Children's Services

For approval in January after amendments:
Staying Healthy, Acute Care

For approval in February after amendments:
Mental Health

The Programme Team is ensuring that the Directors of Public Health support the health needs analysis in each report, and most SHA Clinical Leads have provided feedback on the completed reports. Planned Care, Maternity and Newborn and Children's Services reports have been presented to Sandwell PCT's PEC (15th December) by SMOCS Chairs, with the same reports and the Long Term Conditions report being presented to HoB tPCT's PEC on 17th December. Arrangements are being made for the presentation of the remaining approved documents at January/February PEC meetings.

Arrangements are also underway to ensure all SMOCS reports are presented to SWBH's Right Care, Right Here Implementation Board and an agreed wider distribution to partner organisations.

3.2 First and Second Wave Projects Final Review Process

Following the review of the Programme the decision was taken through Programme Delivery Group (PDG) to undertake a formal review of the first and second wave projects. The reviews took place between 6th and16th November 2009 by PDG members with Project Leads, Support Project Leads and Clinical leads in attendance. Project Leads were asked to submit a final project report prior to the formal review meeting to assist in the decision making process.

During the formal reviews Project Leads, or their interim representative, discussed project achievements, current status and their recommendations regarding next steps. PDG members asked questions for clarification and to be clear on the current status on all sub-elements of projects e.g. Musculoskeletal comprises Orthopaedic community triage, outpatients and inpatients, Pain Management outpatients and Rheumatology outpatients.

The recommendations arising out of the review process, the summary of which is set out below, were approved by the Strategy Group on 25th November. It is important to note that there are a number of projects where the recommendation to close is subject to a number of requirements being met, and supplementary actions being taken (see Appendix 2 for this more detailed information).

Project	Recommendation (s)
Urgent Care – HoB tPCT	Close project
Intermediate Care Beds – Rowley	Decision Deferred
Intermediate Care Beds – Sheldon	Close project and commission services
Musculoskeletal	Part closure (Sandwell COS/Consultant-led Outpatient Clinics to be commissioned) Part Transfer to Demand Management – Outpatient and Referrals (O and R) Workstream (HoB tPCt community pain management and orthopaedic beds)
Dermatology Outpatients	Close project and commission services
Gynaecology Outpatients	Decision deferred
Cardiology Outpatients	Close project and continue redesign work through Care Pathway Review
Urgent Care – Sandwell	Transfer to Urgent and Emergency Workstream (maintaining Project Team and redesign work until formal transfer)
Diabetes Outpatients	Close project and commission service
Respiratory Outpatients	Part closure – Asthma and COPD services to be commissioned Part Transfer to Demand Management – O and R Workstream
ENT Outpatients	Close Project (delayed to March 2010 to allow completion of some elements of work)
Ophthalmology Outpatients	Transfer to Demand Management – O and R Workstream

A key output from the review process was to identify key learning to transfer into the process and organisation of the new Workstreams (see Appendix 2) and to acknowledge the achievements of each project (see Appendix 3 – notes to the Final Project Review meeting currently being validated by Project Leads).

A questionnaire has been sent to Project Board members as part of the Final Project Review process to identify key learning to transfer to the process supporting the new Programme Workstreams and identify ideas to improve clinician engagement in service redesign work. The results will be reported, the main points from which will be shared with Workstream Lead Directors to inform project organisation and delivery.

4. Review of Programme

4.1 Joint Overview and Scrutiny Committee Meeting

Given that the Sandwell PCT will report the outcome of its physical infrastructure review at this Board meeting on 28th January 2010, I discussed the proposed timing of our update presentation to the Joint Overview and Scrutiny Committee with the Partnership Board Chair and the Chief Executives. We agreed that it would be sensible to ask for a date in early 2010 when we could be more specific about the shape of the Programme and our forward plans.

The Joint Chairs asked the Partnership Board Chair and I to meet them to discuss what we could identify and agree a way forward. Doug Round and I therefore met Councillor Deirdre Alden and Councillor John Edwards on 11th December. At this meeting, I explained the background to the Programme Review, the issues we were addressing, our plans in outline for the future and it was agreed that we would present to the Joint OSC in February. A date for this is now being agreed.

4.2 Development of Overall Programme Plan

Appendix 4 provides a detailed update on the further work undertaken to develop and put in place a comprehensive Overall Programme Plan. The key points to note are:

- Preparatory work has been undertaken to gather further information and develop the reporting structure based on the Activeplan database, so that we can move quickly to having an Overall Programme Plan when key decisions are made and elements are finalized
- Currently, the work on completing the Activity and Capacity Model Version 5.1 and the PCT physical infrastructure reviews are awaiting completion.
- During January, it is intended to begin consultative sessions with colleagues to achieve the following:
    - Understanding of the purpose and uses of the Overall Programme Plan
    - The methodology for providing updates (by variance reporting) to ensure the plan is maintained as a real time view of the Programme and its progress
    - Definition of reporting requirements of individuals using the database and their organisations
    - Definition of activity to be transferred to specific locations and validation of currently available capacity, or planned capacity, to accommodate this activity
    - Agreement on key milestones in each contributing project and programme of work
    - Identification of key interdependencies between milestones across projects and programmes
    - Identification of critical path items
    - Development of a reporting mechanism for Partnership Board based on regular review of progress against, or variance from, this critical path.

4.3 Establishment of New Workstreams

Most nominations requested from colleagues for the three major service redesign Workstreams have been received, with those outstanding being actively chased. Dates are being sought for meetings to initiate each of the Workstreams but it is likely that it will be January before mutually convenient dates and times can be agreed.

Lorraine Wood, Administrative Manager, and Claire Blackburn, Map of Medicine Manager, have joined the Programme Team during December. In addition, the Programme Administrator has successfully been appointed and, subject to references, is expected to start in post in January 2010. The Programme Analyst post will be advertised on 31st December 2009, with Rod Knight agreeing to be involved in this appointment owing to the Activity and Capacity Model being a key responsibility.

5. Review of Commissioning Arrangements in Birmingham

Following the discussion of this issue at the last Partnership Board meeting, it was agreed after the meeting that the letter I drafted should be sent to Ian Cumming, SHA Chief Executive, rather than to the SHA chair. The letter was amended following circulation to Chief Executives and Chairs and sent. This is attached at Appendix 5.

Although a formal reply has not been achieved, Rob Bacon and John Adler met with Ian Cumming and Peter Spilsbury, Director of Strategy and Regulation at the SHA, and received very positive reassurance about the support of the SHA for the Programme and its need to reach completion.

The Chief Executives and Chairs of the two PCTs and SWBH, and the Partnership Board Chair and I all attended the three Birmingham PCTs' stakeholder engagement event to look at the options for change for commissioning in Birmingham. This was held on 9th December and was structured to provide feedback from groups looking at pre-determined criteria in assessing the value or otherwise of the options. I attach at Appendix 6 the summary of the output from this day.

As will be seen, the Right Care Right Here Programme has been identified in this as an issue which needs to be considered in the review of commissioning arrangements, although the PCTs were not prepared to go as far as including it as a criterion on which options would be judged.

Following the event, I have met with the Director of Commissioning in South Birmingham PCT and we are arranging a session between the Programme and the PCTs to share the extent of care pathways that we have already developed. Those from the Programme will be drawn from the first and second wave projects. This is a means of beginning to ensure that the PCTs in South Birmingham and Birmingham East and North have more detail on the scope and content of the Programme, so that it can be properly taken into account.

As agreed at the last meeting, Richard Nugent, Sue Davis, Doug Round and I met with the Sandwell MPs on 4th December. We identified our concerns and did not request them to take any action as yet, but to maintain a watching brief.

The Partnership Board is recommended to consider what further action it wishes to put in place to secure a continuing high profile for the Programme in the review of Commissioning in Birmingham. This could include;

- Writing to the South Birmingham and Birmingham East and North PCT Chairs and Chief Executives, offering more information and presentations and a perspective on the event on 9th December.
- Providing a written briefing and request for a meeting to Birmingham MPs and Sandwell MPs
- Undertaking a similar exercise for local councillors in Sandwell and the areas affected in Birmingham.

6. Recommendation

The Partnership Board is recommended to:

- Note the content of the report
- Discuss and agree any further action required in the context of the Review of Commissioning Arrangements in Birmingham (Section 5)

Les Williams
Programme Director

2009-12-15 – prog dir report - lnw

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-October 09/10

Key: **CL OPs** Consultant Led Outpatients **NCL Ops** Non Consultant Led Outpatients

PROJECT	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2008/09 Yearend Target	Status	PROJECT LEAD	Comments
	MONTH (2009/10)																	
URGENT CARE - SANDWELL																		
Target (Attendances)	976	976	976	976	976	976	976	0	0	0	0	0	6,832		11,710		Gill Gadd	Activity exceeding target
Actual	865	927	1,008	865	905	1,143	1,243	0	0	0	0	0	6,956				SWBH	
Variance													**124**	**2**				
URGENT CARE - HoB																		
Targets (Attendances):																		
City	2,500	2,500	2,500	2,500	2,500	2,500	2,500	0	0	0	0	0	17,500		30,000		Mark Curran	HoB tPCT in discussions with SWBH regarding transition arrangements to support the
Actual	2,424	2,433	2,113	3,176	2,233	2,014	2,157	0	0	0	0	0	16,550				HOB PCT	notified closure of the UCC at City 31st March 2009
Variance													**-950**	**-5**				
Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0		13,000			
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
REHAB BEDS - SHELDON																		
Targets:																		
Community - D43 (OBDs)	647	647	646	646	647	647	647	0	0	0	0	0	4,527		7,760		Angela Young	Project exceeding targets overall.
Actual	638	783	631	643	643	584	693	0	0	0	0	0	4,615				HOB PCT	
Variance													**88**	**2**				
Care Centres (OBDs)	571	571	571	570	571	571	571	0	0	0	0	0	3,996		6,850			
Actual	595	657	592	662	606	625	652	0	0	0	0	0	**4,389**					
Variance													**393**	**10**				
Comm. Alternatives Sub-Acute D47 (?)	0	0	0	0	0	0	0	0	0	0	0	0	0		2625*			
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
Comm. Alternatives Rehabilitation (Patient Package)	292	292	292	291	291	292	292	0	0	0	0	0	2,042		3,500			
Actual	836	977	1,045	1,132	943	974	935	0	0	0	0	0	**6,842**					
Variance													**4,800**	**235**				
	Note: Target for Community Alternatives Sub-Acute D47 is HoBPCT only - Sandwell target to be agreed.																	
REHAB BEDS - ROWLEY																		
Targets:																		
Community Step Up - ET Ward (OBDs)	317	317	317	316	316	317	317	0	0	0	0	0	2,217		3,800		Chris Gibbs	Significant overperformance for step-down activity but underperformance against the step-up
Actual	48	231	246	285	300	266	279	0	0	0	0	0	1,655				(interim)	target. Up-to-date STAR data reporting underperformance - reasons being explored.
Variance													**-562**	**-25**			SPCT	
Community Step Down - Mc Ward (OBDs)	642	642	642	641	641	642	642	0	0	0	0	0	4,492		7,700			
Actual	1,526	1,663	1,611	1,627	1,588	1,611	1,654	0	0	0	0	0	11,280					
Variance													**6,788**	**151**				
STAR (Av Admits)	83	83	84	83	83	84	83	0	0	0	0	0	583		1,000			
Actual	60	77	75	91	62	86	88	0	0	0	0	0	539					
Variance													**-44**	**-8**				
MUSCULOSKELETAL (includes Orthopaedic beds & outpatients, Rheumatology outpatients & Pain Management																		
Targets:																		
HoB Orthopaedics Triage (NCL OPs)	545	545	545	545	543	543	546	0	0	0	0	0	3,812		6,535		Paul Hazle	Orthopaedic triage activity is exceeding target, with the level of overperformance for the
Actual	530	520	883	874	721	918	1,019	0	0	0	0	0	5,465				SWBH	service increasing, and Community Rheumatology continuing to overperform.
Variance													**1,653**	**43**				
Sandwell Orthopaedics Triage (NCL OPs)	574	574	574	574	573	574	573	0	0	0	0	0	4,016		6,885			Potential impact of Sandwell Communicty MSK service specification being considered by
Actual	585	520	623	669	490	626	661	0	0	0	0	0	4,174					SWBH. Location options for community MSK i.e. Greet being explored.
Variance													**158**	**4**				
Community Rheumatology (CL OPs)	381	381	381	381	378	380	380	0	0	0	0	0	2,662		4,564			HoB community Pain Management Clinic start date postponed indefinitely, contributing to
Actual	387	397	453	496	404	468	512	0	0	0	0	0	3,117					activity for this element of the project being below target.
Variance													**455**	**17**				
Primary Care Rheumatology (CL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		140			Consultant led community orthopaedics outpatient below target - explanation requested from
Actual	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0					Project lead.
Variance													**0**	**n/a**				
Community Orthopaedics (CL OPs)	74	74	74	74	74	75	74	0	0	0	0	0	519		889			Project lead continuing pursuit of primary care rheumatology activity data.
Actual	50	4	43	47	72	56	29	0	0	0	0	0	301					
Variance													**-218**	**-42**				
Community Pain Management (CL OPs)	59	59	59	59	59	56	59	0	0	0	0	0	410		702			
Actual	11	13	15	20	20	35	26	0	0	0	0	0	140					
Variance													**-270**	**-66**				
	Note; Community Pain Management actual activity only includes Lyng activity																	

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-October 09/10

PROJECT	MONTH (2009/10) April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2008/09 Yearend Target	Status	PROJECT LEAD	Comments
OPHTHALMOLOGY																		
Target (CL OPs)	1,273	1,273	1,273	1,272	1,273	1,273	1,273	0	0	0	0	0	8,910		15,274		Vacant	No report submitted as Project Lead post vacant, data not supplied by support project lead.
Actual	1,162	971	1,169	1,183	1,004	1,267	968	0	0	0	0	0	7,724				SPCT	
Variance													**-1,186**	**-13**				
	Note: Rowley Regis MC actual activity not available for Aug-Oct																	
DERMATOLOGY																		
Targets:																		
Community (CL OPs)	267	267	267	265	266	267	266	0	0	0	0	0	1,865		3,198		Vacant	Project exceeding target overall.
Actual	219	250	246	268	138	221	205	0	0	0	0	0	1,547				HOB PCT	
Variance													**-318**	**-17**				
Community - GPwSI (OPs)	134	134	134	132	134	133	134	0	0	0	0	0	935		1,602			
Actual	178	187	260	275	188	288	290	0	0	0	0	0	1,666					
Variance													**732**	**78**				
RESPIRATORY																		
Targets:																		
Community - Nurse-led (OPs)	80	80	90	100	100	100	100	0	0	0	0	0	650		1,034		Sally Sandel	Activity significantly exceeding target.
Actual	276	281	258	248	208	163	193	0	0	0	0	0	1,627				SPCT	
Variance													**977**	**150**				Project Lead to confirm the position regarding the primary care service.
Primary Care - GP/Nurse/GPwSI (OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		432			
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
ENT																		
Target (CL Outpatients)	822	822	822	821	821	822	822	0	0	0	0	0	5,752		9,860		Jane Clark	Actual activity exceeding target, the position representing 62% of total activity occurring in the
Actual	852	883	978	991	739	900	999	0	0	0	0	0	6,342				SWBH	community.
Variance													**590**	**10**				
CARDIOLOGY																		
Targets:																		
Community (CL OPs)	65	65	65	65	65	66	0	0	0	0	0	0	391		782			Partial year-to-date information. October data provided by Andrew Wilson to be validated as
Actual - Rowley & Neptune	61	61	54	79	37	80	n/a	0	0	0	0	0	372				Vacant	no consistent with previous months' data provided by SWBH.
Variance													**-19**	**-5**			SPCT	
Community (NCL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		1,867			
Actual	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0					
Variance													**0**	**n/a**				
GYNAECOLOGY																		
Target (CL OPs)	88	88	88	88	87	87	0	0	0	0	0	0	526		1,053		Therese	Project lead has submitted report but October data not available.
Actual	89	100	88	91	79	82	n/a	0	0	0	0	0	529				McMahon	
Variance													**3**	**1**			HOB PCT	
DIABETES																		
Targets:																		
Community (CL OPs)	486	487	486	486	487	486	0	0	0	0	0	0	2,918		5,835		Olivia Amartey	No report submitted by project lead.
Actual	379	463	631	605	371	518	n/a	0	0	0	0	0	2,967				HOB PCT	
Variance													**49**	**2**				
Primary Care (NCL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		361			
Actual	n/a	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Art Pilot Project
SPONSORING DIRECTOR:	Graham Seager, Director of Estates/New Hospital Project
AUTHOR:	Andrea Bigmore, New Hospital Project Manager
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

The report outlines the purpose and content of the Public Art Strategy, which will support delivery of the New Hospital Development Project and the Trust Art Programme.

The report also updates the Board on the initiation of an Art Pilot Project based on the approach described in the strategy.

The Pilot Project will result in the display of a collection of loaned artwork and the delivery of a community art project to encourage participation of local communities.

The project will be supported by Trust charitable funds.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

For information and to recommend review during July / August 2010.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	21st Century Facilities
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience	**X**	Improved experience through participation in art activities and enjoyment of art on display.
Communications & Media		
Risks		Risks identified in project risk register and where appropriate included in Trust risk register

PREVIOUS CONSIDERATION:

Discussed at Charitable Funds Committee on 3 December 2009

SWBTB (1/10) 005 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

right care right here

RIGHT CARE, RIGHT HERE PROGRAMME
ACUTE HOSPITAL DEVELOPMENT

Report to:	Trust Board
Report of:	Andrea Bigmore, Acute Hospital Development Project Manager
Subject:	Art Pilot Project
Date:	January 2010

1. Purpose of Report

The purpose of this report is to update the Board on the initiation of an Art Pilot Project supported by Trust charitable funds. The project will be an opportunity to test the approach presented in the Public Art Strategy developed for the Acute Hospital Development Project.

2. The Public Art Strategy

A Public Art Strategy has been developed with the help of the Arts Steering Group, and other stakeholders, through a series of workshops and other communications.

The strategy refers to a review of research undertaken by the Arts Council and Department of Heath, which identified a strong evidence base for the benefits of art to health. People are put at ease by humanising the clinical environment and by providing distraction from their illness / treatment. It has been shown that arts can help create a calm relaxing atmosphere to reduce stress, anxiety and fear with positive emotional effects on healing and recovery. Avoidance of the alienation promoted by sterile clinical environments can reduce aggressive behaviours making care easier to provide by staff who also benefit from a pleasant environment. Research in some settings even demonstrated reduction in length of stay, improved sleep quality and reduced need for medication.

The document provides a brief for the Private Finance Initiative (PFI) bidders to enable them to develop strong artistic statements in the new hospital design. In this way art will be seen as integral to the design rather than an ‘add on’. The design will also support display and presentation of public art as required by the Trust Art Programme.

The strategy provides an evidence based delivery framework for the Trust to ensure that a vibrant arts programme is delivered on opening of the new hospital and beyond. The document defines the approach to selecting, acquiring, positioning and caring for art.

The strategy outlines how the Trust will seek funding from charitable foundations, arts organisations / programmes, local sponsorship and other sources. The Trust will develop partnerships to ensure that we benefit from local expertise in fund raising for the arts, delivery of arts programmes and involvement of local people.

Dr Sarinder Sahota provides senior leadership as Art Champion for the Programme. The Art Steering Group includes members of staff and Trust Members to ensure wide involvement in the Art Programme.

The Public Art Strategy was approved by the Acute Hospital Development Project Board in October 2009.

3. The Art Pilot Project

The Art Steering Group was keen to continue the work started at the Strategy Development Workshops by developing / commissioning some artwork prior to the opening of the new hospital. This approach was supported by the Acute Hospital Project Board.

A successful bid to the Board of Trustees has secured a sum of £19,500 from Trust charitable funds to enable a pilot project to go ahead. A further sum of £2,000 will be required for each of the subsequent two years. Funding beyond this point will be through fundraising activities as described in the Public Art Strategy.

Trust income from Government health funding will not be used to support this project or the wider Art Programme.

4. Two Strand Approach

The pilot project will include two strands to be delivered by the Art Steering Group:

4.1 Art Loan

A set of paintings will be acquired for display in the Birmingham Treatment Centre and / or Sandwell General Hospital using a company that specialises in loan of artwork. The company will help us involve Trust members and staff in selection of work from their collection and provide arrangements for security and insurance.

4.2 Community Project

A community art development project will be facilitated by an Art Development Facilitator. The project will involve local people in the development of artwork for display encouraging participation and pride in achievement. This will increase opportunities for involvement with local groups and communities.

5. Art Map

An Art Map will be developed to allow patients, staff and visitors to navigate the exhibition and gain maximum enjoyment from the work on display. Attachments to the map will provide opportunities for evaluation and seeking interest in sponsorship and / or long term local involvement in the programme.

6. Implementation

The Art Steering Group will meet in February to plan project delivery. The timetable will be as follows:

Activity	Timescale
Select art loan provider and facilitator	January - February 2010
Select, deliver and prepare loaned Art	March - May 2010
Community Project Workshops	March - May 2010
Complete art map, installation and launch	June - July 2010
Evaluation	Autumn 2010

7. Recommendations

It is recommended that the Board:

- Note the report
- Review progress in July / August 2010
- Support wide involvement in the project

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Proposed naming of the New Acute Hospital
SPONSORING DIRECTOR:	Jessamy Kinghorn, Head of Communications and Engagement
AUTHOR:	Jessamy Kinghorn, Head of Communications and Engagement
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

- The report sets out the proposed approach to naming the new acute hospital development in Smethwick
- Staff, stakeholder, patient and public involvement is crucial to engender a sense of ownership and identification with the new hospital.
- Enabling staff and local people to actively get involved with the naming process would help ensure a clear identity for the hospital and facilitate the development of an ongoing relationship with the communities we serve.
- A wide variety of communications and engagement methods should be employed.
- A sufficient timescale should be allowed.
- The Trust Board should consider all the suggestions made and devise a shortlist that is consulted on further.
- Staff and public engagement about the name of the new hospital should take place as soon as possible, but alongside or after agreement is reached on the names for the community hospitals. This will be after the outcome of the programme review and therefore not before March 2010. It may also be sensible to wait until after the spring general election.

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 approve the recommended approach and discuss the timetable.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	21st century facilities
Annual priorities	
NHS LA standards	
Core Standards	Engagement with local population, including hard to reach groups
Auditors' Local Evaluation	Engagement with local population, including hard to reach groups

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

Financial		
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity	**X**	Ensures a wide range of views can be considered
Patient Experience		
Communications & Media	**X**	Significant communications and media activity required
Risks		

PREVIOUS CONSIDERATION:

Acute Hospital Project Board – May 2009 and December 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Right Care, Right Here Programme – Acute Hospital Services Development

Proposed naming of the New Acute Hospital, Grove lane, Smethwick

To	Trust Board
From	Head of Communications and Engagement
Author	Head of Communications and Engagement; Engagement Manager
Date	January 2010

1.0 Introduction

In May 2009, the Acute Project Board considered a paper concerning the naming of the new hospital and an estimated timetable for a thorough engagement process. The paper was reviewed in December 2009 following approval of the Outline Business Case (OBC) and further consideration of the methods and timescales involved in agreeing a name for the new hospital. The Project Board requested that the paper be presented to the Trust Board for approval.

2.0 Purpose of the Report

- To set out the proposed approach to naming the new acute hospital development in Smethwick

3.0 Strategic Objectives Supported by this paper

Strategic Objective	Communications and Engagement Strategy Objective	New Hospital Communications and Engagement Strategy Objective
21st Century Facilities	We will engage with staff, partners, patients, their carers and local people to develop and promote plans for the new hospital	To improve opportunities for staff, patient and public involvement in the design process for the new hospital
	We will develop our approach to engagement with patients, carers, stakeholders and local people to improve our services and undertake meaningful consultation and involvement in relation to changes and access to services	To involve staff, patients and members of the public in planning the new hospital and engender a sense of public ownership

4.0 Context

This report was initially prepared following a brief discussion at the April 2008 Acute Project Board meeting about the naming process for the new hospital. It was discussed by the Project Board in May 2009 and has been further developed since then. The report is intended to provide an overview of the process for naming the hospital and start a discussion about the most appropriate approach.

4.1 Drivers for change

The Right Care Right Here programme will result in major changes to health and social care by delivering an ambitious redevelopment of local health services.

Central to that process is the building of a single site new acute hospital in Grove Lane in Smethwick.

Early naming of the hospital will help engender a sense of ownership from staff and local people, although there is a small risk that genuine engagement from staff and local people will be limited until building work starts and they start to see the new hospital as a reality.

4.2 Important considerations

- The new hospital will not be built on either of the main existing hospital sites and so will not be a 'natural successor' to one or other of the hospitals

- The new hospital will combine two existing acute hospitals which each have well-established names

- Unusually, the new hospital will be built on land not currently owned by the NHS and therefore not previously known by any name associated with healthcare

- The two existing acute hospital sites will continue to be used for NHS healthcare in the form of community hospitals

- The existing hospitals (City and Sandwell) have long histories, rich in tradition and heritage, and there is deep affiliation to the hospitals from local people with many generations of the same family using the hospitals from birth to death

- Anecdotally there are mixed views about the current names: Some local residents in Sandwell say the hospital should have been called West Bromwich General Hospital to give it a clearer identity; Many local Birmingham residents still call City Hospital 'Dudley Road' Hospital, despite its name having changed many years ago; There is often confusion about the large number of names of healthcare facilities situated on or around the site of the acute hospitals, and what the different facilities are, for example: West Heath Hospital, Hallam Street Hospital, Sandwell General Hospital, Edward Street Hospital

- Some residents and service users will be opposed to any change of the hospital names, and there will not be complete consensus on any one name

- Trust consultants have strong views on the new hospital name

- Choosing an existing name might reinforce the notion held by a small number of staff on each site that one hospital 'took over' the other when the Trust merged in 2002. This applies both to staff thinking City took over Sandwell and to staff believing Sandwell took over City

- The name of the hospital will be a key marketing tool for the Trust that will symbolise the Trust, its vision and values. It would be sensible for

the organisation to develop some prompts as to what type of name it is looking for (i.e. one that reflects the modern facilities, partnership with the local community, high quality care, caring staff etc.)

5.0 Approach

5.1 Case Studies from other parts of the UK

- University Hospital Birmingham came up with their preferred name and found they were unable to use it. They came up with a list of 10 suggestions and asked for staff and public feedback before choosing their preferred option which was a variation on their original choice
- Walsall left naming their new hospital until 6 weeks before the topping out ceremony. The Trust wanted to simplify the temporary names and get better local ownership. They asked for ideas, suggesting it could be named after famous people from Walsall or the local area. Local press (including the Birmingham Mail and Walsall papers) appealed for ideas, and the appeal was featured in their internal new developments newsletter. They received a number of different names, including the names of existing consultants. They gave three weeks for ideas after which time the Board choose their preferred names for the three buildings. There were no names that stood out or appeared very popular so they kept existing names, changing them slightly. Their tip would be to allow more time and fully involve the public as this will add more meaning to the building.
- Derby's project team came up with two names – both had 'royal' in the title and required time being allowed to get royal assent. Their consultants wanted to keep the name 'University' in the title and weren't so keen on the proposals. The Trust involved the Chair of LINks, a local historian and a patient to promote the chosen option, but with hindsight would have done more public engagement. Their tips are to start early, involve as many people as possible and involve the communications and engagement team.
- Newcastle upon Tyne chose three names they felt were appropriate and asked children to decide the name for the new children's hospital. They used local press and a local footballer to promote the engagement and asked all children coming into hospital. They promoted a text voting competition through the local press. Each of the names was backed by a different celebrity:
    - The Greenhouse Children's Hospital, backed by Sunderland-born TV Presenter Lauren Laverne, which expresses not only the striking green copper exterior of the new building, but also its nurturing environment.
    - Northern Lights Children's Hospital, supported by Newcastle-born Donna Air, which signifies not only the light and bright colours that will flow through the new building, but also the ray of light and hope that children bring to our lives.
    - The Great North Children's Hospital, championed by Teesside's Dame Tanni Grey Thompson, capturing the magnitude of the

hospital as a beacon of pride for people of the North East to celebrate and call their own.
    - The Great North Children's Hospital was decisively selected by the children entering the competition. Children and local people seem to have been particularly keen on the word 'North'.
- Manchester Evening News ran a competition for readers to suggest names and then vote for their preferred name. More than 650 people voted, with 45% voting for Royal Manchester Children's Hospital and 41% for Manchester Children's Hospital.

5.2 Staff /Public and Patient Involvement

Staff, stakeholder, patient and public involvement is crucial to engender a sense of ownership and identification with the new hospital.

Enabling staff and local people to actively get involved with the naming process would help ensure a clear identity for the hospital and facilitate the development of an ongoing relationship with the communities we serve. Effectively this would enable the Trust to maximise the benefits and minimise any potential negative impact resulting from the naming process.

Involvement / name generation techniques will include:

- Surveys and questionnaires
- Group creativity, through focus groups and think tanks
- Staff and public contests that urge contributions at the outset and help select the final name through existing communications channels (email, team brief hot topics, FT newsletter, Heartbeat, GP Focus, intranet, internet, local media, text etc.)
- Engagement with key stakeholders, such as Birmingham and Sandwell Councils, members of the Trust, politicians, partner organisations and community groups

Non involvement techniques could include:

- Detailed searches through archives on previous programs.
- Research history of Grove Lane site and surrounding area
- Computerised name generation, using published software.

Staff and local people have already been involved in helping identify items, people or geographical areas of 'civic pride', in order to generate ideas for inside the hospital, such as art, exhibitions or ward names.

5.3 Media

To ensure maximum involvement, the name process will be publicised through the local media, and community media in the local area. This will be at three key stages:

- Generating the initial long-list
- Debating the short-listed options

- Announcing the final decision

Public 'champions' will be sought for each of the short-listed options, and we will seek to engage with local broadcast and print media to encourage local people to give us their views.

5.4 Local context

There are a lot of new buildings and health care developments taking place in Sandwell and the heart of Birmingham over the next six to seven years as part of the Right Care Right Here programme. The new hospital is a key feature of the programme and the selection of its name cannot be done in isolation.

An integrated approach with the Right Care Right Here Programme will be important to avoid confusion as acute services continue to be delivered on the existing sites until the new hospital opens in 2015/16, and as community facilities are developed on the existing sites. The coordination of this approach is due to be discussed at the RCRH Communications and Engagement meeting at the start of February.

5.5 Timescale

5.5.1 Launch date

Staff and public engagement about the name of the new hospital should take place alongside or after agreement is reached on the names for the community hospitals. This will be after the outcome of the programme review and therefore not before March 2010. It may also be sensible to wait until after the spring general election.

5.5.2 Stages of engagement

Stage One:

- Launch of process
- Engagement and communications and media activities to generate ideas from staff, patients and local people
- Research to generate ideas
- Collation of suggestions and reports to Project Board and Trust Board
- Shortlist selected by the Trust Board from the suggestions made

Stage Two

- Legal and linguistic research on shortlist
- Graphic demonstrations of shortlisted options
- Media campaign (preferably with celebrity champions)
- Internal communications campaign
- Engagement activities and market research on short-listed options
- Analysis of results and reports to Project Board and Trust Board
- Decision and publication of decision

Options for stage two engagement on the shortlist can range from qualitative feedback to quantifiable voting or, more realistically, a hybrid of the two to enable a more meaningful analysis.

5.5.3 Duration of process

The naming process can take as little as one month (as in the case of Walsall Hospitals NHS Trust) or much longer (it took University Hospital Birmingham over a year to gain royal assent to use the name it chose after the first choice was rejected by the Ministry of Justice).

The Trust is committed to genuine staff and public engagement which it emphasises in its values, and in its communications and engagement strategy. The Right Care Right Here programme is also committed to communications and engagement with local people. It is important that all communities in Sandwell and western Birmingham have the opportunity to put their views forward and enough time needs to be allowed for the Trust to engage with both easy and hard to reach groups.

Formal public consultations require at least 12 weeks of public engagement in order to enable sufficient time to gather views. Whilst formal consultation of this kind is not required to name the hospital, it would be good practice to allow a similar amount of time at each engagement stage. This would enable the Trust to carry out the kind of engagement that is central to its values.

To secure genuine engagement in both the generation of ideas and discussion of a shortlist, the timetable below is proposed.

Proposed new hospital naming plan:

Action	Duration (by month)											
	Mth 0	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 98	Mth 9	Mth 10	Mth 11
Launch of engagement process												
Fact finding, engagement and media activities to generate list of ideas												
Collation of suggestions												
Report to project board												
Shortlist agreed by Trust Board												
Preliminary legal availability search												
Linguistic evaluation (optional)												
Comprehensive searches												
Graphic demonstration												
Engagement activities and market research on short-listed options												
Press campaign												
Analysis of results												
Report to Project Board (name decision)												
Project Board recommendation to Trust Board												

6.0 Resource Implications

At present there are no financial implications resulting from the adoption of this report. However, some of the searches and optional actions will require the time of a specialist consultancy.

7.0 Conclusions

The approach to the naming of the new hospital in Smethwick should involve extensive staff, stakeholder, patient and public engagement to generate a sense of 'ownership' of the new building. This is both in terms of communications methods and timescale and is in the spirit of the Design Vision for the hospital and the work in hand around its design.

The process for naming the new hospital should be undertaken in partnership with the wider Right Care Right Here programme, and it would lessen confusion if it took place at the same time or after agreement is reached on the names of the community hospitals.

The name of the new hospital should be consistent with the vision and values of the Trust.

When selecting the name, consideration can be made to other aspects of the hospital itself, such as the names of wards and outbuildings, and it is possible that when the Trust Board agrees the shortlist, some of the suggestions that are not selected could be put forward as options on the academic building, or individual wards or units rather than the hospital itself.

The approach should be:

- To use a wide range of communications and engagement techniques discussed in section 5 of this paper to ask for ideas (from staff, patients, carers, local people and stakeholders) for a name before the Trust Board agrees a shortlist from those suggestions that it is happy with, which is then consulted on further.

- To use a wide variety of methods to gather views on the final shortlist, including celebrity champions of the different options (if possible), before the Trust Board makes a decision on the evidence it receives.

8.0 Recommendations

The recommendations are that:

1. The Trust Board agrees the suggested approach
2. The Trust Board discusses the timing for the start of this work

JK January 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance – Month 9
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

The report is provided to update the Trust Board on financial performance for the nine months to 31st December 2009.

In-month surplus is £160k against a target surplus of £124k; £36k above plan.

Year to date surplus is £1,859k against a plan of £1,931k, £72k below plan.

In-month WTEs are 40 below plan, excluding the effect of agency staff.

Cash balance is approximately £1.3m greater than the revised plan at 31st December.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

- To receive and note the monthly finance report.
- To 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	Deliver the financial plan including achieving a financial surplus of £2.269m and a CIP of £15m.
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	Reporting and management of financial position.

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

Financial		Potential to fail to meet statutory financial targets.
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		Potential to fail to meet statutory financial targets.

PREVIOUS CONSIDERATION:

Financial Management Board and Trust Management Board on 19 January 2010 and Finance and Performance Management Committee on 21 January 2010

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2009

EXECUTIVE SUMMARY

• In the period 1st April 2009 to 31st December 2009, the Trust has generated an overall I&E surplus of £1,859,000 which is £72,000 lower than the planned position. During the month of December, the Trust produced a net surplus of £160,000 exceeding the planned budget surplus by £36,000. This result continues the trend for some months of slightly exceeding the planned in month surplus.

• Fully coded and priced activity information is available for November and patient related SLA income included within this report is based on this position.

• At month end, WTE's (whole time equivalents) excluding the impact of agency staff were 40 below plan and total pay expenditure, including agency costs, for the month £496,000 above plan. This includes £508,000 of agency expenditure during December which is an increase compared with levels in November.

• The month-end cash balance is approximately £1.3m above the revised cash profile.

• With some exceptions (most notably Surgery A, Medicine A and Facilities), performance in month has been relatively strong although heavily dependent on additional income. The favourable income variance during November in part reflects a profile agreed with commissioners where anticipated to produce lower than average activity.

Financial Performance Indicators

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	36	-72	> Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	42	-18	> Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	-496	-2,585	< Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	-654	-2,450	< Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	40	65	< Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	1,314	1,314	> = Plan	> = 95% of plan	< 95% of plan
CIP Actual v Plan £000	-8	-68	> 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	1,931	1,859
Capital Resource Limit	7,650	6,184
External Financing Limit	---	14,433
Return on Assets Employed	3.50%	3.60%

2009/2010 Summary Income & Expenditure Performance at December 2009	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	331,698	28,047	29,264	1,217	249,069	253,904	4,835	339,058
Other Income	38,159	3,279	3,254	(25)	28,365	28,547	182	38,341
Operating Expenses	(340,740)	(28,966)	(30,116)	(1,150)	(255,437)	(260,472)	(5,035)	(348,233)
EBITDA	29,117	2,360	2,402	42	21,997	21,979	(18)	29,166
Interest Receivable	150	13	7	(6)	113	59	(54)	61
Depreciation & Amortisation	(16,444)	(1,370)	(1,370)	0	(12,265)	(12,265)	0	(16,444)
PDC Dividend	(8,374)	(698)	(698)	0	(6,280)	(6,280)	0	(8,374)
Interest Payable	(2,180)	(181)	(181)	0	(1,634)	(1,634)	0	(2,140)
Net Surplus/(Deficit)	**2,269**	**124**	**160**	**36**	**1,931**	**1,859**	**(72)**	**2,269**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – December 2009

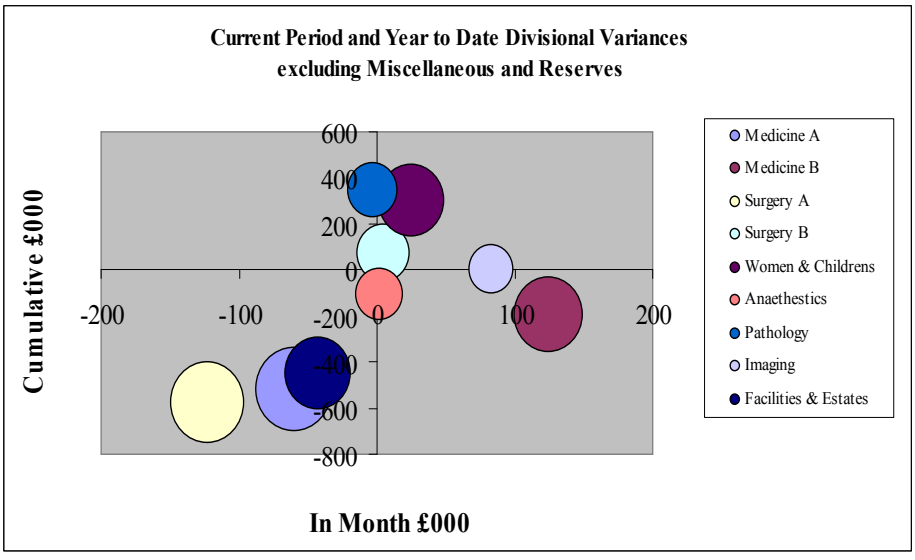
Divisional Performance

• As has been experienced over the last few months, the overall position of the Trust has improved slightly and the shortfall against the year to date I&E target is now reduced to £72k. This improvement in performance continues to be wholly driven by the net effect of additional activity related income over and above expenditure, primarily relating to patient related SLAs.

• Pay costs remain significantly above plan now reaching £2,585k for the year to date with a further worsening in month of £496k. WTE numbers, excluding the impact of agency staff, remain below planned levels. After taking into account agency staff, actual wte's are approximately 21 above plan which is a significant improvement on the numbers reported for November. The non pay position also continues to be significantly higher than plan, particularly in areas linked with patient related activity plus the ongoing impact of additional cleaning and environmental improvements. High levels of expenditure for both pay and non pay reflect significant increases in patient activity levels with significant additional capacity being open at both City and Sandwell.

• Despite a general overall improvement, during the month, Surgery A, Medicine A and Facilities have generated deficits. To a large extent, this performance reflects activity shortfalls in certain areas and commensurate income performance relative to ongoing high levels of expenditure (including, for example, additional waiting list sessions). The results in these divisions are in part at least, driven by movements in case mix and out-patients with procedure. On the cost side, many operational divisions continue to experience significant pressures on both pay and non pay although in some cases these are balanced by over achievement of income.

• The performance for the Trust overall continues to be assisted by favourable budget positions within corporate divisions with a year to date performance of £535,000 better than plan.



The tables adjacent and overleaf show a mixed position across divisions. The performance, in particular of Surgery A, Medicine A and Facilities worsened in month while Medicine B in particular improved. Other divisions were closer to break even. However, Medicine A, Medicine B, Surgery A and Facilities all continue to report sizeable year to date net deficit positions.

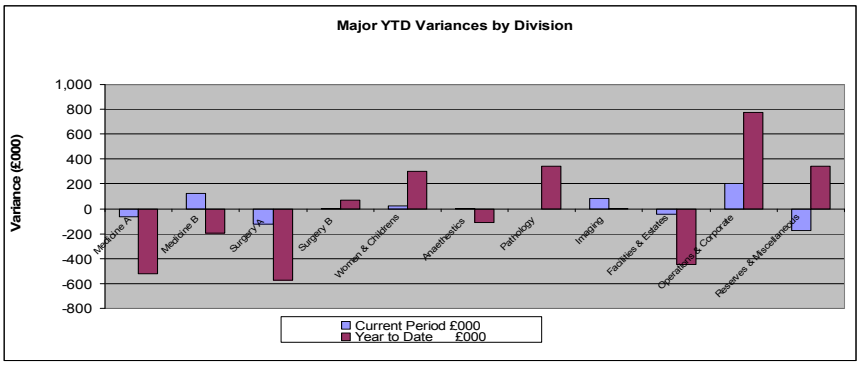
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2009

Divisional Variances from Plan

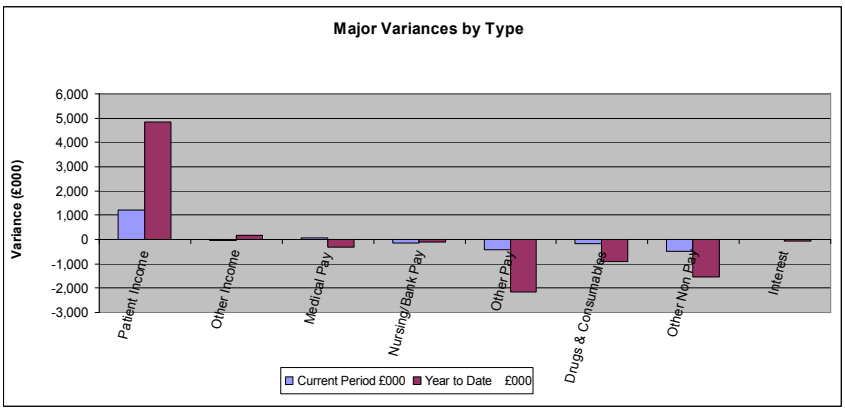
	Current Period £000	Year to Date £000
Medicine A	-60	-523
Medicine B	125	-194
Surgery A	-122	-577
Surgery B	5	69
Women & Childrens	25	300
Anaethestics	2	-106
Pathology	-3	343
Imaging	83	2
Facilities & Estates	-43	-448
Operations & Corporate	202	772
Reserves & Miscellaneous	-173	343



The tables below illustrate that overall, income continues to perform better than plan for the month and year to date, primarily driven by higher levels of patient related SLA (service level agreement) activity. Despite this positive overall SLA income position, issues do exist regarding casemix and the relationship between short stay and long stay admissions, especially where the former results in a reduced reimbursement level for the divisions affected. Overall pay expenditure remains significantly above plan and expenditure on bank and agency remains high. In month, non pay expenditure remains in excess of plan, particularly in respect of medical equipment and consumables, in part reflecting the additional activity undertaken.

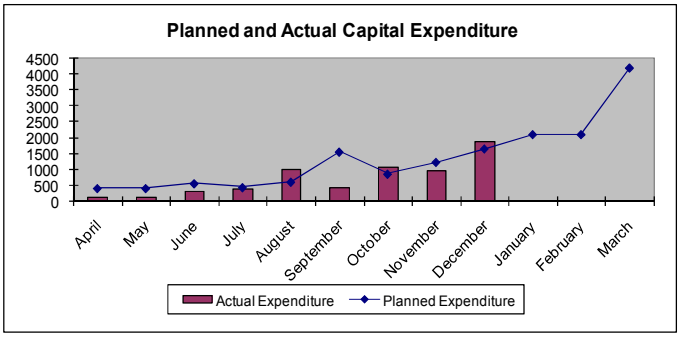
Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	1,217	4,835
Other Income	-25	182
Medical Pay	53	-307
Nursing/Bank Pay	-125	-106
Other Pay	-424	-2,172
Drugs & Consumables	-181	-898
Other Non Pay	-473	-1,552
Interest	-6	-54



Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Expenditure of £1,812,000 was incurred in December mainly relating to medical equipment (including Imaging) and statutory standards. This brings total capital expenditure for the year to date up to £6,184,000.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

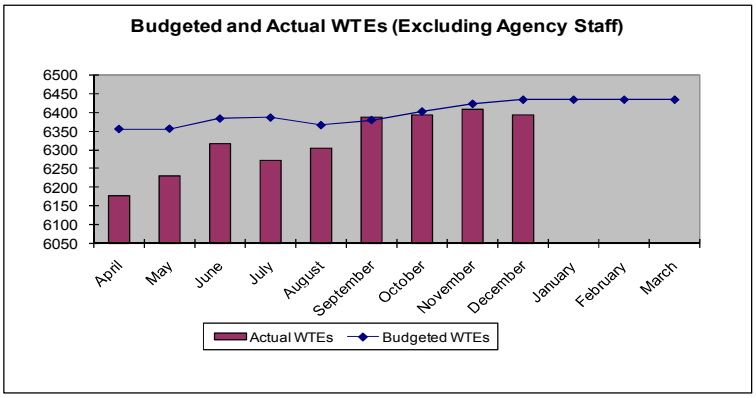
Financial Performance Report – December 2009

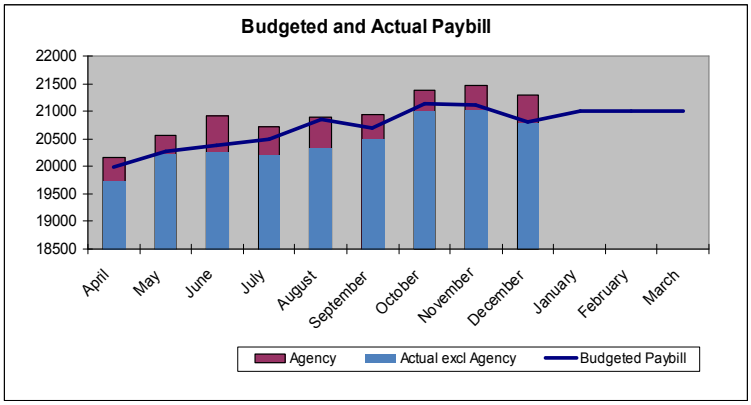
Paybill & Workforce

• Overall workforce numbers (wtes), excluding the effect of agency staff, are 40 below plan for December, which is a significant improvement on the position for November. The number of actual wte's in post has decreased by approximately 15, primarily driven by a reduction in bank staff. Taking an estimate of the wte effect of agency staff, wte numbers are effectively 93 above plan, again an improvement on the position reported in November.

•Paybill (including agency staff) is £496,000 above budgeted levels for the month and £2,585,000 for the year to date. This represents a further worsening of performance against planned levels and continues to be a key risk that must be managed in terms of delivering the yearend forecast surplus.

•In month expenditure on agency staff was £508,000, an increase of nearly £80,000 against expenditure in November.





Pay Variance by Pay Group

• The table below provides an analysis of all pay costs by major staff category by removing both bank and agency costs and allocating these into the appropriate main pay group.

• The table demonstrates that the major areas of pay overspend continue to lie within medical staffing and healthcare assistants and support staff, the latter group being broken down primarily into two sub groups: healthcare assistants in clinical divisions and support staff (primarily domestics) within Facilities.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2009

Analysis of Total Pay Costs by Staff Group

	Year to Date to December					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	54,891	55,032		1,581	56,613	-1,722
Management	10,314	9,644		0	9,644	670
Administration & Estates	20,920	20,434		897	21,331	-411
Healthcare Assistants & Support Staff	9,137	9,055	1,445	912	11,412	-2,275
Nursing and Midwifery	65,287	60,616	3,263	690	64,569	718
Scientific, Therapeutic & Technical	25,165	24,598		144	24,742	423
Other Pay	28	15			15	13
Total Pay Costs	185,742	179,394	4,708	4,225	188,327	-2,585

Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the IFRS based audited accounts for 2008/2009.

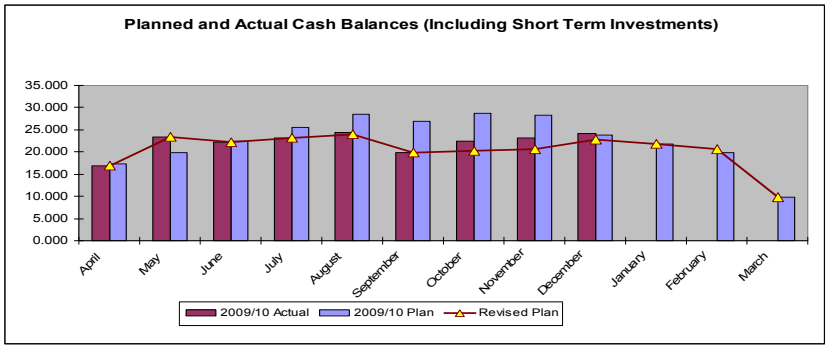
• Cash balances at 31st December are approximately £1.3m higher than the revised plan, a lower figure than that for 30th November. The Trust is still planning to hold the same year end cash balance as included in its original financial plan for the year.

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at March 2009 £000	Balance as at December 2009 £000	Forecast at March 2010 £000
Non Current Assets	Intangible Assets	547	470	522
	Tangible Assets	277,912	271,831	257,371
	Investments	0	0	0
	Receivables	1,158	1,150	1,200
Current Assets	Inventories	3,295	3,305	3,300
	Receivables and Accrued Income	19,138	22,150	18,500
	Investments	0	0	0
	Cash	8,752	24,183	9,751
Current Liabilities	Payables and Accrued Expenditure	(28,516)	(43,878)	(31,321)
	Loans	0	0	0
	Borrowings	(1,885)	(1,880)	(1,880)
	Provisions	(5,440)	(2,111)	(2,200)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	0	0	0
	Borrowings	(33,627)	(32,027)	(31,127)
	Provisions	(2,193)	(2,193)	(1,943)
		239,141	241,000	222,173
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	161,047
	Revaluation Reserve	60,699	60,699	40,966
	Donated Asset Reserve	2,531	2,531	2,391
	Government Grant Reserve	1,985	1,985	1,805
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	4,637	6,496	6,906
		239,141	241,000	222,173

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – December 2009



Cash Flow

• The table below shows cash receipts and payments for December 2009 and a forecast of expected flows for the following 12 months.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT December 2009

ACTUAL/FORECAST	Dec-09 £000s	Jan-10 £000s	Feb-10 £000s	March-10 £000s	April-10 £000s	May-10 £000s	Jun-10 £000s	Jul-10 £000s	Aug-10 £000s	Sep-10 £000s	Oct-10 £000s	Nov-10 £000s	Dec-10 £000s
Receipts													
SLAs: Sandwell PCT	**13,013**	13,040	13,040	13,040	13,236	13,236	13,236	13,236	13,236	13,236	13,236	13,236	13,236
HoB PCT	**7,195**	7,198	7,198	7,198	7,306	7,306	7,306	7,306	7,306	7,306	7,306	7,306	7,306
South Birmingham PCT	**1,263**	1,264	1,264	1,264	1,282	1,282	1,282	1,282	1,282	1,282	1,282	1,282	1,282
BEN PCT	**1,733**	1,732	1,732	1,732	1,757	1,757	1,757	1,757	1,757	1,757	1,757	1,757	1,757
Pan Birmingham LSCG	**1,213**	1,213	1,213	1,213	1,231	1,231	1,231	1,231	1,231	1,231	1,231	1,231	1,231
Other PCTs	**2,223**	2,496	2,496	2,496	2,534	2,534	2,534	2,534	2,534	2,534	2,534	2,534	2,534
Over Performance Payments	**0**	0	0	0	1,000								
Education & Training	**1,445**	1,501	1,501	1,501	1,523	1,523	1,523	1,523	1,523	1,523	1,523	1,523	1,523
Loans	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Interest	**7**	6	7	6	11	8	8	8	8	8	8	8	8
Other Receipts	**5,160**	2,412	2,412	2,412	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300
Total Receipts	**33,252**	30,861	30,861	30,861	32,181	31,178	31,178	31,178	31,178	31,178	31,178	31,178	31,178
Payments													
Payroll	**12,315**	12,520	12,520	12,520	12,674	12,674	12,674	12,674	12,674	12,674	12,674	12,674	12,674
Tax, NI and Pensions	**9,086**	8,571	8,571	9,981	8,676	8,676	8,676	8,676	8,676	8,676	8,676	8,676	8,676
Non Pay - NHS	**2,896**	2,465	2,465	3,096	2,440	2,440	2,440	2,440	2,440	2,440	2,440	2,440	2,440
Non Pay - Trade	**6,035**	6,785	6,785	7,111	5,880	5,940	5,940	6,250	6,200	6,200	6,200	6,200	6,200
Non Pay - Capital	**1,568**	1,850	2,158	4,932	500	500	500	501	501	501	501	501	501
PDC Dividend	**0**	0	0	3,500	0	0	0	0	0	4,200	0	0	0
Repayment of Loans	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Interest	**0**	0	0	0	0	0	0	0	0	0	0	0	0
BTC Unitary Charge	**354**	325	325	325	335	335	335	335	335	335	335	335	335
Other Payments	**16**	70	70	70	355	355	356	357	358	359	360	361	362
Total Payments	**32,270**	32,586	32,894	41,535	30,860	30,920	30,921	31,233	31,184	35,385	31,186	31,187	31,188
Cash Brought Forward	**23,201**	24,183	22,458	20,425	9,751	11,071	11,329	11,585	11,530	11,523	7,316	7,307	7,298
Net Receipts/(Payments)	**982**	(1,725)	(2,033)	(10,674)	1,321	258	257	(55)	(6)	(4,207)	(8)	(9)	(10)
Cash Carried Forward	**24,183**	22,458	20,425	9,751	11,071	11,329	11,585	11,530	11,523	7,316	7,307	7,298	7,287

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – December 2009

SLA Performance

•The table below shows a summary of both activity and financial performance for major patient types across the Trust's SLA's. This demonstrates that the majority of the financial gain is the result of higher than planned levels of out-patient activity. Final SLA performance remains subject to data processing rules generated via the CBSA. The Trust has challenged the interpretation of activity performance levels by the CBSA and PCT and is working collaboratively in resolving these.

Year to Date Key Performance Against SLA

PERFORMANCE UP TO NOVEMBER	Activity			Finance		
	Planned	Actual	Variance	Planned £000	Actual £000	Variance £000
Accident & Emergency	220,740	154,403	(339)	11,330	11,743	413
Admitted Patient Care - Elective	41,653	43,873	2,220	37,743	39,555	1,812
Admitted Patient Care - Non Elective	38,871	41,595	2,724	61,620	60,519	(1,101)
Excess Bed Days	24,273	24,245	(28)	5,025	4,912	(113)
Other	72	72	0	51,156	52,243	1,087
Out-Patients First Attendance	106,161	108,317	2,156	17,876	17,947	71
Out-Patients Follow Up	252,104	271,931	19,827	21,866	24,003	2,137
Out-Patients With Procedure	5,096	15,549	10,453	1,060	3,335	2,275
Unbundled Activity	10,053	39,507	29,454	7,517	7,952	434
Total	**699,023**	**699,492**	**66,467**	**215,193**	**222,208**	**7,015**

Note: This analysis does not cover all services provided under SLAs

SLA Performance by Commissioner

• The table adjacent shows overall financial performance by commissioner for the Trust's major commissioners. This demonstrates that over performance is spread over a large number of commissioners including specialised service agencies.

Year to Date SLA Performance by Commissioner

PERFORMANCE UP TO NOVEMBER	Finance		
	Planned £000	Actual £000	Variance £000
SANDWELL PCT	103,906	105,277	1,371
HEART OF BIRMINGHAM TEACHING PCT	57,675	58,827	1,151
BIRMINGHAM EAST & NORTH PCT	13,886	13,969	83
SOUTH BIRMINGHAM PCT	10,137	11,440	1,303
PAN BIRMINGHAM LSCG	9,730	11,275	1,545
WALSALL PCT	4,311	4,325	15
WEST MIDLANDS SCT	3,503	3,555	52
DUDLEY PCT	3,022	3,450	428
WORCESTERSHIRE PCT	1,802	2,051	249
SOLIHULL CARE TRUST	1,572	1,729	157
OTHERS	5,648	6,309	661
TOTAL	**215,193**	**222,208**	**7,015**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – December 2009

SLA Performance by Specialty

• The table adjacent shows overall financial performance by specialty or service area for those services making the largest contribution to the Trust's net over performance. This is a summary of all types of activity within any given specialty or service area and includes both admitted patient care and out-patients. It therefore needs to be considered only as a broad indication of performance within each area as there may be different issues affecting various patient types within a service.

Year to Date SLA Performance: Variances From Plan

PERFORMANCE UP TO NOVEMBER	Finance		
	Planned £000	Actual £000	Variance £000
Gastroenterology	3,060	5,177	2,117
Cardiology	6,848	8,913	2,064
Elderly	13,071	14,347	1,276
Respiratory Medicine	1,703	2,792	1,089
Urology	4,682	5,712	1,031
Clinical Haematology	2,704	3,688	984
Other	15,376	16,257	881
Ophthalmology	15,511	16,189	678
ENT	3,442	4,115	673
Direct Access	3,415	4,011	596
Neurology	1,346	1,905	559
Maternity	16,503	17,047	545
Oncology	8,810	9,247	438
Vascular Surgery	1,605	2,041	436
Dermatology	3,158	3,568	410
Paediatrics	6,719	7,105	386
Oral Surgery	674	1,036	362
Plastic Surgery	2,234	2,580	346
Rehabilitation	0	256	256
Gynaecological Oncology	1,580	1,832	252
Diabetes	841	1,042	201
Gynaecology	5,910	6,069	159
General Surgery	13,775	12,997	(777)
A&E	13,648	12,821	(827)
Trauma & Orthopaedics	17,243	16,406	(837)
General Medicine	25,268	18,182	(7,086)
Others	26,069	26,870	801
TOTAL	**215,193**	**222,208**	**7,015**

Note: the performance of general medicine needs to be viewed alongside other medical specialties with planned general medicine activity actually delivered within medical sub specialties.

Risk Ratings

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	8.4%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	99.9%	4
Return on Assets	Surplus before dividends over average assets employed	3.6%	3
I&E Surplus Margin	I&E Surplus as % of total income	0.7%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	3.5	1
Overall Rating			**2.4**

Risk Ratings

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

•The only significantly weak area remains liquidity which will only be substantially corrected with the introduction of a working capital facility.

Sandwell and West Birmingham Hospitals NHS

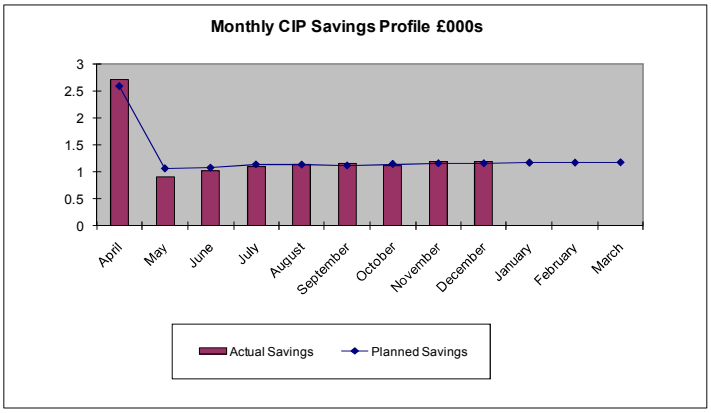
NHS Trust

Financial Performance Report – December 2009

Cost improvement Programme

•The adjacent graph shows the monthly profile of the Trust's cost improvement programme and actuals achieved up to December.

•As at December, there is a shortfall against planned levels of £104k or 0.9% which represents a slight worsening against the position reported for November.



External Focus and Forward Look

• Based on performance up to November, the Trust is forecasting a further significant increase in the rate of over performance against its Service Level Agreements with PCTs. Although there are still outstanding data challenge issues, this level of over performance will impact on the financial position of PCTs, particularly as they are experiencing over performance elsewhere in the acute sector.

• Both Sandwell and Heart of Birmingham PCTs continue to report significant over performance both for Sandwell and West Birmingham Hospitals and for a number of other providers (some pressure has subsided for HoBtPCT in respect of HEFT (Heart of England NHS Foundation Trust) and UHB (University Hospitals Birmingham NHS Foundation Trust) which is offset by additional costs in mental health services. Although this over performance is causing financial pressures for the PCTs, they are expecting to achieve overall financial plans at the year end.

• Work on the 2010/11 LDP with Sandwell and Heart of Birmingham PCTs continues in the context of Right Care, Right Here although the changes announced in the 2010/11 Operating Framework will have a significant impact on patient related income. This is dealt with as a separate item.

• Clearly, if the Trust is to meet its Income and Expenditure target at the end of the year, it is imperative that performance is sustained and improved for the remainder of the year. This particularly applies to pay expenditure which is generally more difficult to control in the shorter term.

• Given the expectation of a very tight financial settlement, particularly from 2011/2012 onwards, it is essential that the Trust is in the best possible financial position to move forward over the next few years. Part of this process will need to be to ensure that underlying financial performance is sound.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – December 2009

Conclusions

• For the year to 31st December 2009, the Trust has generated an overall income and expenditure surplus of £1,859,000 which is £72,000 below plan. For the current month, the actual surplus of £160,000 was £36,000 above plan.

• Capital expenditure in December was again a sizeable increase on levels experienced earlier in the year, predominantly related to medical equipment purchases and statutory standards work, although actual spend still remains below the expected profile for the year.

•At 31st December, cash balances are approximately £1.3m higher than the revised cash plan.

• Surgery A, Medicine A and Facilities have generated significant in month deficits. Surgery A, along with Anaesthetics and Critical Care, Medicine A, Medicine B and Facilities all have significant year to date deficits. This is balanced by better than planned performance in other divisions and, in particular, within corporate services.

• Expenditure against pay budgets continues to worsen in month with a further deterioration of £496k. Excluding agency staff, actual numbers of whole time equivalents (wtes) in post has decreased by 15 in month, predominantly driven by changes in bank numbers. Taking into account an estimated effect on wtes of agency staff, wte numbers are 93 greater than planned. It remains imperative that staff costs, and particularly the use of agency staff, are realigned to budgeted levels.

• Controls on pay and staffing remain in place and will continue to be strengthened over the remainder of the year and into the new year. It must be recognised that activity and winter pressures over the final quarter of the year that leads to opening additional capacity will continue to place significant pressures on both pay and non pay costs.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report; and

ii. ENDORSE 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:	28 January 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 – December 2009.

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	
Core Standards	
Auditors' Local Evaluation	Internal Control and Value for Money

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

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

PREVIOUS CONSIDERATION:

Financial Management Board, Trust Management Board and Finance and Performance Management Committee.

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - DECEMBER 2009

EXECUTIVE SUMMARY

<table>
<tr><th>Note</th><th>Comments</th></tr>
<tr><td>a</td><td>The percentage of Cancelled Operations reduced to 0.7% during December, with reductions seen on both sites.</td></tr>
<tr><td>b</td><td>Delayed Transfers of Care increased to a similar level on both sites (3.9% overall). Of the 23 delays attributable to Social Services, 14 relate to Sandwell and 9 relate to Birmingham.</td></tr>
<tr><td>c</td><td>The Care Quality Commission has recently published the definition for assessment of 'Time to reperfusion for patients who have had a heart attack', which is part of the commission's Periodic Review process. The definition includes assessment of Primary Angioplasty performance, within 150 minutes of patients calling for professional help. This indicator and current performance is included in the report, in addition to performance within 90 minutes of patients calling for professional help.</td></tr>
<tr><td>d</td><td>Stroke Care - the proportion of patients spending at least 90% of their hospital stay on a Stroke Unit reduced during the month of November to 46.4%.</td></tr>
<tr><td>e</td><td>Accident & Emergency 4-hour waits - performance during December fell to 96.2%. Performance for the month by the specific units was; Eye Centre 99.9%, Sandwell Acute 96.7% and City Acute 94.7%. Performance for the year to date remains above the 98% operational threshold, at 98.49%.</td></tr>
<tr><td>f</td><td>The overall number of cases of C Diff reported across the Trust during the month of December (14) is identical to the number reported for each of the preceding two months. The numbers reported on the City site increased to 11 during the month. There were no cases of MRSA Bacteraemia reported during the month. The Trust continues to meet National and Local performance trajectories.</td></tr>
<tr><td>g</td><td>Referral to Treatment Time data for December was not available for inclusion within this report.</td></tr>
<tr><td rowspan="6">h</td><td>CQUIN:</td></tr>
<tr><td>Outpatient source of Referral - Performance remains well within the trajectory set for this target.</td></tr>
<tr><td>Caesarean Section Rate - The rate for the month reduced to 22.0%. The rate for the year to date is 23.1%, within the trajectory for the period.</td></tr>
<tr><td>Brain Imaging - During the month of December the proportion of patients admitted as an emergency following a stroke who received a brain scan within 24 hours of admission was 86.4%.</td></tr>
<tr><td>Hip Fracture - Performance during December was 88.0%, comparing favourably with a year to date trajectory of 85.0%.</td></tr>
<tr><td>Smoking Cessation Referrals - The number of referrals made to PCT smoking cessation services of patients specifically prior to listing for Elective Surgery for the month of December reduced to 59. Year to date referrals total 373.</td></tr>
<tr><td>Inpatient Patient Satisfaction Survey - The second survey has been concluded with at least 50 responses received to the questionnaire per ward.</td></tr>
<tr><td>i</td><td>Detailed analysis of Financial Performance is contained within a separate paper to this meeting.</td></tr>
<tr><td>j</td><td>The number and percentage (of overall admissions) of Same Sex Accommodation breaches are included in the report. Data is effective from the start of November 2009.</td></tr>
<tr><td>k</td><td>Activity (trust-wide) to date is compared with the contracted activity plan for 2009 / 2010 - Month and Year to Date.
<table>
<tr><th></th><th colspan="4">Month</th><th colspan="4">Year to Date</th></tr>
<tr><th></th><th>Actual</th><th>Plan</th><th>Variance</th><th>%</th><th>Actual</th><th>Plan</th><th>Variance</th><th>%</th></tr>
<tr><td>IP Elective</td><td>1059</td><td>1040</td><td>19</td><td>1.8</td><td>10312</td><td>9736</td><td>576</td><td>5.9</td></tr>
<tr><td>Day case</td><td>4181</td><td>3946</td><td>235</td><td>6.0</td><td>39302</td><td>36954</td><td>2348</td><td>6.4</td></tr>
<tr><td>IPE plus DC</td><td>5240</td><td>4986</td><td>254</td><td>5.1</td><td>49614</td><td>46690</td><td>2924</td><td>6.3</td></tr>
<tr><td>IP Non-Elective</td><td>5620</td><td>5995</td><td>-375</td><td>-6.3</td><td>50231</td><td>54414</td><td>-4183</td><td>-7.7</td></tr>
<tr><td>OP New</td><td>12585</td><td>12614</td><td>-29</td><td>-0.2</td><td>122687</td><td>121298</td><td>1389</td><td>1.1</td></tr>
<tr><td>OP Review</td><td>33118</td><td>30546</td><td>2572</td><td>8.4</td><td>312891</td><td>290764</td><td>22127</td><td>7.6</td></tr>
</table>
Activity to date is compared with 2008 / 09 for the corresponding period
<table>
<tr><th></th><th>2008 / 09</th><th>2009 / 10</th><th>Variance</th><th>%</th></tr>
<tr><td>IP Elective</td><td>9936</td><td>10312</td><td>376</td><td>3.8</td></tr>
<tr><td>Day case</td><td>37935</td><td>39302</td><td>1367</td><td>3.6</td></tr>
<tr><td>IPE plus DC</td><td>47871</td><td>49614</td><td>1743</td><td>3.6</td></tr>
<tr><td>IP Non-Elective</td><td>51792</td><td>50231</td><td>-1561</td><td>-3.0</td></tr>
<tr><td>OP New</td><td>113255</td><td>122687</td><td>9432</td><td>8.3</td></tr>
<tr><td>OP Review</td><td>278301</td><td>312891</td><td>34590</td><td>12.4</td></tr>
</table></td></tr>
<tr><td>l</td><td>Data on Outpatient Appointment Cancellations is included, effective from the start of October. The number of cancellations is differentiated by those initiated by the Trust and those initiated by Patients.</td></tr>
<tr><td>m</td><td>Bank and Agency - The Nurse Bank Fill Rate fell to 78.6%. A fall in the number of Nurse Bank Shifts worked during the month (555) was partly offset by an increase in the number of Nurse Agency Shifts worked (240) during the same period. Medical Agency, Medical Locum and Other Agency costs remain at similar levels to those in the preceding month.</td></tr>
<tr><td>n</td><td>Overall Sickness Absence has averaged 4.29% for the first 9 months of the year. December's level is 4.73%. Focus on sickness absence by department and service area will be an integral feature of forthcoming Divisional Performance Reviews.</td></tr>
<tr><td>o</td><td>Overall compliance with Mandatory Training modules is reported as 55.7% at the end of December. This increased slightly to 56.4% by the date (14 January 2010) of compilation of this report, with variable compliance reported by module and division. The number of PDRs reported as completed reduced significantly during December to 99, the Trust is approximately 9% short of its target compliance rate for the period to date.</td></tr>
</table>

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - DECEMBER 2009

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS			August	September	October	November			December			To Date	TARGET		Exec Summary Note	THRESHOLDS			06/07 Outturn	07/08 Outturn	08/09 Outturn
				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	09/10							
RW	Net Income & Expenditure (Surplus / Deficit (-))		£000s	177 ▲	257 ▲	251 ▲	→		135 ▼	→		160 ▲	1859	1931	2269		0%	0 - 1%	>1%	3399	6547	2535
RK	Cancer	2 weeks	%	93.7 ▲	92.8 ■	94.5 ■	→		96.1 ▲	→			93.8	=>93	=>93		No variation		Any variation	100	97.1	98.6
		31 Days	%	99.4 ▼	100 ▲	99.4 ▼	→		99.4 ■	→			99.7	=>96	=>96		No variation		Any variation	99.9	99.9	100
		62 Days	%	87.9 ▲	94.0 ▲	89.2 ▼	→		89.9 ▲	→			89.8	=>85	=>85		No variation		Any variation	99.3	99.7	98.6
RK	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.6 ■	0.5 ▲	0.6 ▼	0.6 ▼	1.4 ■	1.0 ■	0.4 ▲	1.0 ■	0.7 ■	0.8	<0.8	<0.8	a	<0.8	0.8 - 1.0	>1.0	0.9	0.9	1.0
		28 day breaches	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0		3 or less	4 - 6	>6	4	0	0
	Delayed Transfers of Care	Total	%	2.1 ▲	2.6 ▼	3.6 ■	2.0 ▲	3.3 ■	2.6 ■	3.8 ■	4.1 ■	3.9 ■	2.8	<3.0	<3.0	b	<3.0	3.0 - 4.0	>4.0	4.0	2.7	3.1
RK	Coronary Heart Disease	Primary Angioplasty (<90 mins)	%	83 ■	85 ▲	79 ■	55 ■	100 ■	64 ■				76.3	80	80	c	>80	75-80	<75	n/a	63.0	70.5
		Primary Angioplasty (<150 mins)		80 ■	92 ▲	90 ▼	67 ■	100 ■	75 ■				85.9	80	80		>80	75-80	<75	n/a	n/a	83.6
		Rapid Access Chest Pain	%	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	99.8	=>98	=>98		>99	98 - 99	<98	99.7	99.6	100.0
		Revascularisation >13 weeks	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0		0		>0	0	0	0
		Thrombolysis (60 minutes)	%	no pts	no pts	no pts			no pts				no pts	80	80		>80	75-80	<75	57	50	0
DO'D	Stroke Care	>90% stay on Stroke Unit	%	60.4 ■	65.5 ■	59.4 ■	→		46.38 ▼	→			54.6	68.5	70	d	+>70	65 - 70	<65	n/a	n/a	36.5
RK	A/E 4 Hour Waits		%	99.2 ▲	98.6 ▼	99.0 ▲	96.1 ■	97.1 ■	96.7 ■	96.7 ▲	96.0 ▼	96.2 ▼	98.49	=>98	=>98	e	=>98		<98	98.20	98.28	98.16
	GUM 48 Hours	Patients seen within 48 hours	%	91.2 ■	88.2 ■	87.0 ▼	→		86.3 ▼	→		87.5 ▲	88.0	=>90	=>90		=>90	80-89	<80	n/a	n/a	81.0
		Patients offered app't within 48 hrs	%	100 ■	100 ■	99.5 ▼	→		100 ▲	→		100 ■	99.8	=>98	=>98		=>98	95-98	<95	35.8	80.7	98.3
R0	Infection Control	C. Diff - EXTERNAL (DH) TARGET	No.	15 ▼	10 ▲	14 ▼	5 ▲	9 ▼	14 ■	3 ▲	11 ■	14 ■	113	201	264	f	No variation		Any variation	n/a	355	163
		C. Diff - INTERNAL (LHE) TARGET	No.	15 ▼	10 ▲	14 ▼	5 ▲	9 ▼	14 ■	3 ▲	11 ■	14 ■	113	183	220		No variation		Any variation	n/a	355	163
		MRSA - EXTERNAL (DH) TARGET	No.	0 ▲	1 ▼	1 ■	0 ▲	2 ■	2 ▼	0 ■	0 ■	0 ▲	10	27	33		No variation		Any variation	61	43	15
		MRSA - INTERNAL (LHE) TARGET	No.	0 ▲	1 ▼	1 ■	0 ▲	2 ■	2 ▼	0 ■	0 ■	0 ▲	10	18	23		No variation		Any variation	61	43	15
RK	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	95 ■	95 ■	95 ■	→		94 ■	→			94	90	90		>/=90	89.0-89.9	<89	90.0	89.0	87.0
RO	Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	→	99.3 ▼	→	→			→		99.0 ■	99.3	=>99.0	=>99.0		=>99	98-99	<98	99.9	99.5	99.9
		Breast Feeding Status Data Complete	%	→	98.8 ■	→	→			→		99.3 ■	99.1	=>99.0	=>99.0		=>99	98-99	<98	98.3	99.8	97.8
		Maternal Smoking Rates	%	→	11.5 ■	→	→			→		10.9 ▲	11.8	<12.0	<12.0		<12.0	12-14	>14.0	13.2	13.1	12.6
		Breast Feeding Initiation Rates	%	→	62.0 ▼	→	→			→		63.3 ▲	62.7	>57.0	>57.0		>57.0	55-57	<55.0	52.5	55.0	54.2
RK	Patient Access	Inpatients >26 weeks	%	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0.000	0	0		<0.03		>0.03	1	0	0
		Outpatients >13 weeks	%	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0.001	0	0		<0.03		>0.03	4	0	5
RK	RTT Milestones	Admitted Care (RTT <18 weeks)	%	96.5 ▼	97.2 ▲	97.6 ▲	→		93.4 ▼	→			93.4	=>90.0	=>90.0	g	=>90.0		<90.0	52.0	90.6	98.6
		Admitted Care - Data Completeness	%	102.0 ■	109.5 ■	108.4 ■	→		103.5 ■	→			103.5	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	100.4
		Non-Admitted Care (RTT <18 weeks)	%	98.0 ▲	98.0 ■	97.7 ▼	→		97.3 ▼	→			97.3	=>95.0	=>95.0		=>95.0		=<95.0	n/a	95.5	98.8
		Non-Admitted Care - Data Completeness	%	105.0 ■	109.7 ■	108.3 ■	→		98.4 ■	→			98.4	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	98.1
		Audiology Direct Access Waits (<18 wks)	%	100 ■	100 ■	100 ■	→		100 ■	→			100	=>95	=>95		=>95		<95	n/a	n/a	99.0
		Audiology Data Completeness	%	91.0 ■	97.0 ■	108.0 ■	→		110.0 ■	→			110.0	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	96.0
		Diagnostic Waits greater than 6 weeks	No.	14 ▲	0 ■	0 ■	→		2 ■	→		1 ▲	1	0	0		0		>0	996	25	26
DO'D	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	85.5 May '09	80.5 Jun '09	83.4 JuL '09	→		82.3 Aug '09	→		97.8 Sept '09	88.3	Rate only	Rate only					96.4	100.9	105.1
		Peer (SHA) HSMR	HSMR	89.2	89.1	90.7	→		91.5	→		85.7	93.1	Rate only	Rate only					108.8	106.0	103.9
RK	CQUIN	OP Source of Referral Information	%	1.13 ▲	2.02 ▼	1.21 ▲	→		1.06 ▲	→		0.8 ▲	1.33	5.5	5.0	h	No variation		Any variation	n/a	n/a	10.0
DO'D		Caesarean Section Rate	%	21.8 ▼	27.6 ■	23.4 ■	24.9 ▼	23.7 ▼	24.2 ▼	23.0 ▲	21.3 ▲	22.0 ▲	23.1	26.1	26.0		=<26.0		>26.0	n/a	27.7	27.0
		Brain Imaging for Em. Stroke Admissions	%	70.2 ▲	84.6 ■	88.0 ▲	→		83.8 ▼	→		86.4 ▲	86.4	72.0	72.0		=>72.0		<72.0	n/a	n/a	72.0
		Hip Fracture Op's <48 hours of admission	%	96.2 ▲	89.5 ▼	100 ▲	→		83.3 ■	→		88.0 ■	88.0	85.0	87.0		No Variation	0 - 2% Variation	>2% Variation	63.6	70.1	77.8
		Smoking Cesssation Referrals	No.	37 ▲	28 ▼	173 ■	→		65 ■	→		59 ▼	373	750	1000		=>83	per month	<83	n/a	n/a	7
RO		IP Patient Satisfaction (Survey Coverage)	%										Completed				=>90		<90	n/a	n/a	n/a

Exec Lead				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
CLINICAL QUALITY																						
RK	Readmission Rates	(Within 28 days of discharge)	%	11.7	11.6	11.6	13.7	11.3	12.3				11.6	No. Only	No. Only					10.1	n/a	11.6
		(Within 14 days of discharge)	%	8.5	8.6	8.6	10.3	8.1	9.0				8.5	No. Only	No. Only					n/a	n/a	7.3
R0	Infection Control	Savings Lives Compliance	%	99	99	100	→		99	→		100	100	>95	>95		< YTD target		> YTD target	n/a	n/a	99.0
		MRSA Screening (Elective)	No.	1871	2242	2305	→		2192	→		1611	17524	No. Only	No. Only		0 - 10%	10 - 15%	>15%	n/a	n/a	6495
		MRSA Screening (Non-Elective)	No.	332	2209	2133	→		2125	→		2175	11848	No. Only	No. Only		0 - 10%	10 - 15%	>15%	n/a	n/a	n/a
DO'D	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	1	1	2	0	0	0	0	0	0	9	36	48		=<2	3 - 4	>4	n/a	n/a	
		Admissions to Neonatal ICU	%	5.3	8.2	5.5	2.7	5.1	4.1	4.7	4.5	4.6	5.8	=<10	=<10		=<10	10.0-12.0	>12.0	n/a	9.6	
		Adjusted Perinatal Mortality Rate	/1000	9.4	2.0	9.2	13.6	19.0	16.6				16.6	<8.0	<8.0		<8	8.1 - 10.0	>10	n/a	n/a	
FINANCE & FINANCIAL EFFICIENCY																						
RW	Gross Margin		£000s	2382	2462	2493	→		2377	→		2402	21979	21997	29805		0%	0 - 1%	>1%	26429	33250	26436
	CIP		£000s	1105	1126	1079	→		1151	→		1113	11464	11568	15075		0 - 2.5%	2.5 - 7.5%	>7.5%	19679	14027	11084
	In Year Monthly Run Rate		%	4.12	12.23	13.06	→		14.41	→		29.03	-3.73	0	0		NO or a + variation	0 - 5% variation	>5% variation	329	45	1.4
RK	Income / WTE		£s	4917	4892	4960	→		5001	→		5087	4965	5127	5127		No variation	0 - 5% variation	>5% variation	5460	4924	5014
	Income / Open Bed		£s	32904	32353	32496	→		32048	→		32518	32391	31184	31184		No variation	0 - 5% variation	>5% variation	24774	29065	30498
	Income per Spell	Total Income	£s	3082	2853	2762	→		2892	→		2994	2829	2762	2762		No Variation	0 - 4% Variation	>4% Variation	2635	2740	2701
		Clinical Income	£s	2760	2560	2483	→		2572	→		2695	2543	2454	2454		No Variation	0 - 4% Variation	>4% Variation	2317	2449	2400
		Non-Clinical Income	£s	322	293	279	→		320	→		299	286	308	308	i	No Variation	0 - 4% Variation	>4% Variation	318	291	301
	Cost per Spell	Total Cost	£s	3065	2829	2740	→		2880	→		2980	2810	2742	2742		No Variation	0 - 4% Variation	>4% Variation	n/a	2643	2682
		Total Pay Cost	£s	2077	1912	1862	→		1937	→		1960	1886	1825	1825		No Variation	0 - 4% Variation	>4% Variation	1772	1737	1785
		Medical Pay Cost	£s	609	562	570	→		580	→		564	551	544	544		No Variation	0 - 4% Variation	>4% Variation	543	517	532
		Nursing Pay Cost (including Bank)	£s	711	658	638	→		671	→		680	654	639	639		No Variation	0 - 4% Variation	>4% Variation	609	615	625
		Non-Pay Cost	£s	988	917	877	→		943	→		1019	924	917	917		No Variation	0 - 4% Variation	>4% Variation	n/a	906	897
		Mean Drug Cost / IP Spell	£s	122	121	123	→		130	→		134	119	123	123		No Variation	0 - 4% Variation	>4% Variation	n/a	95	120
		Mean Drug Cost / Occupied Bed Day	£s	48	51	52	→		52	→		52	48	48	48		No Variation	0 - 4% Variation	>4% Variation	n/a	35	47
PATIENT EXPERIENCE																						
RK	Same Sex Accommodation Breaches	Number of Breaches	No.	→	→	→	→		590	→		546	1136	No. Only	No. Only	j	To date = since 1 Nov 2009			n/a	n/a	n/a
		Percentage of overall admissions	%	→	→	→	→		5.29	→		5.74	5.50	No. Only	No. Only					n/a	n/a	n/a
KD	Complaints	Number Received	No.	→	216	→	→			→			444	No. Only	No. Only					673	697	789
		Response within initial negotiated date	%	→	65.7	→	→			→			70.9	85	85		80%+	70 - 79%	<70%	77.4	81.2	81.1
	Thank You Letters		No.	→	482	→	→			→			893	No. Only	No. Only					6026	3491	2912
RK	Elective Access Contact Centre	Number of Calls Received	No.	11117	12667	no data	→		no data	→		no data	72895	No. Only	No. Only					n/a	n/a	190434
		Average Length of Queue	mins	1.00	1.54	no data	→		no data	→		no data	1.54	0.5	0.5		No variation	0 - 10% variation	>10% variation	n/a	n/a	0.44
		Maximum Length of Queue	mins	12.5	7.4	no data	→		no data	→		no data	7.4	6.0	6.0		No variation	0 - 10% variation	>10% variation	n/a	n/a	17.4
	Telephone Exchange	Number of Calls Received	No.	77550	81809	86302	→		86020	→		81214	854976	No. Only	No. Only					n/a	1826476	1559688
		Calls Answered	%	88.8	88.4	90.7	→		86.9	→		87.9	81.6	No. Only	No. Only					n/a	81.0	82.3
		Answered within 15 seconds	%	46.7	44.6	51.9	→		42.1	→		45.1	45.1	No. Only	No. Only					n/a	n/a	39.1
		Answered within 30 seconds	%	63.0	60.9	68.5	→		58.5	→		61.0	61.0	No. Only	No. Only					n/a	n/a	55.5
		Average Ring Time	Secs	26.9	28.0	23.1	→		30.7	→		29.5	29.5	No. Only	No. Only					n/a	n/a	28.8
		Longest Ring Time	Secs	719	877	774	→		1068	→		447	447	No. Only	No. Only					n/a	n/a	695
STRATEGY																						
RK	Referrals	Total By Site	No.	14708	16618	16561	→		15760	→			129302	118773	178070		No Variation	0 - 2% Variation	>2% Variation	138580	151755	178070
		Total GP Referrals	No.	9609	11061	10685	→		10313	→			84865	80613	120138		No Variation	0 - 2% Variation	>2% Variation	98476	95857	120138
		Total Other Referrals	No.	5099	5557	5876	→		5447	→			44437	38160	57932		No Variation	0 - 2% Variation	>2% Variation	40104	55898	57932
		By PCT - Heart of B'ham	No.	4108	4438	4621	→		4420	→			35308	33007	49859		No Variation	0 - 2% Variation	>2% Variation	40394	41628	49859
		By PCT - Sandwell	No.	7210	8441	8185	→		7734	→			64670	58724	87779		No Variation	0 - 2% Variation	>2% Variation	72580	77592	87779
		By PCT - Other	No.	3390	3739	3755	→		3606	→			29324	27042	40453		No Variation	0 - 2% Variation	>2% Variation	25606	32535	40453
		Conversion (all referrals) to New OP Att'd	%	84.4	87.4	90.0	→		88.8	→			85.0	No. Only	No. Only					91.5	87.0	85.9

Exec Lead	ACTIVITY			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	Spells	Elective IP	No.	1078	1224	1200	391	772	1163	359	700	1059	10312	9736	13077	k	No Variation	0 - 2% Variation	>2% Variation	13887	13395	13106
		Elective DC	No.	3839	4402	4616	2061	2575	4636	1890	2291	4181	39302	36954	49636		No Variation	0 - 2% Variation	>2% Variation	45831	46304	50873
		Total Elective	No.	4917	5626	5816	2452	3347	5799	2249	2991	5240	49614	46690	62713		No Variation	0 - 2% Variation	>2% Variation	59718	59699	63979
		Non-Elective - Short Stay	No.	1452	1427	1421	563	516	1079	656	646	1302	13823	13075	13745		No Variation	0 - 2% Variation	>2% Variation	12414	11575	12770
		Non-Elective - Other	No.	3685	3903	4248	1709	2493	4202	1876	2442	4318	36408	41339	54971		No Variation	0 - 2% Variation	>2% Variation	52662	55163	56226
		Total Non-Elective	No.	5137	5330	5669	2272	3009	5281	2532	3088	5620	50231	54414	68716		No Variation	0 - 2% Variation	>2% Variation	65076	66738	68996
	Outpatients	New	No.	12407	14517	14904	4735	9260	13995	4222	8363	12585	122687	121298	159666		No Variation	0 - 2% Variation	>2% Variation	127449	131941	152923
		Review	No.	31282	36396	37203	12849	22755	35604	12063	21055	33118	312891	290764	385680		No Variation	0 - 2% Variation	>2% Variation	370970	361113	374867
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	15415	15233	16084	6896	7499	14395	6490	8675	15165	145961	150069	197122		No Variation	0 - 2% Variation	>2% Variation	200561	195093	191141
	A/E Attendances	Type II (BMEC)	No.	2955	3079	2971	→	2448	2448	→	2532	2532	26338	23409	30749		No Variation	0 - 2% Variation	>2% Variation	31373	29803	30800
PATIENT ACCESS & EFFICIENCY																						
RK	Length of Stay	Average Length of Stay	Days	4.4	4.7	4.2	4.8	4.2	4.5				4.4	5.0	5.0		No Variation	0 - 5% Variation	>5% Variation	5.7	5.0	5.0
		All Patients with LOS > 14 days	No.	292	281	298	156	160	316	194	150	344	344	No. Only	No. Only					n/a	345	312
		All Patients with LOS > 28 days	No.	157	142	147	81	82	163	85	72	157	157	No. Only	No. Only					190	174	152
		Min. Stay Rate (Electives (IP/DC) <2 days)	%	91.59	91.39	92.0	94.4	90.6	92.2	94.9	90.4	92.3	92.1	92.0	92.0		No Variation	0 - 5% Variation	>5% Variation	88.3	90.5	91.6
	Admissions	Day of Surgery (IP Elective Surgery)	%	86.3	84.3	84.5	90.9	82.8	85.8	89.8	86.6	87.7	84.7	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	63.2	76.5	79.4
		Day of Surgery (IP Non-Elective Surgery)	%	69.68	66.44	63.0	71.0	65.21	67.9	61.1	64.41	62.7	68.0	No. Only	No. Only					n/a	68.3	70.2
		With no Procedure (Elective Surgery)	%	10.5	11.1	9.4	8.5	11.4	10.4				10.1	No. Only	No. Only					10.6	n/a	10.6
		Per Bed (Elective)	No.	5.08	5.07	6.81	4.54	5.79	5.18	4.78	5.92	5.37	5.58	5.90	5.90		No Variation	0 - 5% Variation	>5% Variation	4.66	4.87	5.33
	Discharges	Pt's Social Care Delay	No.	11	17	15	8	7	15	15	8	23	23	<18	<18	b	No Variation	0 - 10% Variation	>10% Variation			
		Pt.'s NHS & NHS plus S.C. Delay	No.	5	11	9	4	5	9	7	3	10	10	<10	<10		No Variation	0 - 10% Variation	>10% Variation			
	Beds	Occupied Bed Days	No.	25595	25898	27392	12973	14751	27724	13120	15112	28232	246777	254659	342000		No Variation	0 - 5% Variation	>5% Variation	378060	348676	342793
		Occupancy Rate	%	84.3	86.1	86.5	93.6	88.1	90.7	90.9	82.2	86.4	86.1	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	88.6	90.8	90.3
		Open at month end (exc Obstetrics)	No.	942	966	976	485	515	1000	469	531	1000	1000	975	975		No Variation	0 - 2% Variation	>2% Variation	1039	1007	975
	Day Case Rates	All Procedures	%	76.2	76.1	78.1	83.1	74.7	78.2	82.1	74.5	77.8	77.4	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	76.0	76.9	79.0
		BMEC Procedures	%	79.09	77.93	78.81	→	80.29	80.29	→	77.28	77.3	78.3	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	71.5	77.2	79.7
	Non-Admitted Care	New : Review Rate	Ratio	2.52	2.50	2.50	2.72	2.44	2.54	2.86	2.52	2.63	2.55	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	2.91	2.74	2.45
		DNA Rate - New Referrals	%	15.3	13.4	14.0	11.7	13.3	12.8	15.0	16.4	15.9	13.8	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	10.8	10.9	12.0
		DNA Rate - Reviews	%	12.6	12.2	11.9	12.4	12.0	12.2	14.2	13.7	13.9	12.2	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	12.8	13.5	13.5
		OP Cancellations - Trust Initiated	No.			2770	→		2705	→			5475	No. Only	No. Only	l	To date = since 1 Oct 2009			n/a	n/a	n/a
		OP Cancellations - Patient Initiated	No.			3273	→		3524	→			6797	No. Only	No. Only					n/a	n/a	n/a
	Pathology	Cervical Cytology Turnaround	Weeks	2.4	1.8	1.8	→		0.8	→		0.8	0.8	<4.0	<4.0		<4.0	4.0-6.0	>6.0	1.7 - 4.0	1.5 - 2.9	2.7
	Ambulance Turnaround	In Excess of 30 minutes	%	n/a	n/a	n/a	29.8	23.8	26.6	23.9	22.3	23.0	23.0	<10.0	<10.0		<10	10 - 12.5	>12.5	n/a	29.1	19.0
		(West Midlands average)	%	n/a	n/a	n/a	→		35.2	→		31.3	31.3	No. Only	No. Only					n/a	31.1	21.0
		In Excess of 60 minutes	No.	n/a	n/a	n/a	31	36	67	25	35	60	60	0	0		0	1 - 5	>5	n/a	n/a	
THEATRE UTILISATION																						
RK	Sitrep Declared Late **Cancellations** by Specialty	General Surgery	No.	1	3	3	5	4	9	3	3	6	62	45	60	a	0-5% variation	5 - 15% variation	>15% variation	n/a	75	104
		Urology	No.	1	4	4	1	2	3	0	2	2	24	36	48		0-5% variation	5 - 15% variation	>15% variation	n/a	67	102
		Vascular Surgery	No.	0	0	4	0	0	0	0	0	0	5	2	3		0-5% variation	5 - 15% variation	>15% variation	n/a	1	7
		Trauma & Orthopaedics	No.	7	5	8	4	4	8	4	2	6	53	54	72		0-5% variation	5 - 15% variation	>15% variation	n/a	100	75
		ENT	No.	0	1	3	0	4	4	0	5	5	18	9	12		0-5% variation	5 - 15% variation	>15% variation	n/a	19	23
		Ophthalmology	No.	5	7	10	2	18	20	0	11	11	107	81	108		0-5% variation	5 - 15% variation	>15% variation	n/a	139	153
		Oral Surgery	No.	4	1	0	0	4	4	0	3	3	20	6	8		0-5% variation	5 - 15% variation	>15% variation	n/a	10	19
		Cardiology	No.	1	0	0	0	2	2	0	0	0	6	16	21		0-5% variation	5 - 15% variation	>15% variation	n/a	28	31
		Gynaecology / Gynae-Oncology	No.	10	3	4	1	3	4	2	1	3	38	41	54		0-5% variation	5 - 15% variation	>15% variation	n/a	69	71
		Plastic Surgery	No.	0	1	0	0	1	1	0	0	0	9	9	12		0-5% variation	5 - 15% variation	>15% variation	n/a	17	21
		Dermatology	No.	0	5	0	0	0	0	0	2	2	18	18	24		0-5% variation	5 - 15% variation	>15% variation	n/a	4	24
		TOTAL	No.	29	30	36	13	42	55	9	29	38	360	316	422		0-5% variation	5 - 15% variation	>15% variation	n/a	529	630

Exec Lead	WORKFORCE			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	WTE in Post	Total	No.	6304 ▼	6388 ■	6394 ■	→		6408 ▲	→		6393 ▲	6393	6433	6241		No Variation	0 - 1% Variation	>1% Variation	6000	5875	6042
		Medical and Dental	No.	770 ▼	763 ▲	769 ▼	→		770 ▲	→		759 ▲	759	788	761		No Variation	0 - 1% Variation	>1% Variation	822	736	755
		M'ment, Admin. & HCAs	No.	2050 ■	2054 ▲	2038 ▲	→		2033 ■	→		2025 ▲	2025	2018	1952		No Variation	0 - 1% Variation	>1% Variation	1806	1765	1852
		Nursing & Midwifery (excluding Bank)	No.	2337 ▲	2360 ▼	2396 ▼	→		2409 ▼	→		2404 ▲	2404	2603	2547		No Variation	0 - 1% Variation	>1% Variation	2481	2255	2259
		Scientific and Technical	No.	959 ▼	958 ▲	966 ▼	→		958 ▲	→		973 ▼	973	1021	981		No Variation	0 - 1% Variation	>1% Variation	891	869	913
		Bank Staff	No.	188	253	225	→		238	→		232	232	No. Only	No. Only					n/a	250	260
		Gross Salary Bill	£000s	20887 ▲	20944 ▼	21389 ▼	→		21461 ▼	→		21290 ▼	188327	185742	243342		No Variation	0 - 1% Variation	>1% Variation	220244	219667	238674
RK	Bank & Agency	Nurse Bank Fill Rate	%	87.2	86.5	86.9	→		84.8	→		78.6	85.2	No. Only	No. Only	m				n/a	87.6	81.8
		Nurse Bank Shifts covered	No.	5429 ■	4908 ■	4966 ▼	→		5261 ▼	→		4706 ▲	46114	46377	61836		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	67330	68707	69675
		Nurse Agency Shifts covered	No.	263 ■	254 ▲	250 ▲	→		459 ■	→		699 ▼	3475	3729	4972		0 - 5% Variation	5 - 10% Variation	>10% Variation	2879	5524	4765
		Nurse Bank AND Agency Shifts covered	No.	5692 ■	5162 ▲	5216 ▼	→		5720 ■	→		5405 ■	49589	50106	66808		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	70209	74231	74440
		Nurse Bank Costs	£000s	510 ▲	522 ▼	509 ▲	→		544 ▼	→		536 ▲	4688	4817	6423		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	6883	6980	6844
		Nurse Agency Costs	£000s	89 ■	68 ■	97 ■	→		72 ■	→		167 ■	710	744	992		0 - 5% Variation	5 - 10% Variation	>10% Variation	474	1078	832
KD		Medical Agency Costs	£000s	238 ▼	156 ▲	159 ▼	→		167 ▼	→		164 ▲	1563	894	1192		0 - 5% Variation	5 - 10% Variation	>10% Variation	693	1296	2026
RK		Other Agency Costs	£000s	224 ▲	218 ▲	135 ▲	→		192 ▼	→		177 ▲	1953	1057	1410		0 - 5% Variation	5 - 10% Variation	>10% Variation	1661	2223	3759
KD		Medical Locum Costs	£000s	238 ▲	265 ▼	275 ▼	→		273 ▲	→		247 ▲	2221	1687	2250		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	2566	2445	2747
RK/KD		Agency Spend cf. Total Pay Spend	%	2.64 ▼	2.11 ■	1.83 ■	→		2.01 ■	→		2.39 ▼	2.24	<2.00	<2.00		<2	2 - 2.5	>2.5	1.50	2.15	2.77
CH	Sickness Absence	Long Term	%	3.19 ▼	3.18 ▲	3.42 ■	→		3.25 ■	→		3.40 ■	3.00	<3.00	<3.00	n	<3.0	3.0-3.35	>3.35	2.50	3.52	3.16
		Short Term	%	1.17 ■	1.23 ▼	1.59 ■	→		1.59 ■	→		1.33 ■	1.29	<1.25	<1.25		<1.25	1.25-1.40	>1.40	2.17	1.26	1.22
		Total	%	4.36 ▲	4.41 ▼	5.00 ■	→		4.84 ▲	→		4.73 ■	4.29	<4.25	<4.25		<4.25	4.25-4.75	>4.75	4.67	4.78	4.38
	Recruitment & Retention	Permission to Recruit	wte	72	90	100	→		61	→		42	680	No. Only	No. Only					n/a	1143	1124
		New Starters	wte	274	142	85	→		50	→		28	843	No. Only	No. Only					n/a	855	1066
		Leavers	wte	245	94	73	→		43	→		65	701	No. Only	No. Only					n/a	1004	999
		Inductions	No.	104	87	83	→		71	→		31	666	No. Only	No. Only					n/a	442	896
	Learning & Development	PDRs (includes Junior Med staff)	No.	632 ▲	499 ▼	295 ■	→		185 ▼	→		99 ▼	3633	4005	5341	o	0-5% variation	5 - 15% variation	>15% variation	n/a	1963	4518
		Mandatory Training Compliance	%			40.1 ■	→		41.4 ▲	→		55.7 ▲	55.7	100	100		=>80	50 - 79	<50	4313 (No.)	2770 (No.)	4044 (No.)

KEY TO PERFORMANCE ASSESSMENT SYMBOLS

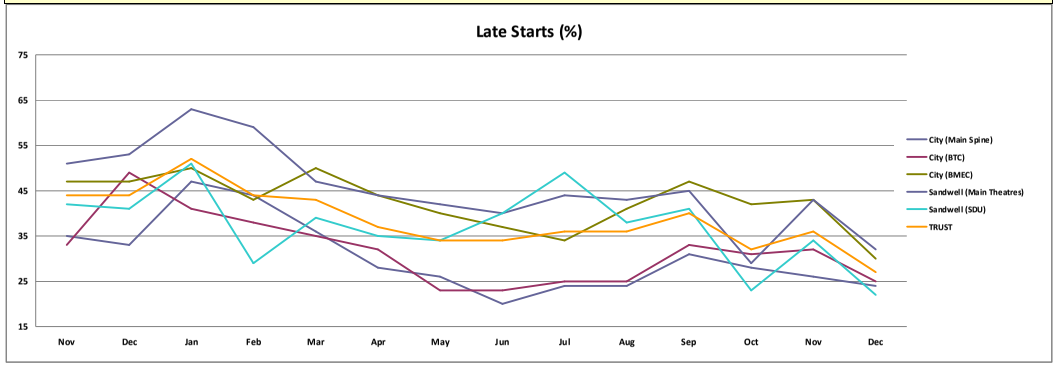
▲	Fully Met - Performance continues to improve
■	Fully Met - Performance Maintained
▼	Met, but performance has deteriorated
▲	Not quite met - performance has improved
■	Not quite met
▼	Not quite met - performance has deteriorated
▲	Not met - performance has improved
■	Not met - performance showing no 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

SUPPLEMENTARY DATA THEATRE UTILISATION

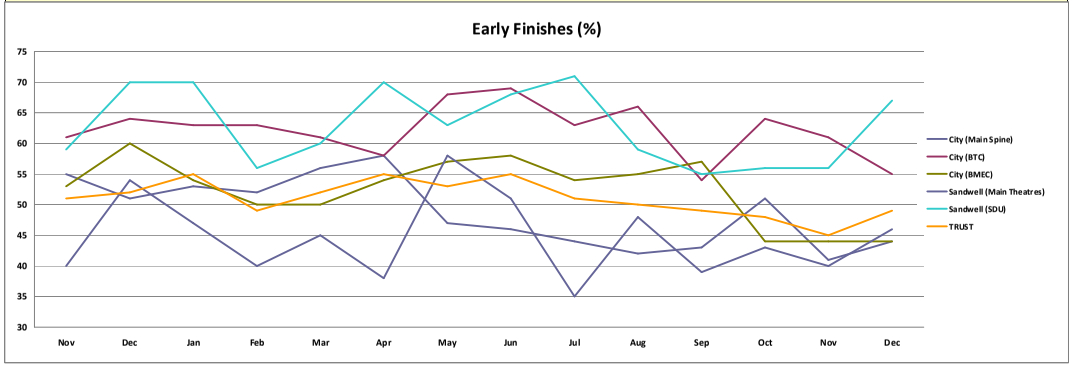
LATE STARTS (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	35	33	47	44	36	28	26	20	24	24	31	28	26	24			
City (BTC)	33	49	41	38	35	32	23	23	25	25	33	31	32	25			
City (BMEC)	47	47	50	43	50	44	40	37	34	41	47	42	43	30			
Sandwell (Main Theatres)	51	53	63	59	47	44	42	40	44	43	45	29	43	32			
Sandwell (SDU)	42	41	51	29	39	35	34	40	49	38	41	23	34	22			
TRUST	44	44	52	44	43	37	34	34	36	36	40	32	36	27			

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



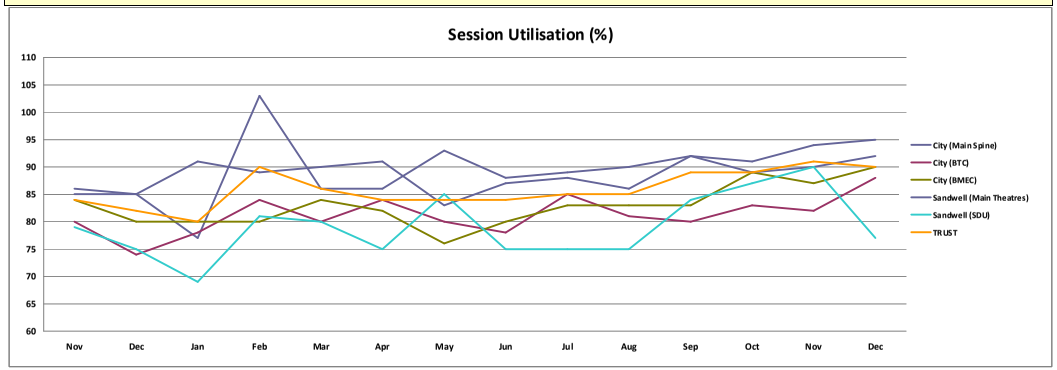
EARLY FINISHES (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	55	51	53	52	56	58	47	46	44	42	43	51	41	44			
City (BTC)	61	64	63	63	61	58	68	69	63	66	54	64	61	55			
City (BMEC)	53	60	54	50	50	54	57	58	54	55	57	44	44	44			
Sandwell (Main Theatres)	40	54	47	40	45	38	58	51	35	48	39	43	40	46			
Sandwell (SDU)	59	70	70	56	60	70	63	68	71	59	55	56	56	67			
TRUST	51	52	55	49	52	55	53	55	51	50	49	48	45	49			

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



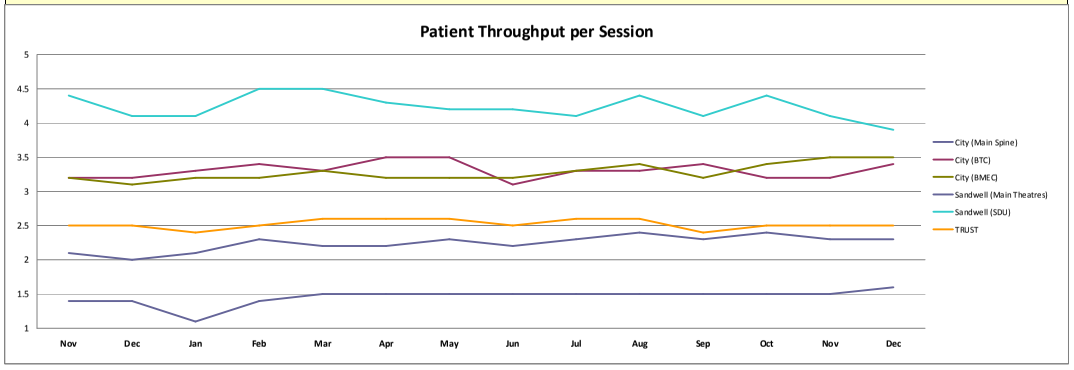
SESSION UTILISATION (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	86	85	77	103	86	86	93	88	89	90	92	91	94	95			
City (BTC)	80	74	78	84	80	84	80	78	85	81	80	83	82	88			
City (BMEC)	84	80	80	80	84	82	76	80	83	83	83	89	87	90			
Sandwell (Main Theatres)	85	85	91	89	90	91	83	87	88	86	92	89	90	92			
Sandwell (SDU)	79	75	69	81	80	75	85	75	75	75	84	87	90	77			
TRUST	84	82	80	90	86	84	84	84	85	85	89	89	91	90			

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



THROUGHPUT / SESSION	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	1.4	1.4	1.1	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.6			
City (BTC)	3.2	3.2	3.3	3.4	3.3	3.5	3.5	3.1	3.3	3.3	3.4	3.2	3.2	3.4			
City (BMEC)	3.2	3.1	3.2	3.2	3.3	3.2	3.2	3.2	3.3	3.4	3.2	3.4	3.5	3.5			
Sandwell (Main Theatres)	2.1	2.0	2.1	2.3	2.2	2.2	2.3	2.2	2.3	2.4	2.3	2.4	2.3	2.3			
Sandwell (SDU)	4.4	4.1	4.1	4.5	4.5	4.3	4.2	4.2	4.1	4.4	4.1	4.4	4.1	3.9			
TRUST	2.5	2.5	2.4	2.5	2.6	2.6	2.6	2.5	2.6	2.6	2.4	2.5	2.5	2.5			

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:	28 January 2010

SUMMARY OF KEY POINTS:

The **NHS Performance Framework Monitoring Report** provides an assessment of the Trust's performance mapped against the indicators which comprise the framework. Please note the following changes to the framework:

- Assessment of 'Cancer 31-day second or subsequent treatment' performance is differentiated into Surgical Treatment and Drug Treatment. The weightings for all three components of the 31-day cancer target assessment have been revised, although the sum of all weightings remains unaltered.
- A number of 'Achieve' and 'Fail' thresholds have been revised, against which performance since October has been assessed. Of particular note is that the Stroke (Stay on Stroke Unit) Indicator Achieve and Fail thresholds have been revised to 60% and 30% from 80% and 50% respectively.
- Areas of underachievement identified in the report for Q3 are Accident & Emergency 4-hour waits and Stroke Care (Stay on Stroke Unit).

Foundation Trust Compliance Report – the Trust's Governance Risk Rating remains AMBER due to current A/E 4-hour wait performance, and in-year non-compliance with two Care Quality Commission Core Standards.

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	
Core Standards	
Auditors' Local Evaluation	Internal Control and Value for Money

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

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

PREVIOUS CONSIDERATION:

Finance and Performance Management Committee on 21 January 2010.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2009/10

Operational Standards and Targets

Indicator	Weight	Thresholds Achieve	Thresholds Fail	2009 / 2010 October	Score	Weight x Score	November	Score	Weight x Score	December	Score	Weight x Score	Q3	Score	Weight x Score
A/E Waits less than 4-hours	1.00	98.00%	97.00%	99.00%	3	3.00	96.70%	0	0.00	96.20%	0	0.00	97.26%	2	2.00
Cancelled Operations - 28 day breaches	1.00	5.0%	15.0%	0	3	3.00	0	3	3.00	0	3	3.00	0	3	3.00
MRSA Bacteraemia	1.00	0	>1.0SD	1	3	3.00	2	3	3.00	0	3	3.00	3	3	3.00
Clostridium Difficile	1.00	0%	>1.0SD	14	3	3.00	14	3	3.00	14	3	3.00	42	3	3.00
18-weeks RTT (Admitted)	1.00	90.0%	85.0%	97.6%	3	3.00	93.4%	3	3.00	>90.0%*	3	3.00	>90.0%*	3	3.00
18-weeks RTT (Non-Admitted)	1.00	95.0%	90.0%	97.7%	3	3.00	97.3%	3	3.00	>95.0%*	3	3.00	>95.0%*	3	3.00
• Achievement in all specialties (inc. DAA Audiology, exc. Orthopaedics)	0.50	95.0%	90.0%	>95.0%*	2	1.00	>95.0%	3	1.50	>95.0%*	3	1.50	>95.0%*	3	1.50
• Achievement in Orthopaedics	0.50	95.0%	95.0%	97.4%	3	1.50	96.4%	3	1.50	>95.0%*	3	1.50	>95.0%*	3	1.50
Cancer - 2 week GP Referral to First Outpatient Appointment	1.00	93.0%	88.0%	94.5%	3	3.00	96.1%	3	3.00	>93.0%*	3	3.00	>93.0%*	3	3.00
Cancer - 31 day second or subsequent treatment (surgery)	0.33	94.0%	89.0%	100%	3	0.99	97.6%	3	0.99	>98.0%*	3	0.99	>98.0%*	3	0.99
Cancer - 31 day second or subsequent treatment (drug)	0.33	98.0%	93.0%	100%	3	0.99	100%	3	0.99	>96.0%*	3	0.99	>96.0%*	3	0.99
Cancer - 31 day diagnosis to treatment for all cancers	0.33	96.0%	91.0%	99.4%	3	0.99	99.4%	3	0.99	>96.0%	3	0.99	>96.0%	3	0.99
Cancer - 62 day referral to treatment from screening	0.33	90.0%	85.0%	100%	3	0.99	100%	3	0.99	>90.0%*	3	0.99	>90.0%*	3	0.99
Cancer - 62 day referral to treatment from hospital specialist	0.33	85.0%	80.0%	93.8%	3	0.99	75.0%	0	0.00	>85.0%*	3	0.99	>85.0%*	3	0.99
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%	89.2%	3	0.99	89.9%	3	0.99	>85.0%*	3	0.99	>85.0%*	3	0.99
3-month revascularisation breaches (as % admissions)	1.00	0.1%	0.2%	0.0%	3	3.00	0.0%	3	3.00	0.0%*	3	3.00	0.0%*	3	3.00
2-week Rapid Access Chest Pain	1.00	98.0%	95.0%	100%	3	3.00	100%*	3	3.00	100%*	3	3.00	100%*	3	3.00
48-hours GU Medicine Access	1.00	98.0%	95.0%	99.50%	3	3.00	100%	3	3.00	100%	3	3.00	99.8%	3	3.00
Delayed Transfers of Care	1.00	3.5%	5.0%	3.60%	2	2.00	2.60%	3	3.00	3.90%	2	2.00	3.40%	3	3.00
Stroke (Stay on Stroke Unit)	1.00	60%	30.0%	59.4%	2	2.00	46.4%	2	2.00	30 - 60%*	2	2.00	30 - 60%*	2	2.00
Outpatient Waits >13 weeks (% of First OP Attendances)	0.50	0.03%	0.15%	0.000%	3	1.50	0.000%	3	1.50	0.000%*	3	1.50	0.000%*	3	1.50
Inpatient Waits >26 weeks (% of Elective Admissions)	0.50	0.03%	0.15%	0.000%	3	1.50	0.000%	3	1.50	0.000%*	3	1.50	0.000%*	3	1.50
				* Except Gastroenterology			* Projected			* Projected			* Projected		
Sum	**16.00**					**45.44**			**42.95**			**42.94**			**45.94**
Average Score						**2.84**			**2.68**			**2.68**			**2.87**

Scoring:	
Fail	0
Underachieve	2
Achieve	3

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

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2009/10

Financial Indicators

Criteria	Metric	Weight (%)		SCORING 3	SCORING 2	SCORING 1	2009 / 2010 October	Score	Weight x Score	November	Score	Weight x Score	December	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	3	0.15	0	3	0.15	0	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	-0.04%	3	0.6	-0.03%	3	0.6	-0.02%	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.	7.80%	3	0.15	7.86%	3	0.15	7.78%	3	0.15
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	0.00%	3	0.6	0.00%	3	0.6	0.00%	3	0.6
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	7.69%	3	0.15	7.76%	3	0.15	7.73%	3	0.15
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45
Underlying Financial Position	Underlying Position (%)	10	5	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	0.61%	3	0.15	0.60%	3	0.15	0.60%	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	7.69%	3	0.15	7.77%	3	0.15	7.74%	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	68.00%	2	0.05	69.00%	2	0.05	70.00%	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	57.00%	1	0.025	67.00%	2	0.05	67.00%	2	0.05
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	1.05	3	0.15	1.05	3	0.15	1.04	3	0.15
	Debtor Days		5	Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	20.35	3	0.15	21.00	3	0.15	22.10	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	42.53	2	0.1	44.19	2	0.1	46.80	2	0.1
						Weighted Overall Score			**2.9**			**2.9**			**2.9**

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Corporate Objectives 2009/10 – Progress Report (Quarter 3)
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Ann Charlesworth, Head of Corporate Planning
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

The report contains a summary of progress, at the end of Quarter 3, towards the achievement of the Trust's Corporate Objectives set out in the Annual Plan 2009/10.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To note progress made on the corporate objectives at Q3.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Outlines progress towards those objectives.
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Trust Management Board on 19 January 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ANNUAL PLAN 2009/10
CORPORATE OBJECTIVES PROGRESS REPORT (QUARTER THREE)

INTRODUCTION

The Trust's Annual Plan for 2009/10 set a series of corporate objectives for the year to ensure that we make progress towards our six strategic objectives. Progress on the majority of these objectives is reported to the Board at regular intervals either through routine monthly reports on finance and performance or through specific progress reports. Progress across all objectives is also reported quarterly to ensure the Board has a clear overview of our position.

QUARTER THREE PROGRESS

A summary of the position on each objective at the end of Quarter 3 is set out in the table that accompanies this report. An overview of the Q3 RAG assessment for each objective is set out in the table below.

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
1. Accessible and Responsive Care				
1.1 Ensure continued achievement of national access targets				
1.2 Deliver Single Equality Scheme for 2009/10				
1.3 Improve compliance with single sex accom. standards				
1.4 Improve communication with patients about their care				
1.5 Identify key hospital actions to improve public health				
2. High Quality Care				
2.1 Infection control - achievement of national and local targets				
2.2 Complete implementation of surgical reconfiguration				
2.3 Improve quality of care for patients with stroke / TIA				
2.4 Deliver improvements in the Trust's maternity services				
2.5 Deliver the Trust's "Optimal Wards" programme				
2.6 Develop approach to clinical quality				
2.7 Deliver CQUIN targets				
2.8 Achieve NHSLA standards				
2.9 Improve care provided to Vulnerable Adults and Children				
2.10 Ensure the Trust fully meets the EWTD standards				
3. Care Closer to Home				
3.1 Right Care Right Here Programme exemplar projects				
3.2 Outpatient facilities in Aston HC, Rowley Regis Hospital				
3.3 Community Ophthalmology service for S. Birmingham PCT				
4. Good Use of Resources				
4.1 Delivery of planned surplus of £2.3m				
4.2 Delivery of CIP of £15m				
4.3 Service improvement - theatres, outpatients and bed mgt.				
4.4 Introduce routine service line reporting				

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
5. 21st Century Facilities				
5.1 Continue to deliver New Hospital Project as planned				
5.2 Deliver the capital programme				
5.3 With PCTs design major community facilities				
6. An Effective NHS FT				
6.1 Continue to pursue NHS FT status				
6.2 Continue to achieve Annual Healthcheck Core Standards				
6.3 Mandatory training and the LiA "Time to Learn" project				
6.4 Spread staff engagement through Listening into Action				
6.5 Next stages of the Trust's clinical research strategy				
6.6 Improve the Trust's approach to leadership development				
6.7 Improve response to the national carbon reduction strategy				

At the end of the third quarter, more than half of the objectives are now assessed as green. Following the adjustment to objective 6.1 regarding NHS FT status, at the end of the last quarter, this is now assessed as amber.

There are two red rated objectives. Objective 1.5 remains red, where there has been no progress with PCTs on identifying hospital actions to improve public health. Objective 2.8 has been changed to red reflecting the fact that the NHSLA level 2 general assessment has had to be deferred to 2010/11.

CONCLUSION AND RECOMMENDATIONS

This report and the accompanying table present an overview of the position on our corporate objectives for 2009/10 at the end of Q3. The Trust Board is recommended to:

1. NOTE the progress made on the corporate objectives at Q3.

Ann Charlesworth
January 2010

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
TRUST OBJECTIVES 2009/10: QUARTER THREE PROGRESS REPORT

PROGRESS REPORTING

Progress with many of the corporate objectives will be reported to the Board monthly through for example the monthly performance and finance reports (e.g. progress with 2009/10 financial plan and progress with national access targets) or through specific monthly reports (e.g. 'Right Care Right Here' programme reports). In addition to this and in order to ensure that the Board has a clear view of progress across the corporate objectives as a whole it is intended to report progress quarterly, as we have throughout the last year, using a traffic-light based system at the following Board meetings:

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

CATEGORISATION

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

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

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Three (Dec 2009)**	**Red / Amber / Green Assessment**
1.	***Accessible and Responsive Care***			
1.1	Ensure continued achievement of national access targets (A&E, cancer, inpatient, outpatient and diagnostics and GUM). RK	• A&E 4 hour target achievement • Cancer target achievement (2 weeks, 31 days and 62 days) • 18 week referral to treatment targets • Maximum waits for IP, OP and diagnostic treatment (13 wks OP, 26 wks IP, 6 wks diagnostic) • Rapid access chest pain 2 week target achievement • GUM 48 hour access targets	• A&E(4 hour) = 98.48% 9/12 YTD, 97.29% in Q3 • Cancer targets (Mths 7&8): 2 Weeks = 95.2% threshold = >93% 31 Days = 99.4% threshold = >96% 62 Days = 89.5% threshold = >85% • 18 weeks (Month 08): Admitted RTT = 95.5% Non-Adm. RTT = 97.5% • Max. Waits: IP = max wait 19 weeks (Month 08) OP = max wait 12 weeks (Month 08) Cardiac = max wait 6 weeks (Month 08) Diagnostics = 2 greater than 6 weeks, none >13 weeks (Month 08) • Rapid access chest pain = est. 100% (based on 2 mths data for the quarter) • GUM 48 hour access: Offered App't = 99.8% for Q3 Seen = 86.8% for Q3	**3**
1.2	Deliver commitments in Single Equality Scheme for 2009/10 RO	• Evidence of Impact Assessment of both policies and services • Training reports show good update of training • Workforce demographic data published on website and an action plan for managing diversity	Impact assessments continue to be completed. A database is established and trend analysis is being undertaken. SES has been revised for the next TB report. Interpreter review planned.	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Three (Dec 2009)**	**Red / Amber / Green Assessment**
1.3	Improve patient privacy and dignity by increasing compliance with single sex accommodation standards. RK	• Improvement with single sex standards demonstrated through audits	Latest position and plans for further work agreed by Trust Board in December 2009. Routine monitoring of breaches now in place and will be included in corporate performance report. Privacy and Dignity prioritised during December. Position at City will be kept under review but progress made since summer.	**3**
1.4	Continue to improve communication with patients about their care. RO	• Evidence from two inpatient surveys per year plus national survey • Patient experience action plan updated and reported to Trust Board.	Inpatient surveys continue. Plans are being developed for surveys of vulnerable patients/patients who do not speak English as a first language. Easy read version now available.	**3**
1.5	Work with Sandwell and HoBtPCTs to identify key hospital actions that will contribute to improvements in public health. DOD	• Agreement of plan with PCTs. • Achievement of measures included in plan	Initial discussions have been held with PCT Directors of Public Health and further detail is due to be worked up shortly Follow up meeting deferred by PCT due to illness and snow.	**1**
2.	***High Quality Care***			
2.1	Ensure continued improvement in infection control and achievement of national and local targets. RO	• MRSA targets achieved. • C difficile target achieved. • Compliance with Hygiene Code • Meeting national cleanliness standards • Improvements in hand hygiene audits • Increased access to hand wash facilities	Targets continue to be achieved at Q3. MRSA Screening: • Elective Screens = 6108 • Non-Elec. Screens = 6433 C. Diff: • 42 cases (target trajectory <65) MRSA Bacteraemia: • 3 cases (target trajectory <9)	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Three (Dec 2009)**	**Red / Amber / Green Assessment**
2.2	Complete implementation of surgical reconfiguration RK	• Reconfiguration completed by June 09	Surgical reconfiguration now complete following changes to T&O in May 2009. Impact will be reviewed at 6 months and 12 months.	**3**
2.3	Deliver significant improvements in quality of care for patients with stroke / TIA. DOD	• Agreement of stroke services plan • Delivery of actions set out in plan • Improved % of time on stroke unit • Improved access to CT scan within 24 hours.	Stroke Action Team set up to implement Stroke Plan developed in 2008/09. Stay on Stroke Unit (Month 08): • The proportion of patients spending >90% of their hospital stay on a stroke unit has fallen from 67.3% in August to 46.4% in Nov. Further work is underway to understand the reasons for this underperformance. Access to CT Scan (Q3): • 86.0% patients received Scan within 24 hours admission 24/7 CT now implemented both sites	**2**
2.4	Deliver significant improvements in the Trust's maternity services. JA	• Successful delivery of action in Maternity Integrated Development Plan. • Improved performance on key measures (see monthly Performance Report). • Successful delivery of Risk Mitigation Action Plan • Complete configuration review	Risk Mitigation Plan continues to be fully operational. Sandwell theatre staffing issue now resolved (prev red risk). Remaining short term risks relate to midwifery staffing (particularly community). Medium term reconfiguration consultation progressing and concludes mid January. On track for reports to February Boards. Dashboard indicators continue positive trends. [Caesarean Section Rate 24.6% - Q3]	**3**
2.5	Deliver the Trust's "Optimal Wards" programme. RO	• Ward reviews undertaken. • Results demonstrate progress in key areas. • Improvement in ward accreditation scores over the year.	Optimal Wards continues. 21 wards now in the programme. Ward reviews are currently being undertaken again. Staff establishment review completed for medicine. Surgical review commenced.	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Three (Dec 2009)**	**Red / Amber / Green Assessment**
2.6	Develop the Trust's approach to measuring and managing clinical quality. DOD	• Launch of Quality Management Framework • Production of Quality Account • Regular assessments of mortality rates at specialty level and at Trust Board	Quality Management Framework reviews have commenced. 2nd cycle commenced Jan 2010. Clinical Executive Team launched successfully. Extended to include Clinical Directors Work has commenced on producing Quality Account.	**3**
2.7	Deliver CQUIN targets: - time to surgery for fractured neck of femur; - access to CT scan for stroke patients; - reduced caesarean section rate; - improved outpatient data quality (referral source); - introduction of patient surveys; - referral of patients to smoking cessation services - provide annual report for Neonatal and Cardiology Specialised Services - improve reporting of Neonatal Intensive Care data DOD	• Achievement of targets agreed in the detail of the CQUIN agreement.	Aim to integrate CQUIN data into QMF and monitor regularly. Hip Fracture: • 83.8% (Q3) [88.0% - Dec] received operation within 48 hours admission (target 85.0%) CT Scan Access: • 86.0% (Q3) patients received Scan within 24 hours admission (target 72%) Data definitions clarified. Caesarean Section Rate: • 24.6% (Q3) (target 26.0%) OP Source of Referral Info: • 1.01% (Q3) not stated (target <5.5%) Smoking cessation • 297 (Q3) (target = 250) • 373 YTD (target = 750) Smoking cessation target is now at risk despite a promising start to the electronic referral system.	**2**
2.8	Achieve NHSLA standards Level 2 (general) by December 2009 and new Level 1 (maternity) by March 2010. KD	• Achievement of NHSLA standards.	Despite progress in moving forward the outstanding issues relating to mandatory training, the time taken to achieve this resulted in the Trust having to defer a Level 2 assessment in December. A revised date has been requested from the NHSLA, preferably in the first quarter of 2010/11. Work is continuing to address the areas of non-compliance and ensure there is no loss in momentum.	**1**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Three (Dec 2009)**	**Red / Amber / Green Assessment**
			In line with NHSLA requirements, a Level 1 assessment of the general standards is scheduled for March 2010. Work is on track for the CNST maternity level one assessment in March 2010. Action plans for both assessments are managed at monthly project groups.	
2.9	Improve the quality of care provided to Vulnerable Adults (e.g. patients with mental health difficulties or learning disabilities) and Children – to include Safeguarding Children standards. RO	• Agreement of plan for improvement for both vulnerable adults and children including performance measures • Establish structures • Delivery of plan • Compliance with core standards	Structure in place. RAG action plans in place. Training now being recorded and reported. Some concerns about resourcing incident investigation and report writing.	**2**
2.10	Ensure the Trust fully meets the EWTD standards for junior doctors by August 2009. KD	• Achieve EWTD compliance	EWTD compliant working patterns for all junior doctors employed by the Trust (366) have been introduced. Full compliance with the EWTD requirements for all junior doctors has therefore been achieved. This corporate objective has been met.	**3**
3.	***Care Closer to Home***			
3.1	Ensure full Trust participation in delivery of Right Care Right Here Programme exemplar projects. RK	• Exemplar projects achieve their targets for 2009/10	Exemplar projects and project targets agreed for 2009/10. Projects making progress against targets for this year. Some projects where further work needed on data flows to ensure evidence of delivery of changes. Trust contributing to development of next set of projects for 2010/11.	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Three (Dec 2009)**	**Red / Amber / Green Assessment**
3.2	Make full use of outpatient facilities in Aston HC, Rowley Regis Hospital. RK	• Plans agreed to make maximum use of facilities • Increased volumes of outpatients delivered from these locations.	Currently delivering range of specialties from Aston. Expect to deliver 1,500 – 2,000 atts per annum on current plans. Rowley Regis delivering c. 10,000 atts per annum. Short-term expansion of services at Rowley will concentrate on Ophthalmology (subject to availability of capital). Discussions continuing with HoB about the future of Aston and Greet HCs. Trust has tendered to provide a community cardiology service from Greet HC.	**2**
3.3	Deliver successful community ophthalmology service for South Birmingham PCT. RK	• Activity delivered in South Birmingham community service.	Community service now operational from Hall Green and Edgbaston and West Heath locations providing a range of clinics per week from each venue. Work remains in progress on options for fourth location in Selly Oak area.	**3**
4	***Good Use of Resources***			
4.1	Delivery of planned surplus of £2.3m. RW	• Achievement of financial target.	Current year end forecast remains on target although there are a handful of divisions with ongoing budgetary pressures. At present income related overperformance is keeping pace with costs such that the Trust can continue to forecast B/E by year-end.	**3**
4.2	Delivery of CIP of £15m. RW	• Achievement of CIP.	The position on CIP delivery continues to improve and is presently forecast to deliver in full. There is now a very small undershoot, however for this reason the rating remains amber. Full details are reported to FMB and F&PMC.	**2**
4.3	Develop approach to service improvement concentrating on theatres, outpatients and bed management RK	• Service improvement plan agreed. • Improved theatre and outpatient utilisation.	Service improvement and elective access teams continuing to improve outpatient processes concentrating on handling of referrals. Has resulted in significant improvement in outpatient waiting times in many specialties.	**2**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Three (Dec 2009)**	**Red / Amber / Green Assessment**
			Theatre improvement work concentrating on second wave of activity including planning for launch of Productive Operating Theatre programme. December and January theatre data shows improvements in late starts. Bed management work continues to concentrate on development of real-time bed management system.	
4.4	Introduce routine service line reporting to support development of clinical management structure. RW	• Service line reporting in place. • Impact demonstrated through F&PC reviews of Divisions.	SLM group recently met with Ardenta and also received a presentation from a leading FT advanced in the implementation of SLR/M. The Trust's most recent position statement for specialties has been published and there are plans to provide further quarter based updates in this financial year. However, as these are still being worked on, the rating remains as amber.	**2**
5	***21st Century Facilities***			
5.1	Continue to deliver New Hospital Project as planned. GS	• OBC approved • Land acquired where possible through voluntary agreement • CPO launched and statutory process ongoing • Draft OJEU procurement documentation prepared and ready for PFU approval • OBC review documentation prepared	OBC approved by DH Some land owners engaged on voluntary basis CPO launched OJEU documentation being prepared RCRH Programme affordability review to reflect revised long term financial planning assumptions initiated	**2**
5.2	Continue to improve current facilities through the delivery of the capital programme including: - replacement MRI scanner at City - upgrade of accommodation at City (MAU and D16) GS	• Major capital projects delivered in line with programme • Programme managed to deliver Trust objectives • Capital Budget managed in line with project delivery.	Major construction projects on plan reported in detail to SIRG	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Three (Dec 2009)**	**Red / Amber / Green Assessment**
5.3	Fully engage with PCTs in design of major community facilities (Aston, BTC, Rowley Regis and Sandwell). GS	• Submission of Business case/LIFT stage 1 approval for each development agreed with PCTs through Right Care Right Here Programme.	Revised guidance on business case content may challenge submission date RCRH Programme affordability review to reflect revised long term financial planning assumptions initiated	**2**
6	***An Effective NHS Foundation Trust***			
6.1	Continue to pursue NHS Foundation Trust status and explore complementary approaches to further increasing patient, public and staff engagement. JA	• Trajectory for FT or alternative status agreed with SHA by 31/3/09	National FT status deadline extended to 2013. New Operating Framework requires FT or alternative trajectory to be agreed with SHA by 31/3/09. Plans in hand to meet that deadline but time for planning is constrained. Links also to RCRH/Acute Hospital scenario planning.	**2**
6.2	Continue to achieve Annual Healthcheck Core Standards KD	• Core standards achieved.	Core standards C20b (compliance with single sex accommodation standards) was declared by the Trust as 'not met' and carried forward into 2009/10. The date for implementing the actions to address the issues identified was December 2009. A report confirming achievement was presented to the December Trust Board. Informed by the work to prepare for the NHHSLA assessment, difficulties in meeting the requirements for mandatory training came to light. Actions are on-going to address the difficulties identified. As a consequence, core standard C11b was declared as 'Not Met', given that there is insufficient assurance of compliance. The plan is to address this by 31st March 2010	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Three (Dec 2009)**	**Red / Amber / Green Assessment**
			In order to avoid confusion with trusts' applications for CQC registration, which will start in January 2010, this year's core standards assessment is to be based on a mid-year declaration, i.e. the position as at 31st October 2009. Two of the 24 core standards (C11b and C20b) were declared as 'not met' in the declaration to the Care Quality Commission.	
6.3	Deliver improved uptake of mandatory training and implement the LiA "Time to Learn" project. LB/GD	• Uptake of mandatory training	Internal web-based IT solution developed and introduced. Work on-going to validate data and ensure accurate compliance reporting. Additional mandatory training capacity to be provided from Jan-Mar 2010 including increased access via e-learning A 'Learning Passport' for the 'Time to Learn' Project has been designed and a revised implementation plan is being drawn up.	**2**
6.4	Continue to spread staff engagement through Listening into Action including delivery of the LiA "Enabling Our People" projects. JA	• Spread of LiA projects • Progress with "Enabling Our People" • Staff views reported through staff survey	Further increase in new projects. New project management arrangements in place and working well. LiA used for QuEP planning, clinical engagement and sustainability projects. Paper on strategic future of LiA to January Board.	**3**
6.5	Establish the next stages of the Trust's clinical research strategy. DOD	• Strategy agreed • Progress with implementation • Recruitment of patients into clinical trials	New Director of R&D – 1st June New Head of R&D – 4th May Review of R&D currently being undertaken in order to develop strategy. Aim for 1st draft Strategy by end Sept and complete by Jan 2010. Draft strategy now out to consultation	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Three (Dec 2009)**	**Red / Amber / Green Assessment**
6.6	Improve the Trust's approach to leadership development. LB/GD	• Review of current management and leadership development activity • Agreed programme of future work	The ethos and principles of the Trust's Staff Engagement approach (LiA) has been included in all existing management development programmes. The review of leadership development activity is complete and makes a further recommendation for future work to commence to develop an overarching framework to govern leadership development activity and associated organisational processes.	**2**
6.7	Improve the environmental sustainability of the Trust's operations by responding to the national carbon reduction strategy. GS	• Agreed plan to improve sustainability • Improved performance in measures identified in the plan	Presentation on Sustainability given to Board. Sustainability plan developed and approved Work on action plan ongoing Sustainability group established	**3**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Sustainable Development Management Plan Update
SPONSORING DIRECTOR:	Graham Seager, Director of Estates/New Hospital Project
AUTHOR:	Rob Banks, Head of Estates
DATE OF MEETING:	28 January 2010

SUMMARY OF KEY POINTS:

The purpose of this paper is to update the Trust Board on the progress to date with the sustainability agenda following the previous sustainability management action plan presented to the Board in November 2009.

KEY POINTS:

- Sustainable Development Group action plan finalised (Appendix 1)
- Good Corporate Citizenship Assessment Model (Appendix 2)
- Sustainability Champions (Appendix 3)

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 progress made to date.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Improve the environmental sustainability of the Trust's operations by responding to the national carbon reduction strategy.
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	Standard 2.3.4 – Trust can demonstrate commitment to sustainability

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

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

PREVIOUS CONSIDERATION:

The Sustainability Development Group has approved:

- The Sustainability Action Plan
- The GCC Assessment
- The Sustainability Champion

Sustainability Update to the Trust Board

Introduction

The purpose of this report is to update the Trust Board on progress to date with sustainability and identify next steps.

Sustainable Development Management Plan

The Sustainable Development Management Plan was presented to the Trust Board at the November meeting. The action plan has been further developed to incorporate feedback from Hot Topics. Subsequently the Sustainability Steering Group have agreed timescales for completion of short, medium and long term priorities and have assigned leads for each of the actions. The timescales for actions are as follows:

Short term – December 2010
Medium term – December 2013
Long term – December 2016 (New Acute Hospital)

The action plan is shown as Appendix 1. Success in achieving these actions will improve the Trusts contribution to the sustainability agenda.

Good Corporate Citizenship Assessment Model (GCCAM)

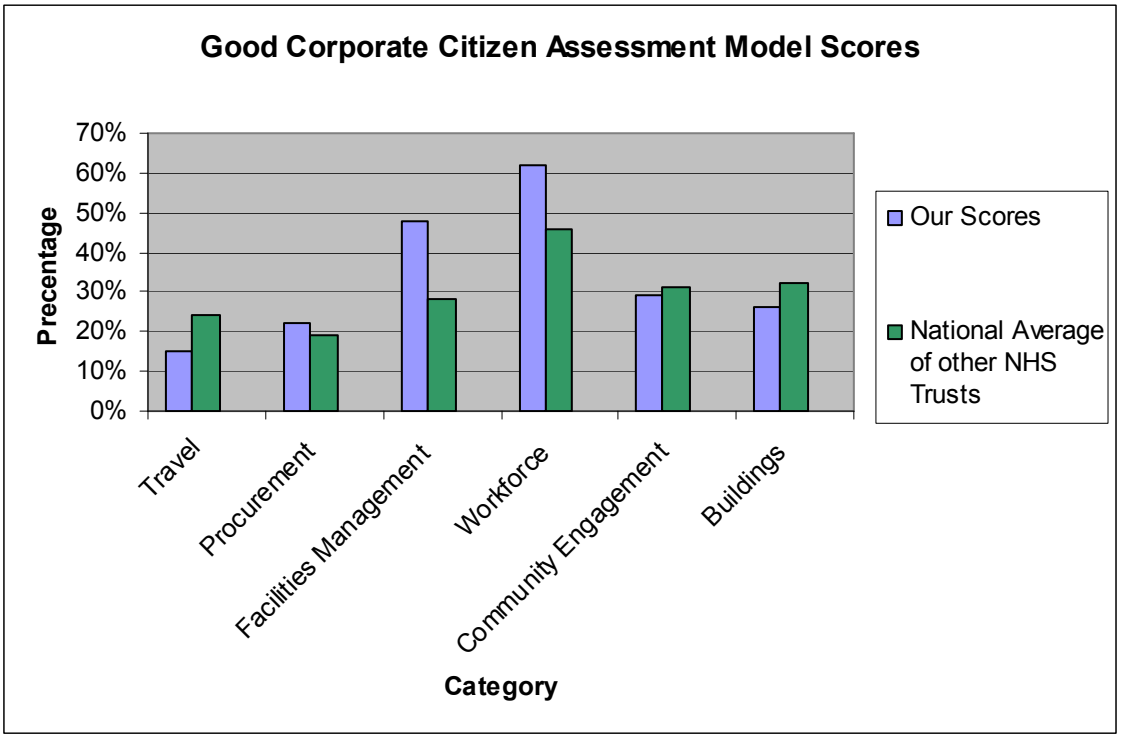
The GCCAM is a voluntary sustainable development assessment tool which covers the following areas:

- Travel
- Procurement
- Facilities Management
- Workforce
- Community Engagement
- Buildings

A range of questions are asked for each of the section identified above with score awarded on a scale of 0 to 9 split up into categories

0, 1, 2 and 3 – getting started
4, 5, and 6 – getting there
7, 8 and 9 – excellent

Each of the 6 areas has been assessed by the most appropriate person or department in the Trust. A summary of the results are shown below and further details of the assessment are shown in Appendix 2.



To help to understand where our organisation should aim to be (at a minimum) over the period from here to 2020, the Sustainability Development unit has produced the guidance below:

- By 2012, your organisation should be “Getting there” (min. score of 4) in at least two questions in each area of the test – or achieve a minimum of 37% in each area of the results
- By 2015, your organisation should be “Excellent” (min. score of 7) in at least two questions in each area of the test – or achieve a minimum of 70% in each area of the results
- By 2020, your organisation should score a minimum of two top-marks in “Excellent” (score of 9) and all other scores must be at least “Excellent” (range 7-9) – or achieve a minimum of 85% in each area of the results.

Our results compared to other NHS Trusts show that areas for development are Travel, Procurement ,Community Engagement and Buildings to achieve in the very least “getting there “ 37% by 2012.

Positive outcomes from GCC can be seen in relation to Workforce and Facilities Management as we have already achieved 2012 targets however, these areas need to be sustained and improved upon year on year.

The Trust Sustainability action plan has identified actions on all areas for development which should contribute to improvements across all 6 categories. A further assessment will be undertaken in twelve months following completion of the short term actions of the sustainability action plan.

Sustainability Champions

One of the key issues raised during the Sustainability Listening into Action event and endorsed by the Sustainability Steering Group is the need to establish sustainability champions across all sectors of the Trust. Some staff have already expressed an interest in becoming a sustainability champion. However, further work is required to ensure we have a good level of representation across the Trust. To achieve that a flyer has been produced (see Appendix 3) explaining the role of the sustainability champions and the commitment required of them. A training session is being arranged for March 2010. The need for sustainability champions will be included in Hot Topics to encourage recruitment of potential champions to attend the training sessions

Rob Banks
Head of Estates

APPENDIX 1

Sustainability Development Group

ACTION PLAN

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
1.00	**TRAVEL ARRANGEMENTS (patients, visitors, staff)**								
1.01			S	M	L				
a)	More clinical activity in the community – less patients travel				✓			RIGHT CARE RIGHT HERE GS	
b)	Patients – travel details supplied with appointments and suggestions of how to get to the hospital				✓			RIGHT CARE RIGHT HERE GS	
c)	If patient have several appointments at hospital manage time so they only have to come once				✓			RIGHT CARE RIGHT HERE GS	
d)	Reduction in patients' visits – more towards RCRH modes of care				✓			RIGHT CARE RIGHT HERE GS	
1.02	Staff travel/general travel arrangements		S	M	L				
a)	Travel – single permit for car parking rather than two, transport links improved, car sharing, free bicycle for staff who live near the Trust – car parking only for staff who lives further than 3 miles			✓				DA/SC/JB/DH FACILITIES	
b)	One day a month no vehicles on site			✓				DA/SL/RB/SC	
c)	Regular competitions to promote sustainable travel			✓				DA/SL/RB/SC	
d)	Smarter driving – all Trust's vehicles on bio fuel, smart driving lessons			✓				DH/SC/SS FACILITIES	
								RIGHT CARE	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
e)	Fully integrated transport systems – bus services, direct onto hospital site, re open local railway station				✓			RIGHT HERE GS	
f)	Replace shuttle bus with more sustainable vehicle			✓				DN/SS/SC FACILITIES	
g)	Shuttle bus could pick up from central point to get to work			✓				DH/SS/SL FACILITIES	
h)	Review car parking charges for low emission of carbon vehicles			✓				DA/DH/SS/SL FACILITIES	
i)	Green travel plan	The creation of travel plan will include items A-H & J	✓					DA/SC/RB/SL	
j)	Link up with Toyota who make Hybrids to get some deal on corporate sponsorship for negotiated rates			✓				DH/SC FACILITIES	
k)	Do not pay travel expenses to staff that choose to drive between Sandwell and City, rather than using the shuttle bus?		✓					SL/FINANCE/TMB	
2.00			**S**	**M**	**L**				
a)	Essential to measure all critical areas to ensure progress can be measured and reported against – smart meters, energy monitoring, put in more controls on heaters, energy efficient electrical equipment			✓				RB/SL/KR	
b)	Change all light bulbs to eco friendly	Lighting schemes to incorporate design for energy saving on future projects	✓			• Estates and Capital to ensure that energy saving lighting is considered for future projects • Estates to ensure that all lighting when replacement as a reactive or proactive task utilise energy saving technology	• Estates have replaced a large number of lights across the Trust with energy saving fittings	RB/IH/ESTATES	Dec 09
c)	Double doors that shut automatically			✓				PF/ESTATES	
	Heating on/off appropriate time of	Utilise Building Management				• Collect data for Sandwell and	• Ongoing modification to	SK/ESTATES	Dec 09

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
d)	the year/day	System to control heating and review / update schedules	✓			City space utilisation including times of use	heating controls under statutory standards funding		
e)	Energy performance	Energy usage to be publicised across the Trust to show status	✓			• Use Trust Media to pass information	• Display Energy Certificates displayed to all Buildings over 1000m2	RB/PF/ESTATES	
f)	Energy hotline, sustainability well publicised on website	To promote work of SWG and how staff can assist to achieve corporate goal	✓			• Update webpage regularly • Hold awareness sessions • Utilise all user emails • Use Estates Helpline answer phone for energy tips • Energy Tips to be put on intranet • Energy Champion request	• Two Energy Awareness days held in Dec 09 in conjunction with Energy Saving Trust • Sustainability email address established • Links on Estates webpage to external bodies for advice	SL/KR/PM	Dec 09
g)	Fit low energy measurers to buildings (sensor lighting, sensor laps)	To incorporate in design of new areas or upgrades		✓		• To be made standard in design brief • New Technology to be reviewed and evaluated for potential use	• Sensor Taps fitted to all upgrades	RB/KR/ESTATES	Dec 09
h)	Servers powering down when not in use, energy efficient computer rooms				✓			SP/JB	
i)	Turning temperature down 2C and cut down external lighting		✓					SL/RB	
j)	Being able to turn off patient line monitors when not in use		✓					SC/SL/IT/ML	
k)	Windows that open easily?			✓				PF/ESTATES	
l)	Experimenting with Biomass Fuels, schemes and production plants are now being developed as part of the sustainable fuels initiative, such operations could claim support under the Renewable Obligation and Climate Change Levy. .				✓			RIGHT CARE RIGHT HERE GS	
m)	Turn off plugs/lights out of hours at plug point		✓					RB/IH/ESTATES	
n)	Heating on and windows open, close doors		✓					RB/SL/ESTATES	
o)	Turn heating off in some areas for the weekend	See comments for 2d as duplicate	✓					RB/SK/ESTATES	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
	Non touch light switches motion sensors								
p)	Buy stand by savers for computers		✓					SP/IT/ESTATES	
q)	More reminders to switch off the light – stickers to put up in all areas	To promote switch off campaign	✓			• Supply SWBH labels to Energy Champions to fit • To provide posters with examples of how much can be saved and what it relates to in patient care • Develop Energy Champion packs • Provide Energy Champion sessions	• Energy Awareness days have provided a number of potential energy champions	ENERGY CHAMPIONS ESTATES SL	
r)	Green gas, electricity, burning recycled waste				✓			RIGHT CARE RIGHT HERE GS	
s)	Switch it “off” campaign	See comments for 2q	✓					ENERGY CHAMPIONS ESTATES SL	
t)	Funds from Salix Finance for refurbishment of buildings			✓				RB/GS/SWG	
u)	Make staff cost aware of what is spent on energy – monthly energy spend advised to staff in “Heartbeat	See comments for 2e	✓					SL/SWG	
v)	Practical implementation – double glazing, modernising buildings to preserve energy, A-rated appliances		✓					RB/KR	
w)	Wherever possible use our own waste to generate fuel, use solar panels for water heating and energy				✓			RIGHT CARE RIGHT HERE GS	
x)	Energy smart equipment, ground source heat pumps, solar films				✓			RIGHT CARE GS	
y)	Competition between wards/departments for the most	To provide enthusiasm to continue involvement of departments through local	✓			• Establish a quarterly award and determine prize and funding	• Support for annual award given by John Adler at LiA review in Dec 09	SL/SWG/ ENERGY CHAMPIONS	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
	energy efficient department	reward				• Establish a yearly Trust Award • Establish submission document			
3.00	**GOVERNANCE**								
a)	Sustainability development budget plans for all prospects			✓				GS/SL/TMB	
b)	Carbon officers for departments (similar to H&S)	To promote locally work of SWG and Trust to reduce carbon footprint	✓			• Develop Energy Champion packs • Provide Energy Champion sessions • Hold regular updates and utilise Trust media to promote role • Contact all interested parties • Present to Senior Nurse Forum	• Energy Awareness days have provided a number of potential energy champions	RB/SL/SWG	Dec 09
c)	Pilot some ideas before moving to the new hospital to see what works and what not		✓					ESTATES/ SWG RB	
d)	Employ energy manager		✓					GS/RB/SL	
e)	Introduce sustainability award	See comments 2y	✓					SL/RB	
f)	Introduce budget holder responsibility			✓				GS/RB/SL/TMB	
g)	Energy reduction schemes implemented	To implement major schemes to Trust Infrastructure through capital funding or externally sourced fund		✓		• To complete schemes as identified in 2009/10 Statutory Standards funding • Risk Assessment to be updated to identify future actions and savings that can be produced	• Works identified and works ongoing	KR/SL/ESTATES	Dec 09
h)	Trust needs an environment policy	To provide a framework for the Trust to work too and identify roles and responsibilities				• Policy to be approved by TMB • Policy to be promoted across organisation	• Policy in draft format	KR/SL/ESTATES	Dec 09
i)	Mandatory environmental training as part of the induction		✓					AA/RB/L & D	
j)	Study days or workshops for greener Trust	See comments as 3b	✓					AA/RB/SL/SWG	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
k)	Choose one champion for each department to monitor energy saving/recycling/making the ward greener and money saving team	See comments 3b	✓					SL/JK/SWG	
l)	Sanction for breaking the roles should be implemented with regards to greener environment in a workplace			✓				SWG/GS	
m)	Introduce rewards for lowering carbon footprint	See comments 2y		✓				GS/RB/SL/SWG/TMB	
n)	Cascade information – set targets for environmental training			✓				AA/SL/L & D	
o)	Local budgeting				✓			GS/RB/TMB/ ESTATES	
p)	Introduce reporting of sustainability programmes at Trust level – pass on shared experience		✓					GS/SL/JC/SWG	
q)	Carbon management programme		✓					PF/SL/RB	
r)	Carbon survey from Carbon Trust			✓				SL/PF/RB	
s)	Responsibility for every employee – targets, aims, objectives		✓					KR/GS/SWG	
t)	Steering Group	To promote sustainability across the Trust	✓			• Members to take lead for actions as shown in this action plan • Provide point of contact • To monitor and review organisation with regard to sustainability	• Meeting developed with terms of reference • Meetings scheduled for 2010 • Action plan developed	GS/RB/SL	Dec 09
u)	Focus groups to reach high energy users		✓					RB/PF/SL/SWG	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
v)	Include in PDR's	To make as a corporate objective and on all individuals PDR		✓		• Create Trust policy for Sustainability and identify individuals actions • Speak with Unions for involvement	• Spoke to HR advised policy is best route to avoid revisiting all JDs	GS/RB/SL/SWG/TMB	Dec 09
w)	Liaise with other hospitals, City Council	To share best practice with others and learn from others	✓			• Gather ideas and formats used to avoid time wasting • Look for good ideas	• External agencies now members of SWG from PCT and Birmingham Council • Contacted other Trusts and Universities and have been given names and address to speak with.	SL/SWG	Dec 09
x)	Devolution of responsibilities to each department	To provide guidance on roles and responsibilities through Trust Policy		✓		• Policy to be approved by TMB • Policy to be promoted across organisation	• Policy in draft format	GS/RB/SWG/TMB	
y)	Awareness of carbon impact of decisions			✓				SL/JK/SWG/ TMB	
z)	Give financial rewards for green departments	See comments 2y		✓				GS/JK/SWG/TMB	
a1)	Consult with staff non compliance		✓					GS/SL/JK/SWG	
a2)	Strategy needed for equipment replacement – to environmentally friendly			✓				RB/LB/SWG	
4.00	**PROCUREMENT**								
a)	Re use of envelopes for internal letters		✓					SL/JK/TMB/SWG	
b)	Encourage to bring their own food to work			✓				JO/SC	
c)	Use email to communicate information on sustainability	To communicate to a Trust wide audience	✓			• Send regular all user emails • Communicate to champions on regular basis	• Sustainability email address set up Oct 09 • Articles in Green Heartbeat Nov 09	SL/KR/RB	Nov 09
d)	Holding staff events and suggestion schemes	To communicate to a Trust wide audience	✓			• Energy Champion events • Attend departmental LiA events on sustainability	• LiA Event held Oct 09 • LiA Estates events in Oct 09 • Energy Awareness days in Dec 09	SL/KR/RB	Nov 09
	Pharmaceutical procurement –							BH/JM	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
e)	educating staff about the life cycle of the product, this could encourage appropriate level of purchase rather than		✓						
f)	Shop around for best eco friendly option		✓					JM	
g)	Nitrous free anaesthesia		✓					BH	
h)	Material reclamation facilities		✓					DH/SS/SWG	
i)	Paper, food, waste recycling/anaerobic digestion (offices and other areas)		✓					SC/SS/SWG	
j)	Reduced computer print outs		✓					SP/IT/SWG	
k)	Reduction and correct segregation of clinical waste		✓					SS/SWG	
l)	Stock control audits, internal stock supply, fewer deliveries		✓					JM/SWG	
m)	Have on site shredding facility, use recyclable products		✓					SS/JM/SWG	
n)	Repair rather than throw		✓					SL/BH/JM/JC/SS/SWG	
o)	Buying of pharmaceuticals from companies which concentrate on lowering their carbon footprint			✓				BH/JM/JK	
p)	Buying medical devices from carbon footprint aware manufacturers			✓				LB/JM	
q)	Don't waste resources by sending questionnaires etc to home addresses, use email, internal mail		✓					JK	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
r)	Stop sending staff payslips home		✓					SL/FINANCE/SWG	
s)	Issuing electronic payslips where possible would increase efficiency and reduce costs long term.		✓					SL/FINANCE/SWG	
t)	The Trust should not send mail to the home addresses of employees where they can use the internal mail.		✓					SL/KR/TMB SWG	
u)	Learn how to rotate stock efficiently		✓					JM/SWG	
v)	Recycling bins and systems to be put in place, on site biomass/waste energy		✓					SS/SWG	
w)	Stock rationalisation group to include ethical			✓				JM/SWG	
x)	Avoid sterilization of unneeded item			✓				MC/SWG	
y)	Measure carbon output – for individual departments			✓				RB/SL/SWG	
z)	Documents to be viewed on line, double sided printing		✓					SP/IT/TMB/SWG	
aa)	Food – local, seasonal, anaerobic digestion Food – less meat		✓					SC/JO/SWG	
bb)	Electronic payslips, e-invoicing, twitter, e-procurement		✓					GS/FINANCE/SWG	
cc)	Use of own mugs, caps no plastic ones, stop deliveries of bottled water		✓					JM/SWG	
dd)	Share photocopiers		✓					SP/IT/SWG	
		To promote sustainability in		✓		• Promote use of email address	Sustainability email address set up		

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
ee)	Open 2014 hotline	Trust				by staff and champions to request information • To send information via email address			
ff)	Cut down on instructions in pocket drugs			✓				BH/RB/SWG	
gg)	Make better use of video conferencing		✓					ML/BH/SWG	
hh)	Regular email remainders about environmental issues	See comments ll	✓					SL/IT/SWG	
ii)	Could NHS mail be used more reducing resource required for Trust email, archive and Blackberry servers?		✓					SL/RB/SWG	
jj)	Installing laser jet printers for secretaries as these are more cost effective than desk jets in the long run		✓					SP/IT/ML/SWG	
kk)	Standardise equipment, such as printers, so cartridges could be bought in bulk, rather than piecemeal.		✓					SP/IT/SWG	
ll)	IT to look at printers, every printer is different and requires different ink cartridges. Be aware of how much cartridges cost, some printers may be cheap but the ink is expensive.		✓					SP/IT/JM/SWG	
mm)	Are there areas where a large, shared, leased printer/photocopier /scanner is available and staff still have individual printers on desk?		✓					SP/IT/JM/SWG	
nn)	Why so many staff have costly colour laser printers? Could Medical Illustration print high quality colour when required?		✓					SP/IT/JM	
oo)	Monitoring the use of the photocopier – assigning a cost code whereby an invoice gets sent to each department instead of the Nursing division or for all of Arden House. Need to maintain a record/ know of who is spending		✓					JM/SWG	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
	what.								
pp)	There is no need for photocopying reams of notes/reports, Maintain electronic files which could save cost of not also printing out every email for the paper file- double entry and waste of paper/ink			✓				JH	
rr)	Heartbeat could be printed for each group of staff rather than individuals, or could there be an e-version to save even more money (and trees).		✓					JK/KE/JM/SWG	
ss)	Don't duplicate information leaflets i.e. if already given out ante-natal, do not then give them out again post-natal.		✓					JK/JM/SWG	
tt)	Unnecessary dispensing of medication. Make sure medication is actually required. Inappropriate prescribing does the patient need analgesia on discharge. Large amounts of analgesia are dispensed and then returned to Pharmacy unused.		✓					BH/SWG	
uu)	Use patients' medication more efficiently on admission. Improve advertising, via appointment letters encouraging that they always bring in their medication to hospital. This also helps with drug reconciliation and drug history taking, but also means that drugs already dispensed from outside the hospital are utilised correctly and assessed for suitability. Advertise in GP surgeries, out-patient departments and the BTC with posters and leaflets.			✓				BHSWG	
ww)	Should we review the quantity of drugs supplied for short stay surgery patients. Patients are discharged on up to 28 days supply. Drugs are re-supplied when there is less than 14 days supply remaining. Surgery patients may not require such a large quantity			✓		•		BH/SWG	
xx)	Education at all levels – do not use/open thing you do not need			✓		•		SL/RB/SWG	
yy)	Implement team working at all times with regards to greener environment			✓		•		SL/RB/SWG	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
zz)	Self discipline for each and everyone			✓		•		GS/TMB	
aaa)	Staff involvement and participation – knowledge and understanding, training, visibility and cooperation			✓		•		GS/KB/RB/SL/SWG	

Members of Sustainability Steering Group

Graham Seager (GS)	Jilly Croasdale (JC)	Brian Hebron (BH)	Adam Andrews (AA)	Rob Ashley (RA)
Rob Banks (RB)	Diane Alford (DA)	Sally Fox (SF)	Steve Lawley (SL)	Jessamy Kinghorn (JK)
David Newbould (DN)	Jenny Marshall (JM)	Simon Sims (SS)	Paul Russell (PR)	Hamish Brown(HB)
Ali Shaukat (AS)	Keith Budden (KB)			

Others

IT - Information Technology
L & D - Learning and Development
DT - Debbie Talbot
MC - Mike Caufield
LB – Lawrence Barker
SC - Steve Clarke
JO - Jane Owen
ML - Martin Lynch
RCRH - Right Care Right Here (RB/GS)

Timescales

Targets	Time Scale
Short term	Dec 2010
Medium term	Dec 2013
Long term	Dec 2016 (New Acute Hospital)

Group Involved – lead of the group highlighted in yellow

Good Corporate Citizen Assessment Model Scores

View your scores

Submitted on 15/01/2010 at 08:38

Travel	
Policies and performance	1
Area planning	2
Service delivery and estates design	2
Active travel	1
Business travel	1
Traffic management	1
Procurement	
Policies and performance	4
Procurement skills	2
Procurement process	2
Engaging suppliers	1
Minimising waste	1
Ethical procurement	2
Facilities Management	
Policies and performance	4
Energy use and carbon	5
Waste	5
Water	4
Hazardous substances	4
Green space	4
Workforce	
Policies and performance	5
Diversity and inclusion	7
Valuing workforce	n/a

Healthy workplace	5
Childcare and carer support	6
Learning and development	5
Community Engagement	
Policies and performance	2
Local partnership and planning	4
Community participation	4
Healthy and sustainable food choices	n/a
Assets and resources	1
Communication	2
Buildings	
Policies and performance	4
Planning	3
Design	2
Sustainable procurement	2
Energy and carbon	2
Green space	1

Become a Local Sustainability Champion

As part of the "Sustainability Awareness Campaign", the Trust is recruiting "Local Sustainability Champions" (LSCs) to help reduce our carbon footprint. It will not require a big time commitment but will make a difference, and anyone can take part. Training and full support will be given through the Sustainability Working Group.

The role will require you:

- To be pro-active in promoting good energy /water/waste/transport /carbon reduction/procurement saving practices at a local level.
- To help to co-ordinate activities in your area.
- To attend a 2 to 3 hour training session.
- To report to the Sustainability Working Group ideas for saving energy/water/transport/procurement/waste and carbon reduction. Also to report staff suggestions, complaints or maintenance/operational issues.
- To conduct sustainability walkabouts in your area.
- To raise awareness in your area on sustainability matters, and to promote Trust procedures relating to energy usage, waste management, transport, carbon reduction and procurement
- To act as local contact point for literature/publicity.

If you are interested in becoming Local Sustainability Champion or want more information - get in touch, either by email - sustainability@swbh.nhs.uk or by phone on 0121 507 3504 or 0121 507 5638.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance and Performance Management Committee – v0.2

Venue Ground Floor Cttee Room, Sandwell Hospital **Date** 17 December 2009; 1100h – 1300h

Members Present		In Attendance		Secretariat
Mr R Trotman	[Chair]	Mr T Wharram		Mr S Grainger-Payne
Mrs S Davis		Mr M Harding		
Miss I Bartram				
Mrs G Hunjan		**Guests**		
Dr S Sahota		Mr M Beveridge	[Item 4.1 only]	
Mr J Adler		Mr S Power	[Item 4.1 only]	
Mr R White				
Mr R Kirby				

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies for absence were received from Professor Derek Alderson.	
2 Minutes of the previous meeting – 19 November 2009	**SWBFC (11/09) 220**
The minutes of the previous meeting were reviewed and an amendment was agreed to the phrasing of paragraph 6.1 to indicate that Mrs Davis noted that the shortfall against the CIP had not yet been recovered fully, yet was optimistic that the end of year target could still be reached.	
AGREEMENT: The minutes of the previous meeting were approved subject to minor amendment	
3 Matters arising from the previous meeting	**SWBFC (11/09) 220 (a)**
The updated actions log was noted by the Committee.	
4 Presentation by the Anaesthetics and Critical Care division	**SWBFC (12/09) 228**
Mr Mike Beveridge and Mr Shaun Power joined the meeting to present an overview of the Anaesthetics and Critical Care division's financial position and current activities. The Committee was reminded that the division comprised anaesthetics, critical care and pain management areas. The November financial position was reported to be £109k adverse variance. Total expenditure of £149k was reported to be offset in part by £40k associated with an over recovery on income from pain management work. Capacity has been increased to meet the needs of the additional demand for pain management.	

Plans are being devised with the PCTs to develop community services for this work. Significant pressure on the division is associated with anaesthetics and critical care work. There has been difficulty in recruiting to medical staffing positions in anaesthetics, however these are currently being covered by locum and agency staff. This reflects in the overall financial position of the division, whereby £76k adverse variance in pay is associated with medical staffing. In critical care, capacity may be flexed according to the number of patients being treated, whereby a greater number of high dependency patients will prompt a higher complement of staff. Patient staffing levels are determined by the number of organs requiring support, which in turn suggests the number of points on which the area should be operating. In the first quarter, it had been anticipated that the area would operate on 31 points, although this actually operated on 35 points causing pressure on pay and non-pay expenditure. The Committee was advised that the dependency level had since returned to expected levels and there has been a corresponding decline in the pay bill. Controls around the usage of bank and agency staff have also been introduced and the possibility of flexing resources across sites has been investigated. Little resistance to this suggestion has been received to date. Non-pay issues were highlighted to relate to activity and the source of referrals relates more significantly to medicine than surgery areas. The division's CIP stands at £768k and is on track for delivery as planned. In Quarter 4 approval will be sought for a number of replacement schemes to address the areas of the CIP that are currently off track. Improvements in theatre productivity have been seen, although it was acknowledged that there is significant further work to achieve a greater improvement. The increased number of theatre sessions has added an extra pressure to the work. The Committee was reminded that it would be given an update on progress with addressing theatre utilisation at its meeting in January. The division's Quality and Efficiency Programme (QuEP) contributions were discussed. Mr Beveridge was asked whether any income had been generated for research in the area. He advised that little income has been received in relation to research to date, however this capacity would be developed in the coming months. It is hoped that sponsorship would fund the research. Mr Trotman asked whether the proposed £140k additional income within the division's QuEP was achievable. Mr Beveridge advised that this was a realistic target, given the opportunity in pain management. Mr Trotman asked where improved procurement processes were built into the future plans. He was advised that there is scope for savings across many areas of the division in this respect and preliminary investigations have been undertaken. Mr White added that this would be given greater focus in the coming year on a more comprehensive scale, and will include rationalising the number of deliveries made to the Trust and the standardisation of implants. Mrs Davis remarked that she thought that discussions concerning standardisation of implants had already occurred with the Heathcare Purchasing Consortium (HPC). She was advised that work had been undertaken with HPC, although there was more work to do to ensure more efficient purchasing is undertaken and single tender agreements are minimised. Mr Beveridge highlighted that tubing and masks could be standardised, however the current usage remains reflective of the premerger configuration of the hospitals. Mr Kirby summarised that the financial recovery of the division has been significant	

and is attributable to bank and agency staff control and associated pay rate changes in this area, together with overperformance on income. Mr Beveridge and Mr Power were thanked for their informative presentation.	
5 Trust Board performance management reports	
5.1 2009/10 month 8 financial position and forecast	**SWBFC (12/09) 222** **SWBFC (12/09) 222 (a)** **SWBFC (12/09) 222 (b)**
Mr Wharram reported that an in-month surplus of £135k against a target surplus of £118k was achieved in-month. In-month WTEs were noted to be 15 below plan, with the cash balance being £2.5m greater than the revised plan as at 30 November. It was highlighted that steady progress had been made towards recovering the previous shortfall against budget. Workforce numbers were also reported to have declined against plan and there had not been any need to use general reserves to address the in-month position. The overall position was reported to be reflective of overperformance and the costs to deliver this additional work by opening extra capacity. Some provision has been made to allow for any challenge that the PCTs may make to the overperformance. Surgery B was noted to be affected significantly by this overperformance. Medicine divisions have experienced an increase in costs disproportionate to income received. Mr Trotman asked whether the EBITDA had reduced. Mr Wharram advised that this was the case, although this was a steady reduction. Mr Wharram was asked whether the year-end forecast remained achievable. He advised that there was optimism that the forecast could be attained. Mr White was asked what the position was in respect of outstanding data challenges by the PCTs. He reported that much work had been undertaken to ensure that the PCTs were aware that the overperformance on outpatient with procedure cases, were being offset in part by the savings associated with emergency spells. In terms of the coming financial year, it was highlighted that the position is expected to be challenging, particularly if a punitive tariff for overperformance is to be introduced and work is to be decommissioned. Dr Sahota asked whether there was confidence that the non-pay outturn could be met. He was advised that there is a degree of flexibility and phasing that will assist with meeting this target. Uncommitted reserves will be used for any redundancy costs for the current year. Mr Adler noted that the current arrangements regarding bank and agency staff control were working well. A number of changes to the capital programme were proposed, which were noted to be small scale and were approved.	
5.2 Performance monitoring report	**Hard copy paper**
Mr Harding reported that cancelled operations in ophthalmology, oral surgery and general surgery had increased. The issue in respect of general surgery concerns the demand for beds during the periods. The ophthalmology situation concerns the cancellation of elective cases in favour of emergencies. Mr Kirby highlighted that the current HR issues in some theatres are also contributing to the overall	

performance however work was underway to resolve the matter. In terms of oral surgery, the majority of contributions were associated with the sickness absence of a key surgeon in the area. Performance against the delayed transfers of care target was noted to have improved, although more recent data suggests that the performance may have deteriorated within December. The proportion of cancellations for Birmingham patients in Sandwell was reported to be at its highest level in recent times. Fines may need to be levied if the situation persists. The position regarding performance against the stroke care target was noted to be more disappointing that predicted. It was highlighted that there is much work underway to refine the stroke care pathway, however the recent demand for beds was noted to be hampering good progress. It is anticipated that the situation may be alleviated in the new year. The Committee's attention was drawn to the tension between the single sex accommodation requirements and the expeditious treatment of stroke patients. Mr Adler stressed that the primary responsibility should be to treat stroke patients quickly and efficiently. Performance against the Accident and Emergency waiting time target was noted to have deteriorated, although the impact on the year to date position remains above the overall target. The referral to treatment performance information was reported to be being validated, however Mr Kirby advised that it is likely that the target for meeting inpatient orthopaedics cases waiting times will not have been met. Two diagnostic waiting times were also reported to have exceeded six weeks. In terms of performance against the CQUIN targets, the electronic smoking cessation referrals process has been introduced. The number of referrals has been lower that desired however, therefore Mr O'Donoghue, Medical Director, is investigating the reasons behind this. Performance against ambulance turnaround times was noted to be slightly better the regional position. Mandatory training compliance was reported to stand at 41.4%, although more recent estimates suggest that this had increased to 53.4%. Mr Adler advised that a target of 75% compliance by 31 March 2010 has been set for all areas to ensure compliance with Core Standard C11b.	
5.4 HR dashboard	**SWBFC (12/09) 223** **SWBFC (12/09) 223 (a)**
Mrs Lesley Barnett joined the meeting to present an updated version of the HR dashboard. The Committee was advised that during July to September 2009, a steady increase in the number of contracted WTEs had been seen. A significant recruitment exercise for midwifery and nursing staff was noted to have occurred in September. Diversity across the Trust was reviewed. It was noted that the 'mixed heritage' category was based on a self-assessment by staff. The Committee was advised that the 'not stated' category may increase as fewer people declare their ethnic background. Mrs Davis remarked that there was a possibility that some wards may be comprised of staff from a single ethnic background. Mrs Barnett offered to determine the position and report back to coincide with the next presentation of the HR dashboard. Mrs Davis also asked whether the category 'white' could be broken down into more detail analysis. Furthermore, Mrs Barnett was asked to	

undertake an analysis of the number of declarations of ethnicity received by the Trust in comparison to a more rural trust where the majority of staff would be classed as 'white'. A divisional picture of sickness absence across the divisions was considered. The Committee was informed that the recently published 'High Impact Nursing Actions' aims to reduce nursing sickness absence to 3%. Mr Adler advised that the discussion around sickness absence was being considered in detail by the Financial Management Board and it is planned that a greater focus on sickness management will be given as part of the divisional review process. Mr Trotman suggested that 'real time' information should be fed back to managers to assist with the prompt management of sickness absence. Miss Bartram noted that although there was a small number of disciplinaries, it appeared that a high proportion of these staff were Asian. She asked how many suspensions lead to a disciplinary investigation and activity. Mrs Barnett advised that the majority lead to disciplinary action, however few cases progress from investigation to a disciplinary hearing. It was agreed that the ethnic mix of staff involved with disciplinaries needs to be monitored. Mr Adler suggested that an approach analogous to that for mortality alerts within the Trust should be adopted, whereby a case alert prompts the view of the case notes for the individual. It was noted that the HR dashboard contained a significant amount of information which may need to be refined. It was agreed that Mrs Davis would organise for the Non Executive Directors to meet with the two acting directors of Workforce to discuss the requirements in more detail. Mrs Barnett was thanked for the useful report and discussion.	
ACTION: **Mrs Barnett to present the position regarding wards with comprising staff from a single ethnic group at a future meeting of the Finance and Performance Management Committee** **ACTION:** **Mrs Barnett to present a breakdown of the 'white' ethnicity group at a future meeting of the Finance and Performance Management Committee** **ACTION:** **Mrs Barnett to present an analysis of ethnicity staff responses comparing the Trust's position with that of a rural trust at a future meeting of the Finance and Performance Management Committee** **ACTION:** **Mrs Davis to convene a meeting between the Non Executive Directors and the two Acting Heads of Workforce to discuss refinements to the HR Dashboard**	
5.5 Foundation Trust compliance report	**Hard copy paper**
As the information presented was noted to be a subset of the monthly performance management information, the Committee noted the report. The Governance Risk Rating was amber in reflection of the deterioration of performance against the Accident and Emergency waiting time target and the declaration of non-compliance against the addition Core Standard.	
5.6 NHS performance framework	**Hard copy paper**
Mr Harding presented the Trust's performance against the indicators comprising the	

NHS performance framework. The Committee was pleased to note that the Trust remains classified as a 'performing' organisation, despite the amber rating.	
6 Service line reports 2008/09	**SWBFC (12/09) 224** **SWBFC (12/09) 224 (a)**
Mr White presented a diagrammatic representation of the income and expenditure position for each speciality, showing where each was positioned relative to each other. It was noted that the position had been gained from the annual audited accounts for 2008/09 and had been calculated under HRGv3.5. The position will be reassessed against the tariff due to be issued for 2010/11. Mr White highlighted that if the speciality was represented in the upper right quadrant of the diagram, then a positive net surplus was being made. If in the upper left, efficiencies need to be made. Those specialities of concern, were noted to be represented in the bottom left of the diagram. The size of the circle representing the speciality was reported to be reflective of the number of procedures undertaken by the Trust in relation to the rest of the NHS. An engagement and challenge process for the relevant clinicians is planned, particularly where the speciality had been shown to be non-profit making. Operational efficiencies will be discussed as part of the review process. Mrs Davis asked how long it would be before the information was available on a ward by ward basis. She was advised that it was likely to be nine months before this level of detail was available. It was agreed that the information should be obtained and reviewed on a more regular basis, particularly as the information may be mapped to clinical directorates.	
7 Cost improvement programme (2009/10)	
7.1 CIP delivery report	**SWBFC (12/09) 225** **SWBFC (12/09) 225 (a) -** **SWBFC (12/09) 225 (c)**
Mr Wharram presented the monthly 2009/10 CIP delivery report, which it was noted had been reviewed in detail at the Financial Management Board meeting. It was noted that as a result of a number of changes in the programme, some problematic areas have now been replaced by some successful schemes. The overall shortfall was highlighted to be £65k. The Surgery A position remains an area of focus.	
7.2 Quality and Efficiency programme (QuEP) update	**SWBFC (12/09) 227** **SWBFC (12/09) 227 (a)**
Mr Adler presented a summary of the progress with the workstreams forming the Quality and Efficiency Programme (QuEP). The good progress with the programme was noted. Two further workstreams have been added since the Committee was initially appraised of the plans: cross-organisational IT solutions and High Impact Nursing Actions. In terms of the CIP element of the QuEP, the plans will be signed off for approval by the end of January 2010, together with the divisional and directorate planned contributions to the QuEP. The plans will be presented at the February meeting of Finance and Performance Management Committee and Trust Board, together with	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

any risks and 'hot spots'.	
8 Minutes for noting	
8.1 Minutes of the Strategic Investment Review Group	**SWBSI (12/09) 001**
The Committee noted the minutes of the SIRG meeting held on 10 November 09.	
8.2 Actions and decisions from the Strategic Investment Review Group	**SWBFC (12/09) 227**
The Committee noted the actions and decisions arising from the meeting of SIRG meeting held on 8 December 09.	
8.3 Minutes of the Financial Management Board	**SWBFM (11/09) 113**
The Committee noted the minutes of the FMB meeting held on 17 November 09.	
9 Any other business	**Verbal**
There was none.	
10 Details of next meeting	**Verbal**
The next meeting is to be held on 21 January 2010 at 1430h in the Executive Meeting Room at City Hospital.	

Signed .....

Print .....

Date .....

MINUTES

Sandwell and West Birmingham Hospitals NHS Trust

Governance and Risk Management Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 19 November 2009; 1030h – 1230h

Members Present

Miss I Bartram	[Chair]	Mr R White
Mr R Trotman		Mr D O'Donoghue
Professor D Alderson		Miss K Dhami
Mr J Adler		Miss R Overfield

In Attendance		**Secretariat**
Mrs R Gibson	[Items 1 – 12 only]	Mr S Grainger-Payne
Mr S Parker	[Items 1 – 7 only]	
Miss D Dunn	[Items 12 - 13 only]	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received no apologies for absence.	
2 Minutes of the previous meeting	**SWBGR (9/09) 054**
The Governance and Risk Management Committee approved the minutes of the meeting held on 17 September 2009 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 (9/09) 054 (a)**
The updated actions list was noted by the Committee.	
4 Dr Foster alerts report: mortality	**SWBGR (11/09) 060** **SWBGR (11/09) 060 (a)**
Mr Parker presented an update on mortality alerts from the Dr Foster intelligence system for the previous three months. He highlighted the alert in connection with Non Hodgkinson lymphoma is currently being investigated by the Clinical Director for Haematology. A mortality outlier had been received in respect of peripheral and visceral atherosclerosis. A review of the associated cases has been reviewed by the Clinical Director for colorectal and upper GI surgery, the outcome of which will be reported to the Care Quality Commission. Lessons learned and changes to be made will be	

identified thereafter. It was noted that the response should be issued by Mr O'Donoghue as Medical Director. Mr Parker was asked whether the higher number of incidents during the financial year was significant. He pointed out that number remain small in the overall context of cases handled by the Trust. A further alert has been received in respect of readmissions following hernia repair. Again the Clinical Director for colorectal and upper GI surgery has been asked to undertake a review of the associated case notes. It was noted that this alert had not been received through the Dr Foster alerts system. Mr Trotman asked whether it was possible to link individual consultants to alerts received and if so, whether trends in this respect had been reviewed. Mr O'Donoghue advised that the wider mortality review work will address this issue. Professor Alderson added that the Dr Foster alerts system is not designed to provide trends against individual consultants.	
5 Update from the Mortality Steering Group	**Verbal**
Mr O'Donoghue reported that systems were now in place to ensure that a scanned copy of the notes of every patient that dies is sent to the relevant clinical directors for review, together with an audit tool to facilitate an assessment of whether the death was avoidable or was expected. The process has close links to the risk management and incident reporting system in that deaths that look as though they were avoidable may be classified as a red incident. Miss Bartram asked how long after a patient had been discharged, that a death would be recorded. She was advised that in terms of the Dr Foster system, patients dying within 30 days of discharge will be associated with the Trust. Mr O'Donoghue reported that Standardised Mortality Rates (SMRs) are due to be rebased, which will result in a score of 105 for the Trust. Overall for the Strategic Health Authority, the rebasing has meant a 7% difference to the previous figures, although this is higher for the Trust at 11%. Mr Adler suggested that it would be useful to circulate a summary of the SMR trends across the region.	
ACTION: Mr O'Donoghue to circulate a summary of SMR trends for the local region to the Governance and Risk Management Committee	
6 Clinical audit forward plan	**SWBGR (11/09) 050** **SWBGR (11/09) 050 (a)**
Mr Parker presented the progress report against the clinical audit forward plan and highlighted areas of delay. The Heathcare records audit was noted to have not been completed as planned, although much of the data had now been received. The management of dysfunctional uterine bleeding was also noted to have not been completed as planned. The audit of liver abscesses was highlighted as having been abandoned for the present, due to other, more pressing, priorities. Mr Trotman suggested that those individuals having completed audits on time should be commended. He also suggested that any revised dates for those audits	

delayed should be added into future reports. Professor Alderson asked whether there was a register of audits undertaken year on year. Mr Parker confirmed that a database was established which logged all audit activity undertaken. He was asked if there was a policy of repeating an audit to determine whether the changes suggested by the previous audit had resulted in an improvement. Mr Parker advised that the action plans monitor the implementation of the changes and include a step to undertake a follow up audit. Professor Alderson suggested that the report should make clear which audits are being conducted for the first time and which are repeat audits. A further update on the clinical audit forward plan was requested for the next meeting.	
ACTION: Simon Parker to amend the clinical audit forward plan with suggestions made at the meeting **ACTION: Simon Parker to present an update on the progress with the clinical audit forward plan at the next meeting**	
7 National Service Frameworks action plan monitoring report	**SWBGR (11/09) 059** **SWBGR (11/09) 059 (a)**
Mr Parker advised that the monitoring report had been considered by the Governance Board. It had been agreed that at the start of each financial year, that relevant NSF leads will identify actions that are required to meet the standards. A delay in completing the action plan in connection with the national cancer plan NSF was noted, which was reported to be a consequence of delays in associated national programmes. A delay in the progress with the Mental Heath NSF action plan was also noted, which reflects the delay in implementing the necessary policies. Mr Adler noted that many of the NSFs are long standing and few are now currently being produced. Mr Trotman asked where compliance with safeguarding responsibilities was handled. Miss Overfield advised that safeguarding was not encompassed in any national framework, however safeguarding activities were picked up under the work of the Trust's safeguarding committee. Professor Alderson noted the issues concerning delivery of the chemotherapy aspects of the cancer NSF. He was advised that an excessive influx of patients was not expected as a consequence of the actions planned, however the on call acute system needed to be refreshed to handle patients that do arrive as a result.	
8 Safety alerts update	**SWBGR (11/09) 067** **SWBGR (11/09) 067 (a)**
Mrs Gibson presented an update on all new safety alerts received by the Trust. It was noted that much progress had been made to address the outstanding NPSA alerts since the last meeting. Nine NPSA alerts were noted to be outstanding, with five virtually completed. Among those still outstanding were noted to be alerts in connection with reducing the risk of retaining throat packs after surgery; mitigating surgical risk in patients undergoing hip arthoplasty for fractures of the proximal	

femur; and protecting patients with an allergy associated with latex. Miss Bartram asked Miss Dhami what her view was of the current red alerts. She was advised that the position had improved, although it was acknowledged that there was still further work to be undertaken. Mr Adler noted that there were a number of alerts that date back a significant time and suggested that if there was an issue with completing the alert then this should be escalated through to the Executive Team if necessary.	
9 National Reporting and Learning Service feedback report	**SWBGR (11/09) 061** **SWBGR (11/09) 061 (a)** **SWBGR (11/09) 061 (b)**
Mrs Gibson presented the latest feedback from the National Reporting and Learning Service (NRLS) regarding the data submitted by the Trust and the actions identified in response to the visit by the NPSA. The number of incidents reported per hundred admissions was noted to be 3.9, an increase from 3.33 previously. In this respect, the Trust is within the middle 50% of large acute Trusts nationally for reporting incidents and is also within the middle of local trusts. The improved number of incidents reported is thought to be due to the work with divisions to improve feedback mechanisms and follow up of incidents. The time taken to report incidents has improved from 74 days to 51 days after the incident. Over half of the other Trusts involved in the review were reported to be reporting within 57 days. The number of incidents reported by the Trust that result in severe harm or death was noted to be higher than a number of other trusts across the region. Mr Adler noted that some of the local Trusts appear to have a very good reporting culture, as evidence by the spread of severity and number of incidents reported. Professor Alderson advised that at University Hospital Birmingham Foundation Trust (UHBFT), there had been key initiatives to promote the reporting culture. It was agreed that Mrs Gibson should contact her counterpart at UHBFT to determine if there was any good practice that might be shared.	
ACTION: Ruth Gibson to consider additional methods for improving the incident reporting culture within the Trust	
10 Progress with preparation for the NHS Litigation Authority assessment	**SWBGR (11/09) 066** **SWBGR (11/09) 066 (a)** **SWBGR (11/09) 066 (b)**
Mrs Gibson reminded the Committee that the Trust was due to undergo assessment by the NHS Litigation Authority against both general standards at Level 2 and maternity standards at Level 1. The planned assessment dates are set for December 2009 and March 2010 respectively. In terms of the general standards, some red rated areas remain concerning policies still awaiting approval and, in particular, mandatory training. Data capture has been a particular concern around mandatory training, in addition to attendance on courses. Time has now been devoted to developing more robust information capturing systems.	

Given the circumstances, the Committee was asked to note the intention to defer the planned assessment, to avoid the risk of failure of achieving the standards, however was assured that this would be rescheduled as soon as possible. Miss Bartram asked whether there was a widespread difficulty in achieving a successful accreditation against Level 2 standards. She was advised that this was the case, particularly with issues around mandatory training. Mr Adler advised that 'block' mandatory training courses would be organised in the new year. It was agreed that communication of the decision to defer the assessment should be handled carefully to ensure staff do not lose the momentum gained in preparing for the assessment. Mr Trotman asked whether staff were aware of the financial consequences of achieving accreditation against the standards. Mr Adler advised that there was not a good understanding of this, although staff have received a significant amount of promotional material concerning the process, requirements and implications.	
11 Trust Risk Register	**SWBGR (11/09) 057** **SWBGR (11/09) 057 (a)**
The Governance and Risk Management Committee received and noted the Trust Risk Register covering Quarter 2 of 2000/10.	
12 Integrated risk, complaints and claims report	**SWBGR (11/09) 070** **SWBGR (11/09) 070 (a)**
Mrs Gibson reported that overall the number of incidents has fallen when compared to the same period in 2008/09. There has however been an increase in the number of clinical incidents; Heath and Safety incidents have fallen. The number of red incidents was noted to have increased. In terms of complaints, a reduction in the number of formal complaints was noted compared to 2008/09, although year to date the number of complaints is higher. Red complaints form 0.9% of all those recorded. Claims information was reviewed, which showed that 252 claims cases were open, of which 91 relate to personal injury claims. Mr White asked whether there was a mechanism in place to establish any links and trends between events and subsequent claims cases. Mrs Gibson advised that this was not currently analysed, however it may be possible to obtain this information if needed. Professor Alderson asked whether the drop in infection control red incidents was due to a change in the standards in this area. Mrs Gibson advised that the standards had not changed and that the reduction was due to a smaller number of incidents needing to be graded as red. The information around the red infection control incidents was noted to be discussed at the Executive Infection Control Group and operational committees.	
13 Complaints policy	**SWBGR (11/09) 068** **SWBGR (11/09) 068 (a)**
Miss Dhami presented the revised handling of complaints policy, which she advised had been amended to reflect the new complaints regulations that were introduced	

in April 2009. One of the key changes was noted to be the change to the required response time to complaints, from 25 days to a time agreed directly with the complainant according to the nature of the complaint. Other changes to the policy include the ability of complainants to proceed directly to the Ombudsman if they wish to and an extended timeframe in which a complaint may be lodged after an event. Miss Bartram asked how staff handle informal complaints made by a route other than the accepted complaints policy. Mr O'Donoghue remarked that a number of complaints fall into this category and are either informally resolved or progress to more formal measures in line with the policy. It was noted that the policy will be presented to the Trust Board at its meeting in November.	
14 Infection Prevention and Control update	**SWBGR (11/09) 064** **SWBGR (11/09) 064 (a)**
Miss Overfield reported that the Trust was currently performing within the required trajectories for MRSA and *C difficile* infections. New guidelines on the issuing of antibiotics to assist with the management of *C difficile* cases is due to be issued shortly. Fewer contaminated blood cultures have been reported, suggesting that measures to reduce the incidents are working well. Mortality attributed to *C difficile* infections is also reducing. Mr Trotman asked what level of activity was being seen in connection with swine 'flu. He was advised that four or five cases per week are currently being handled, although very few are converting into critical care admissions. There is a slow and steady uptake of 'flu vaccinations. Miss Overfield reported that the Trust had recently received an unannounced inspection against the hygiene code standards, which appeared to have been positive, although the formal report is awaited.	
15 Update in preparations for ALE 2009/10	**SWBGR (11/09) 063** **SWBGR (11/09) 063 (a)**
Mr White reported that preparations were underway for the collection of evidence to support the forthcoming Auditor's Local Evaluation exercise. It was highlighted that it is likely that the approach adopted will be risk based, whereby only those standards assessed as weak during the last ALE exercise will be reviewed.	
16 Compliance with Core Standards	**Hard copy papers**
Miss Dhami reported that a declaration on compliance with Core Strandards was due to be made, which would be based on the first seven months of 2009/10. The Committee was advised that no inspection schedule had been prepared, as this would be last time that a declaration would be needed prior to registration with the Care Quality Commission (CQC) in January 2010. Any lapse in compliance against the standards between the declaration and registration would still need to	

be reported to the CQC however. During the initial self-assessment, the only standard against which compliance was not achieved was found to be C20b, concerning delivery of single sex accommodation, however since this position statement had been developed, it had been agreed that non-compliance should be reported against standard C11b, in reflection of the issues around attendance at Mandatory Training. Compliance with both standards is expected by the year end however. The declaration will be used by the CQC to inform the registration process for individual Trusts.	
17 Overview of the relationship between the Trust's key governance documents	**SWBGR (11/09) 063** **SWBGR (11/09) 063 (a)** **SWBGR (11/09) 063 (b)**
Mr Grainger-Payne presented an overview of the relationship between the key governance documents, as requested at the July meeting of the Governance and Risk Management Committee. The Committee was guided through a diagrammatical representation of the links between the governance documents and the purpose of each of the corporate objectives progress report, Trust Risk Register and the Assurance Framework was described. Miss Bartram suggested that the report should be issued to all Non Executive members of the Trust Board for reference.	
18 Assurance Framework update	**SWBGR (11/09) 056** **SWBGR (11/09) 056 (a)**
The Committee received and noted the updated Assurance Framework for Quarter 2.	
19 Minutes from the Governance Board	**SWBGB (9/09) 143** **SWBGB (10/09) 169** **SWBGB (10/09) 169 (a)**
The Governance and Risk Management Committee received and noted the minutes from the Governance Board meetings held on 4 September and 9 October 2009. The Committee also reviewed the actions log presented at the meeting held on 6 November 2009.	
20 Minutes from the Clinical Quality Review Group	**SWBGR (11/09) 062**
The Governance and Risk Management Committee received and noted the minutes from the Clinical Quality Review Group meeting held in October 2009.	
21 Schedule of meetings - 2010	**SWBGR (11/09) 065**
The Governance and Risk Management Committee noted the schedule of forthcoming meetings for 2010.	
22 Any other business	**Verbal**

There was none.	
23 Details of the next meeting	**Verbal**
The date of the next meeting is 21 January 2010 at 1030h in the Executive Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

MINUTES

Audit Committee – Version 0.2

Venue Executive Meeting Room, City Hospital **Date** 3 December 2009; 1030h – 1230h

Members		In Attendance	Secretariat	
Mrs G Hunjan	[Chair]	Mr R White	Mr S Grainger-Payne	[Minutes]
Miss I Bartram		Mr T Wharram		
Mr R Trotman		Mr P Westwood		
Dr S Sahota		Mr P Capener		
Prof D Alderson		Ms R Chaudary		
		Mr D Shariff [Part]		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mr Paul Dudfield, Mr Mike McDonagh and Mrs Sarah-Ann Moore.	
2 Minutes of the previous meetings	**SWBAC (9/09) 061**
Subject to minor amendment, the minutes of meeting held on 3 September 2009 were accepted as a true and accurate reflection of discussions.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meetings	**SWBAC (9/09) 061 (a)**
In connection with action SWBACACT.054, Mr Wharram reported that cohabitation was defined as applying to individuals who had been in an exclusive and committed relationship, lived together and were financially dependent.	
3.1 Pharmacy losses	**SWBAC (12/09) 073** **SWBAC (12/09) 073 (a)**
Mr White reminded the committee that the matter of losses incurred due to the need to write off pharmacy consumables had been discussed at the previous meeting of the Audit Committee. The general security arrangements around pharmacy stocks were outlined, however Mr White reported that the pharmacy department recognises some areas for improvement in the arrangements. Swipe cards were reported to be the	

main means of accessing pharmacy products. In August 2009, a write-off £6000 had been necessary, due to the expiry of some drugs and a number of breakages. Dr Sahota asked what mechanism was in place to ensure that older stocks are used before new pharmacy consumables. He was advised that random stock checks are taken to ensure that stocks are used in the correct order of expiry. Mrs Hunjan asked whether there had been any incidents where drugs had been found to be unaccountably absent. She was advised that there had not been any specific event where this had been reported.	
4 External Audit matters	
4.1 External audit progress report 2009/10t	**SWBAC (12/09) 074**
Mr Shariff, attending on behalf of Mr McDonagh and Mrs Moore, reported that field work had been undertaken in respect of the audit of charitable funds. The timetable for the review of the 2009/10 annual accounts review had been agreed. Miss Bartram noted that the registration with the Care Quality Commission was imminent and asked who was responsible for auditing the various performance reports that may need to be submitted as part of this process. Mr Shariff advised that a range of evidence will be required to inform the registration, however it was not a specific responsibility of the external auditors to review the evidence to be submitted. He advised however, that trusts will be required to contribute to the Quality Accounts which will be prepared by the Department of Health from 2010 onwards. Mr Capener added that internal audit had no plan at present to audit the submissions made to the regulators. Mrs Hunjan asked whether there was any feedback on the Trust's annual accounts process. She was advised that performance had improved year on year and some areas of work are now incorporated into the internal financial and operational review process.	
4.2 ALE report	**SWBAC (12/09) 075**
Mr Shariff reported that the Trust had been awarded an improved overall rating of three, due largely to the higher ratings in internal control and financial standing. It is anticipated that there is to be a change in the approach to the 2009/10 evaluation, which is to be more risk based, with trigger events prompting a deeper assessment of some areas. In terms of Key Line of Enquiry 1.1, Mr Shariff advised that only trivial adjustments to the annual accounts are permitted to generate a higher	

rating against this standard. There had however been areas showing a discrepancy in the accounts which had needed to be adjusted, therefore a score of two had been awarded. It was highlighted however, that this did not represent any serious underlying concern. Mrs Hunjan noted that a score of 3 had been awarded for the Internal Control dimension and asked how a score of four could be achieved next time. Mr White advised that although internal control was indeed important, a score of four in this area was not required to obtain an overall score of four for the evaluation. Mr Capener observed that 'Taking it on Trust' had not yet been considered by the Trust Board, however Mr White advised that this was in hand and would be considered by the Governance and Risk Management Committee and Trust Board in January 2010. A self-assessment against board assurance would be undertaken as part of this work. On a separate matter, Mr Trotman asked that any references to 'productivity' be replaced by 'efficiency' in audit reports.	
4.3 IFRS conversion report	**SWBAC (12/09) 076**
Mr Wharram advised that following the review of the IFRS conversion work by external audit, five minor recommendations had been proposed. Overall the report on the work had been positive and reflected good progress in this area.	
5. Internal Audit matters	
5.1 Internal audit progress report and recommendation tracking	**SWBAC (12/09) 064** **SWBAC (12/09) 064 (a)**
Mr Capener advised that the overall outcome of the audit work during Quarter 2 had been positive. Progress against the audit plan and a summary of the key findings from the reports was reviewed. Progress was noted to be broadly in line with plan. It was highlighted that there was significant work underway around financial systems and a number of audit reports were prepared in draft, ready for finalisation. Amendments to the audit plan were reviewed. It was noted that a review of mandatory training is planned in preparation for the forthcoming assessment by the NHS Litigation Authority. Mr Capener was advised that the decision had been taken to postpone the assessment, however Mr Adler was continuing to lead the work on mandatory training. The contingency days within the plan were noted as being carried over from the previous audit plan, however there will be a recurrent reduction in this provision in forthcoming audits. As the Standards for Better Health process is due to be replaced by the registration with the Care Quality Commission, it was	

agreed that this audit would be removed and instead a review of the registration may be more useful. Mr Capener reported that the amendments result in an overall reduction in the audit resource to support the plan by 50 days and an associated reduction in the audit fee will be made.

Mr Trotman noted that recommendations concerning theatre utilisation remained outstanding and asked how this linked with work currently underway, being lead by the Chief Operating Officer. He was advised that the work undertaken focussed specifically on theatre reporting systems and the robustness of the information being used to make an assessment of theatre utilisation.

Reviews completed since the last meeting were considered, where it was noted that full and significant assurance had been provided. The review against the Trust's compliance with European Working Time Directive (EWTD) was discussed in detail. The review included specifically the robustness of the monitoring processes for detecting non-compliance. Mr Capener highlighted that the review looked at the status as a snapshot in time. It was noted that some individuals had signed a waiver to claim exemption for the EWTD regulations.

Dr Sahota asked what the scope of the Charitable Funds review covered. Mrs Chaudary advised that expenditure against funds had been reviewed to establish whether this was in line with agreed procedures, governing matters such as the receipt of funds are receipted, whether the agreed signatory had agreed to the expenditure and whether the funds had been spent for the purpose for which they were donated. The key responsibilities of the Trustees had also been covered by the audit and the governance around meetings and preparation of accounts had been reviewed.

Mrs Hunjan asked that a brief summary of the audit outcome be included in future versions of the report. End dates of the audits are also to be included. The plan of audits is additionally to be incorporated into the updated report, together with an indication of from which audit the various recommendations are generated. A good executive summary of the report was requested.

Mr Capener was asked, under which circumstances a low recommendation would convert into a medium recommendation. He advised that this would rarely occur, as low recommendations generally concern housekeeping issues.

It was noted that a nil response was reported against the recommendation concerning Smart cards in MAU and Accident and Emergency. Mrs Chaudary advised that this matter concerned the need for each individual member of staffing to use their allocated Smartcard when amending patient details. Observed practice highlighted that a single Smartcard may be being used to keep the system active, therefore it was difficult to establish which individual had made the alteration. As a consequence of

the review, all staff have been reminded that individual Smartcards should be used. Mrs Hunjan asked whether there was any further work that could be undertaken to test low priority recommendations that do not appear to be being addressed. Mr Trotman recommended that end dates should be applied to the actions and reasons why these have not been met should be presented if relevant. Mr Capener highlighted that the number of recommendations that have not been implemented has reduced overall, however issues with closure would be escalated where necessary.	
ACTION: Mr. Capener to ensure that the suggested amendments to future versions of the internal audit report are incorporated	
5.2 Evaluation of internal audit and review of KPIs	**SWBAC (12/09) 065** **SWBAC (12/09) 065 (a)**
Mr Capener presented a self-assessment of internal audit's performance against key indicators during 2008/09. The conclusions were noted to be informed by the Audit Commission and post audit questionnaires. Three areas for improvement were reported to have been identified, including the embedding of recommendation tracking; improving the timeliness of issuing draft reports; and ensuring that minor non-conformances identified by the Audit Commission's triennial review are implemented. Overall, the report presented a positive view of internal audit's performance. Mr Capener was asked how many post audit questionnaires had been issued. He advised that the self-assessment was based on ten questionnaires received. It was recommended that an overall assessment of satisfaction should be conducted in the future. This was supported by Mr White who observed that the overall performance position had improved significantly.	
5.3 Review of counter fraud progress report, including an update on open cases	**SWBAC (12/09) 070** **SWBAC (12/09) 070 (a)**
Mr Westwood advised that a revised counterfraud policy was currently being developed. Awareness presentations on counterfraud matters had been given to 227 staff during the period, including as part of staff induction. A draft protocol for communications around counterfraud is to be launched before the end of the financial year. Two exercises in relation to the national fraud initiative had been held. Five new fraud referrals had been received.	

In terms of progress against the counterfraud plan, it was noted that 64.5 days had been delivered. The outturn position is expected to be 149 days delivered. Mr Trotman asked whether counterfraud was incorporated within the suite of mandatory training modules. He was advised that this is not the case at present. Miss Bartram remarked that she felt reassured that matters of fraud are being managed effectively. Dr Sahota suggested that successful cases should be publicised. Mr Westwood advised that this is currently undertaken. Mr White added that some communication through the 'Hot Topics' briefing would be useful.	
5.4 CFSMS compound indicator final report	**SWBAC (12/09) 071** **SWBAC (12/09) 071 (a)**
Mr Westwood presented the CFSMS compound indicator final report for receipt and noting. From the information provided on the compound indicator declaration and upon review of the supporting documentation, the Trust was reported to have been rated as two, adequate performance. Mrs Hunjan asked how this rating compared with other trusts in the consortium. She was advised that the majority achieved the same rating. Mr Capener advised that the number of days purchased appeared to be a factor in achieving a higher assessment and embeddedness of counterfraud within the organisation also contributed.	
5.5 LCFS response and action plan	**SWBAC (12/09) 072** **SWBAC (12/09) 072 (a)**
Mr Westwood presented a summary of the action plan to address the recommendations for improvement included within the compound indictor assessment report. Actions were highlighted to include proactive measures and work in terms of revising policies and procedures is underway. Local counterfraud arrangements are embedding. Mrs Hunjan asked that a summary of progress is presented at the next meeting.	
ACTION: Mr Westwood to present an update on progress with delivery of the LCFS action plan at the next meeting of the Audit Committee	
6 Audit Committee self assessment	**SWBAC (12/09) 066** **SWBAC (12/09) 066 (a)**

Mr White reported that an initial self assessment had been undertaken on behalf of the Audit Committee, which had identified an area requiring attention relating to external audit. The question asked was 'Does the Committee receive and monitor actions taken in respect of prior year's reviews?'. It was noted that a review of the external audit recommendations was not routinely identified as an agenda item. It was therefore proposed to add this on a quarterly basis to the agenda, even if this is a nil return. Mr Grainger-Payne was asked to add this item to the Committee's cycle of business. Professor Alderson suggested that evidence was required to demonstrate the suggested position against the indicators. It was agreed that this evidence would be built into a further iteration of the assessment. Dr Sahota asked whether independence between Audit and Finance Committees needed to be included. It was agreed that it would be very difficult to provide suitable evidence to support this. Mr White advised that the Chair was considering a redistribution of Non Executive responsibilities which may assist with this matter however. Mr Trotman commented that all Non Executive Directors are sufficiently experienced to recognise their fiduciary responsibilities at all levels. A further update on the Audit Committee self-assessment is to be presented at the February meeting of the Audit Committee.	
ACTION: **Mr Grainger-Payne to amend the Audit Committee cycle of business to include consideration of external audit recommendations on a quarterly basis** **ACTION:** **Mr White to present an update on the Audit Committee self assessment at the next meeting of the Audit Committee**	
7 ALE improvement plans	**SWBAC (12/09) 066** **SWBAC (12/09) 066 (a)**
Mr White presented an overview of the plans and timetable for preparing evidence to support the forthcoming annual Auditors' Local Evaluation. He advised that the implications of the proposed risk based approach were currently being considered.	
8 Proposed changes to Standing Orders, Standing Financial Instructions and Scheme of Delegation	**SWBAC (12/09) 063**
Mr White reported that the section in the Standing Orders, Standing Financial Instructions and Scheme of Delegation had been amended in relation to patient services to reflect a more realistic set of delegated authorities. The Committee approved the proposed amendment.	

AGREEMENT: The Audit Committee approved the proposed changes to the 'patient services' section of the Scheme of Delegation	
9 Review of Debtors report	**SWBAC (12/09) 068** **SWBAC (12/09) 068 (a)** **SWBAC (12/09) 068 (b)**
Mr Wharram reported that overdue debts totalled around £4m, representing a significant reduction since the last meeting. There had however been an increase is some of the older overdue debts, the biggest proportion being associated with named patient ophthalmology. These debts relate principally the Lucentis treatment, which is billed in advance for a number of injections. Rotational trainees was also noted to be a contributory factor, although the Committee was advised that as of the beginning of April 2010, no regional trainees will be supported and in terms of ophthalmology regional trainees, those not providing a service component will also be removed. Mr Trotman suggested that the level of outstanding debts attributed to Solihull Care Trust was a concern and should be escalated. Mr White advised that before the Strategic Health Authority could be approached, the Chief Executives of the two trusts needed to discuss the matter. Professor Alderson asked what the total amount of outstanding debt represented as a proportion of business. It was agreed to provide this information at the next meeting. Mrs Hunjan asked for greater clarity as to the position regarding the payment issues associated with Birmingham East and North PCT and South Birmingham PCT. It was agreed to provide this at the next meeting.	
ACTION: Mr Wharram to provide an analysis of the total amount of outstanding debt represented as a proportion of business at the next meeting **ACTION: Mr Wharram to provide a further analysis of the payment of debts by Birmingham East and North PCT and South Birmingham PCT at the next meeting**	
10 Minutes from Trust Board committees	
10.1 Finance and Performance Management Committee	**SWBFC (8/09) 079** **SWBFC (9/09) 192** **SWBFC (10/09) 206**
The Committee noted the minutes from the Finance and Performance Management Committee meetings held on 20 August 2009, 17 September 2009 and 22 October 2009.	
10.2 Charitable Funds Committee	**SWBCF (9/09) 016**

The Committee noted the minutes from the Charitable Funds Committee meeting held on 3 September 2009.	
10.3 Governance and Risk Management Committee	**SWBGR (9/09) 054**
The Committee noted the minutes from the Governance and Risk Management Committee meeting held on 17 September 2009.	
11 Forward schedule of meetings for 2010	**SWBAC (12/09) 069**
The Committee noted the forward schedule of meetings for the coming calendar year.	
12 Any other business	**Verbal**
There was none.	
13 Details of next meeting	**Verbal**
The next meeting is planned for 4 February 2009 in the Executive Meeting Room, City Hospital at 1030h.	
Signed: ……	
Name: ……	
Date: ……	

Charitable Funds Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 3 December 2009 at 1430h

Present		**Guests**	
Dr S Sahota	[Chair]	Mrs J Kinghorn	[Items 9.1 – 9.3 only]
Miss I Bartram		Mrs A Bigmore	[Item 9.3 only]
Mr R Trotman		Mr J Nedrick	[Item 9.3 only]
Mrs G Hunjan			
Mr J Adler			
Mr R White			
Mr P Smith			
Mr S Grainger-Payne	[Secretariat]		

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Mrs Sue Davis, Professor Derek Alderson, Miss Rachel Overfield, Mr Donal O'Donoghue and Mr Richard Kirby.	
2 Minutes of the last meeting	**SWBCF (9/09) 010**
The minutes of the last meeting were accepted as a true and accurate reflection of discussions held on 3 September 2009.	
AGREEMENT: The minutes of the meeting held on 3 September 09 were approved.	
3 Matters arising from the previous meeting	
With reference to action SWBCFACT.025, Mr Smith reported that a standard template is to be completed to show how the required duties under Charitable Funds regulations are being fulfilled for each fund. It had been agreed that separate disclosure of funds over £75k would be made, however it was recommended that this limit be changed to £100k, meaning that six funds would require disclosure.	
4 Investment update	
4.1 Investment review and valuation from Barclays Wealth for the three month period 1 July 2009 to 30 September 2009	**SWBCF (12/09) 012**

Mr White reported that during the period of the review there had been volatility and uncertainty in the stockmarket, therefore the Trustees were asked to consider reducing exposure to the stockmarket, given that this represents 68% of the current portfolio. It was suggested that potential investment in south east Asia might need to be investigated, thereby reducing the exposure to the stockmarket to 57%. It was suggested that as there is currently a significant amount of funds held outside of the Barclays portfolio that £250k of these funds be added into the Barclays funds. It was also proposed that £250k be transferred out of equities into bonds and a further £350k be placed into similar investments. In terms of the bonds, it was recommended that £130k be placed into government bonds, while bonds in other industries be reduced. £120k would be invested in the Aviva Property Trust. The Trustees were recommended to support the proposal not to distribute dividend returns for this quarter and for the foreseeable future. Mr Trotman asked how the proposed changes to the portfolio affect the spread of investment across the sectors. Mr White offered to undertake this analysis, however advised that it was likely that a breach in overseas cash investments may be incurred, although this is likely to provide an overall safer mix of investments. Dr Sahota suggested that overseas stocks may be a consideration for the future, however noted that for now the portfolio had reduced from medium/high level risk to a safer level of exposure and risk. Mrs Hunjan noted that there was a discrepancy between the reported value of the portfolio in the investment report and the values in the Trust's internal assessment. She was advised that this is due to the different cut off times between the two reports, although this will be addressed in future versions.	
ACTION: **Mr White to check how the proposed changes to the portfolio affect the spread of investment across the various sectors** **AGREEMENT:** **The Charitable Funds Trustees approved the proposed changes to the investment portfolio**	
5 Quarterly finance report	**SWBCF (12/09) 013** **SWBCF (12/09) 013 (a)** **SWBCF (12/09) 013 (b)** **SWBCF (12/09) 013 (c)**
Mr Smith presented the quarterly Charitable Funds finance report, covering the period 1 August 2009 – 31 October 2009. Surplus cash in the bank was noted to have reduced by £250k, due to the transfer to the Barclays Wealth portfolio. Prior to this transfer, the cash balance stood at £556k. In terms of income received in the last quarter, £162,500 is declared, representing 72% of the overall donations and legacies received, the total	

income being £225,000. It was noted that the position assumes that the portfolio dividend is paid back as income, therefore this was to be adjusted. Expenditure was reported to be £282,800, representing 82% of the overall expenditure, the total being £343,600. The Trustees were asked to note that the reserve balance was now almost in balance, given the settling stock market position. Cash at bank and in hand was reported to be £828,000 as at 31 October 2009. It was agreed that cash held by Barclays Wealth should not be shown as a fixed asset on the balance sheet. Dr Sahota noted that there were a number of Trust funds that were reporting a negative position. Mr Smith offered to investigate the issue with these funds. Dr Sahota asked what process was followed should spend from a fund be required. He was advised that approval from the finance department is requested through the completion of a standard proforma. It was acknowledged however, that there are occasions when the process is not strictly followed and reimbursement from the Trust fund is requested after the expense has been incurred. Mrs Hunjan remarked that if a fund holder is committing expenditure, it should be their responsibility to ensure that a credit balance is in place first. Mr Smith agreed that this is clearly the responsibility of the fund manager, however policies setting this out are not developed. Mr White reminded the Trustees that the responsibilities with regards to both exchequer funds and charitable funds are set out in the Trust's standing financial instructions. Mr Trotman highlighted a number of trust fund signatories and managers that had left the Trust or had moved to positions in which it would be considered inappropriate for them to act as fund manager. Dr Sahota recommended that a rationalisation of the trust funds was needed, particularly for those that have very small balances. Mr Smith was asked whether requisitions for charitable fund expenditure were processed through the usual procurement route. He advised that any requisitions of this nature are passed to finance as a matter of course.	
ACTION: Mr Smith to investigate the trust funds reporting a negative balance	
6 Rationalisation of funds	**SWBCF (12/09) 014** **SWBCF (12/09) 014 (a)**
Mr Smith reported that the list of funds had been reviewed to establish any	

potential for rationalisation. The review looked specifically at trust funds of less than £100, and those where there appeared to be no transactional movements between April 2008 and September 2009. The Trustees were advised that there were only 11 funds holding a balance of less than £100 where there had been no transactional movement, which totalled £533. Funds held by the same manager had been identified and it had been found that 19 funds could be amalgamated into nine funds. Overall therefore, a reduction in funds by 21 was possible. A further 86 funds had been identified which had showed no transactional movement, to the value of £547,000. Mr Trotman suggested that urgent consideration be given to rationalising the funds given the length of time it had taken to rationalise funds to date. Miss Bartram however, urged caution and highlighted that clear accountability for the agreed use of the funds was needed for donors. Dr Sahota asked that restricted funds be highlighted in future reports. Mr white advised that rationalisation of the funds was cumbersome and time-consuming, therefore proposed that a further plan be presented at the next appropriate Charitable Funds meeting to rationalising the funds in a practical way, yet with minimum intervention. Miss Bartram asked how the name of the funds was created. She was advised that the present list includes a number of historical names, yet fund managers are now able to decide on a name for new funds created.	
ACTION: **Mr Smith to present an updated proposal for the rationalisation of charitable trust funds at the next appropriate meeting of the Trustees**	
7 Draft annual accounts and report 2008/09	**SWBCF (12/09) 015** **SWBCF (12/09) 015 (a)** **SWBCF (12/09) 015 (b)**
Mr Smith presented the draft charitable funds accounts, which were noted to be due for submission by the end of January 2010. Accounts were reported to have been reviewed by the Trust's external auditors and amendments following the review had been incorporated. The Trustees were asked to note the details of the standard financial activities, showing the income and expenditure split between restricted and unrestricted funds. Losses reported in year were due to turbulence in the stockmarket. Compared with the previous year, income and resources were noted to be lower and expenditure had increased. The balance sheet showed that	

overall assets had fallen. Fixed assets in particular fell by £1,107,000. Current assets at £933,000 were broadly in line with those at March 2008. In terms of the annual report, Mr Smith advised that the report was in a similar format to that presented in previous years and conforms to the requirements if the Charities Commission. The Charities and Public Benefit document was reported to have been issued, requiring a statement to be included in the annual report around how the charitable funds meet the public benefit requirements. Information concerning the performance of the portfolio had been amended to reflect the position over the past year. The position regarding reserves had been included in the report, where it was noted that a target of £500,000 is required, although this currently stands at £287,000. It was reported that the auditors needed to be advised as to the agreement by the Trustees as to the target ranges for investment in different areas of the portfolio. In relation to the allocation of support costs and overheads in the accounts, Mr Trotman asked what the £49,000 for governance costs entailed. Mr White agreed to check this allocation.	
ACTION: Mr White to check what the allocation for governance costs concerns	
8 ISA 27 – consolidation of accounts	**SWBCF (12/09) 016** **SWBCF (12/09) 016 (a)**
Mr White reported that ISA 27 concerned the consolidation of charitable funds with NHS exchequer funds. This applies where the Board overseeing the charity is the same as that overseeing the management of the Trust. The Trustees were advised that the plans have the potential to distort the income position for Trusts and was therefore being contested by the Charities Commission, in particular. To avoid the consolidation, a separate Board of Trustees would need to be created, which would manage a separate charity. It was agreed however that this would be a difficult measure to implement. The matter was however, being discussed with the Trust's external auditors in terms of whether the value of funds was above the level regarded as material and therefore whether ISA 27 applied. It is however anticipated that given the value of funds is in excess of £4m, then this would apply. Dr Sahota highlighted that many hospitals have a separate body that reports into the Trust board and recommended that the Association of NHS Charities guidelines should be reviewed as these may provide a working solution to the issue.	
9 Application for the use of Charitable Funds	

9.1 Bid #1 – Wayfinding electronic signage	**SWBCF (12/09) 017**
Mrs Jessmay Kinghorn joined the meeting to present a bid for the use of charitable funds to support the introduction of Wayfinder electronic signage. It was proposed that Wayfinder stations be installed at City and Sandwell Hospitals and provide directions to 72 locations at City Hospital and 55 at Sandwell Hospital. The directions may be printed out from kiosks and would be available in a number of languages. The key benefit is believed to be a better level of service to patients and relatives. All kiosks would be maintained by the Communications Department. In terms of languages available, Mrs Kinghorn reported that the English option would be free, with additional languages available at an extra cost, determined according to the number of kiosks on which it would be added. Mr Trotman urged consideration of the proposal to include Polish as one of the additional languages, given that the Polish population in the region appeared to be reducing. It was agreed that the default language should be English. It was agreed that the ongoing maintenance costs for the system should not be met from charitable funds. It was suggested that a small scale pilot should be conducted before the Trustees were asked to commit further investment. A limit of £30,000 was agreed to be the maximum expenditure limit for the pilot. Mrs Kinghorn was asked to prepare a further proposal outlining the scope of the Wayfinding pilot for the Trustees to consider.	
ACTION: Mrs Kinghorn was asked to prepare a further proposal outlining the scope of the Wayfinding pilot for the Trustees to consider **AGREEMENT: The Charitable Funds trustees agreed that a Wayfinding pilot should be conducted, oat a cost of £30,000 maximum**	
9.2 Bid #2 – Patient Information	**SWBCF (12/09) 018**
Mrs Kinghorn presented a proposal for the use of charitable funds to continue supporting the current patient information system, EIDO. It was noted that the system is currently used around the Trust and around 260 leaflets are included on the system, covering a range of conditions and procedures. The system was reported to be accessed in excess of 2000 times per quarter and feedback from clinicians has been positive. A language option is being developed ready for introduction in the new year. It is anticipated that this system will realise significant cost savings on translation, which was reported to be charged at £125 per language per 1000 words.	

Mrs Kinghorn advised that there are few alternative companies who are able to provide patient information in a format consistent with NHS Litigation Authority risk assessment standards. Dr Sahota expressed concern that the languages to be provided by the company may not be the ones that are needed. Mrs Kinghorn was asked to check whether NHS Evidence was offering any alternative or supplementary patient information system. She advised however, that this had been reviewed and the offering was different. Dr Sahota asked whether the proposal had been considered in any other corporate forum. He was advised that the Executive Team and the Patient Experience Action Group had both been appraised of and supported the plans. The proposal was agreed with the caveat suggested by Mr Trotman, that a timescale for the development of Urdu and Punjabi language options should be agreed with the company providing the information system. The cost of the bid was noted to be £21,900 + VAT.	
AGREEMENT: The EIDO proposal was approved, subject to a timescale for the development of Urdu and Punjabi language options being agreed with the company providing the information system	
9.3 Bid #3 – Arts Pilot	
Mrs Andrea Bigmore and Mr Jason Nedrick joined the meeting to present a proposal for the use of charitable funds to support a public arts programme. Dr Sahota registered his interest in this item based on his membership of the New Hospital Project Board. Mrs Bigmore advised that an arts strategy was being developed to define the artistic statement in the new hospital. An arts steering group has been introduced, which is keen to introduce two parts of the strategy early, one of which was reported to be 'Paintings in Hospitals', where by pieces of art may be borrowed for display at a cost of £2000 per year for around 25 pictures or paintings. Delivery and installation costs and the provision of an art map and evaluation were reported to be additional costs to this element of the proposal. It was also noted to be important to use community engagement to develop the arts strategy, therefore a community initiative is planned, which will be facilitated by a local art development worker on a sessional basis. The cost of this element was reported to be £14,500, making the total bid to be £19,500. The Trustees supported the bid for the use of charitable funds, although suggested that the display of artwork could be extended from the Birmingham Treatment Centre as planned, to some areas in Sandwell	

Hospital which were thought may benefit.	
AGREEMENT: The Charitable Funds Trustees approved the use of charitable funds to support the public arts proposal	
10 Any other business	**Verbal**
Mr White reported that a request had been received for the use of £1000 of charitable funds to support the forthcoming volunteers Christmas dinner. The Trustees approved the bid.	
AGREEMENT: The Charitable Funds Trustees approved the use of charitable funds to support the forthcoming volunteers Christmas dinner	
11 Details of next meeting	**Verbal**
The next meeting of the Charitable Funds Committee is planned for 14 January 2010 at 1430h in the Executive Meeting Room, City Hospital. It was noted that this meeting would be used solely for the approval of the annual accounts and report.	

Signed ……..

Print ……..

Date ……..

Charitable Funds Committee – Version 0.2

Venue Executive Meeting Room, City Hospital **Date** 14 January 2010 at 1430h

Present

Dr S Sahota	[Chair]	Mr P Smith	
Mrs S Davis		Mr S Grainger-Payne	[Secretariat]
Mr R Trotman			
Miss I Bartram			
Mr J Adler			
Mr R Kirby			
Miss R Overfield			

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Professor Derek Alderson, Mrs Gianjeet Hunjan, Mr Robert White and Mr Donal O'Donoghue.	
2 Annual Accounts and Report 2008/09	**SWBCF (1/10) 002** **SWBCF (1/10) 003**
Mr Smith presented the charitable funds annual report and accounts for approval and adoption. The Trustees were reminded that the draft accounts had been considered at the December meeting of the Charitable Funds Committee, however since then, the audit of the accounts by the Trust's external auditors had concluded. No further numerical amendments to the accounts had been made since the draft accounts had been reviewed, however minor amendments to the narrative had been incorporated. In terms of the annual report, amendments to the text had been made, including the inclusion of a risk assessment table and the term 'reserves' had been amended to 'free reserves'. Mr Smith was asked to amend the report to show the period during which Miss Parveen Akhtar acted as a Trustee. All Trustees were asked for and gave their agreement to adopt the accounts and approve the annual report.	
AGREEMENT: **The charitable funds accounts and annual report were adopted and approved respectively by the Trustees**	

3 ISA 260 report	SWBCF (1/10) 003
Mr Smith presented the ISA 260 report, which reported that the external audits planned to issue an unqualified opinion of the annual accounts. The adjustments to the accounts recommended by the auditors had been included in the version approved by the Trustees. Audit recommendations were reviewed and a proposed management response was discussed. The Trustees supported the recommendation to develop a Service Level Agreement between the Trustees and the Trust. In terms of the recommendation to develop a standard proforma for donation, it was agreed that Mr Smith would undertake this work in conjunction with the Communications Department. The Trustees reviewed the recommendation to review progress against audit recommendations at its meetings. It was agreed that the audit report for charitable funds should added to matters for consideration at the next meeting of the Audit Committee and Charitable Funds. The Trustees were advised that a view of the proposed consolidation of the charitable funds with NHS exchequer accounts is to be formed by the Department of Health shortly. The impact of the guidance is to be discussed at a future meeting of the Finance and Performance Management Committee. Mr Adler advised that there had been significant media cover age of the issue. It was noted that the papers to support the meeting had not been issued in a prompt manner from the external auditors and was therefore agreed that this matter should be raised at the forthcoming meeting of the Audit Committee at which the auditors will be present. It was agreed that Mr White should sign the management letter of representation on behalf of the Trustees.	
ACTION: **Mr Smith to develop a standard proforma for donations to the Trust and organise for this to be added to the Trust's website** **ACTION:** **Mr Grainger-Payne to add Charitable Funds audit to the agenda of the next Audit Committee and Charitable Funds Committee meetings** **ACTION:** **Mr Grainger-Payne to the impact of charitable funds consolidation to the agenda of the next Finance and Performance Management Committee meeting** **AGREEMENT:** **It was agreed that Mr White should sign the management letter of representation on behalf of the Trustees** **AGREEMENT:** **The late issuing of paperwork to support the meeting is to be raised at the forthcoming meeting of the Audit Committee**	
4 Any other business	**Verbal**

Mr Trotman reminded the Committee that the term of the appointment of Barclays Wealth as investment advisors had exceeded the agreed one year period. The Trustees agreed that given the current financial climate, that reappointment for a further year would be sensible. Dr Sahota offered to discuss the matter with Mr White. Mr Adler reported that, following the December meeting of the Committee, a revised Wayfinder proposal had been developed by the Head of Communications. Mr Grainger-Payne was asked to send the proposal to Trustees for review.	
ACTION: **Dr Sahota to discuss appointment of investment advisors with Mr White** **ACTION:** **Mr Grainger-Payne to circulate the revised Wayfinder proposal to Trustees** **AGREEMENT:** **The Trustees agreed that the contract with the current investment advisors should be extended by a year**	
5 Details of next meeting	**Verbal**
The next meeting of the Charitable Funds Committee is planned for 6 May 2010 at 1430h in the Executive Meeting Room, City Hospital.	

Signed ……..

Print ……..

Date ……..