Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 29 October 2009 at 1430h

Members			**In Attendance**		
Mrs S Davis	(SD)	[Chair]	Mr G Seager	(GS)	
Mr R Trotman	(RT)		Miss K Dhami	(KD)	
Miss I Bartram	(IB)		Mrs G Deakin	(GD)	
Dr S Sahota	(SS)		Mrs J Kinghorn	(JK)	
Mrs G Hunjan	(GH)		Miss J Whalley	(JW)	
Prof D Alderson	(DA)		Mr J Cash	(JC)	
Miss P Akhtar	(PA)				
Mr J Adler	(JA)		**Guests**		
Mr D O'Donoghue	(DO)		Dr J Middleton	(JM)	[Item 7 only]
Mr R Kirby	(RK)				
Mr R White	(RW)		**Secretariat**		
Miss R Overfield	(RO)		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 24 September 2009 as true and accurate records of discussions*	**SWBTB (9/09) 184**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (9/09) 184 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
7	**Public health matters**	**Presentation**	**JM**
	MATTERS FOR APPROVAL		
8	**Compulsory Purchase Order for the New Hospital Project – emergency action**	**SWBTB (10/09) 187** **SWBTB (10/09) 187 (a)**	**GS**
9	**Estates strategy – annual review**	**SWBTB (10/09) 196** **SWBTB (10/09) 196 (a)**	**GS**
10	**Safeguarding declaration**	**SWBTB (10/09) 188** **SWBTB (10/09) 188 (a)**	**RO**
11	**Grievance and disputes policy**	**SWBTB (10/09) 198** **SWBTB (10/09) 198 (a)** **SWBTB (10/09) 198 (b)** **SWBTB (10/09) 198 (c)**	**GD**

12	**Trust Board Committees' terms of reference**	**SWBTB (10/09) 197** **SWBTB (10/09) 197 (a)** **SWBTB (10/09) 197 (b)** **SWBTB (10/09) 197 (c)** **SWBTB (10/09) 197 (d)** **SWBTB (10/09) 197 (e)**	**SGP**
MATTERS FOR INFORMATION/NOTING			
13	**Quality and Governance**		
13.1	CQC ratings 2008/09	SWBTB (10/09) 200 SWBTB (10/09) 200 (a)	JA
13.2	CQC registration	SWBTB (10/09) 186 SWBTB (10/09) 186 (a)	KD
13.3	Assurance Framework – Quarter 2 update	SWBTB (10/09) 204 SWBTB (10/09) 204 (a)	SGP
14	**Strategy and Development**		
14.1	Corporate objectives progress report – Quarter 2 update	SWBTB (10/09) 192 SWBTB (10/09) 192 (a)	RK
14.2	'Right Care, Right Here' programme: progress report	SWBTB (10/09) 194 SWBTB (10/09) 194 (a) SWBTB (10/09) 194 (b) SWBTB (10/09) 194 (c)	RK
14.3	New acute hospital project: progress report	SWBTB (10/09) 195 SWBTB (10/09) 195 (a)	GS
14.4	PCT procurement strategies	SWBTB (10/09) 203 SWBTB (10/09) 203 (a)	RW
15	**Performance Management**		
15.1	Monthly finance report	SWBTB (10/09) 199 SWBTB (10/09) 199 (a)	RW
15.2	Monthly performance monitoring report	SWBTB (10/09) 205 SWBTB (10/09) 205 (a)	RW
15.3	NHS Performance Framework monitoring report	SWBTB (10/09) 206 SWBTB (10/09) 206 (a)	RW
15.4	Annual audit letter 2008/09	SWBTB (10/09) 190 SWBTB (10/09) 190 (a)	RW
16	**Operational Management**		
16.1	Update on preparedness for swine 'flu pandemic	SWBTB (10/09) 191 SWBTB (10/09) 191 (a) SWBTB (10/09) 191 (b)	RK
16.2	Patient experience action plan: progress report	SWBTB (10/09) 189 SWBTB (10/09) 189 (a)	RO
17	**Update from the Board Committees**		
17.1	Finance and Performance Management Committee		
▶	Minutes from meeting held 17 September 2009	SWBFC (9/09) 192	RT

17.2	Governance and Risk Management Committee		
▶	Minutes from meeting held 17 September 2009	SWBGR (9/09) 054	IB
17.3	Audit Committee		
▶	Minutes from meeting held 3 September 2009	SWBAC (9/09) 061	GH
17.4	Charitable Funds Committee		
▶	Minutes from meeting held 3 September 2009	SWBCF (9/09) 016	SS
18	**Any other business**	**Verbal**	**All**
19	**Details of next meeting** *The next public Trust Board will be held on 26 November 2009 at 1430h in the Anne Gibson Boardroom, City Hospital*	**Verbal**	**Chair**
20	**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 Trust

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 24 September 2009 at 1430 hrs

Present:	Mrs Sue Davis	Dr Sarindar Sahota	Mr Richard Kirby
	Mr Roger Trotman	Miss Parveen Akhtar	Miss Rachel Overfield
	Miss Isobel Bartram	Mr John Adler	Mr Donal O'Donoghue
	Mrs Gianjeet Hunjan	Mr Robert White	
In Attendance:	Mr Colin Holden	Miss Kam Dhami	Mr Graham Seager
	Mr John Cash [Sandwell LINK]		
Guests:	Mr Jonathan Riley [Pinsent Masons] (Item 7)		Mr Robert Banks (Item 7)
	Mrs Jayne Dunn (Item 8)	Mr Andy Dunn (Item 9)	
Secretariat:	Mr Simon Grainger-Payne		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson.	
2 Declaration of interests	**Verbal**
No declarations of interest were made in connection with any agenda item.	
3 Chair's opening comments	**Verbal**
Mrs Davis advised that this was to be the last meeting of the Trust Board that Mr Holden would attend before his retirement. Mr Holden was thanked for his work with the Board over the past years and for his companionship and hard work in occasionally difficult circumstances. In response, Mr Holden said that it had been a privilege to work for the Board and wished the Trust every success for the future. On a separate matter, the Chair reported that Dr Patrick Cadigan had recently been appointed to a position in the Royal College of Physicians. Mr Grainger-Payne was asked to communicate the Board's congratulations to Dr Cadigan.	
ACTION: Mr Grainger-Payne to communicate the Trust Board's congratulations to Dr Cadigan on his recent appointment in the Royal College of Physicians	

4 Minutes of the previous meeting	**SWBTB (8/09) 166**
Subject to minor amendment, the minutes of the meeting held on 27 August 09 were approved.	
AGREEMENT: The minutes of the previous meeting on 27 August 09 were approved as true and accurate reflections of discussions held	
5 Update on actions from previous meetings	**SWBTB (8/09) 166 (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 questions from members of the public in attendance at the meeting.	
7 Initiation of a Compulsory Purchase Order for the New Hospital Project	**SWBTB (9/09) 168** **SWBTB (9/09) 168 (a)** **SWBTB (9/09) 168 (b)** **SWBTB (9/09) 168 (c)**
Mr Seager reminded the Trust Board that approval of the Outline Business Case for the new acute hospital had been received at the end of July 2009. The Trust Board has also approved the request for Mr Seager to seek the Secretary of State's authority to invoke a Compulsory Purchase Order (CPO) to acquire the land for the new hospital at the July Board meeting. Notification has now been received from the Secretary of State that this order may now be made, therefore the Trust Board was asked to confirm its decision to initiate a CPO. The Board was informed that it remains the view of the Land Acquisition Group (LAG) that the land required cannot be acquired without a CPO. A number of land owners remain to be identified. It is possible that a number of premises could be aquired by voluntary acquisition. In considering whether to make a CPO, a number of checks have needed to be made. Firstly, it needs to be confirmed that there are no planning obstacles, which given that outline planning permission has been obtained, is satisfied. There also needs to be a compelling case that the intended use for the land is in clear public interest. As the OBC has been subjected to a public interest test as part of the approvals process, this condition is also satisfied. Thirdly, there needs to be confirmation of the affordability of the scheme and ongoing viability. This matter has been addressed by the recent confirmation by the 'Right Care, Right Here' Partnership Board that the new acute hospital remains pivotal to overall plans for the local health economy and as such adequate funding will be provided to support the scheme. Mr Jonathan Riley, a partner from Pinsent Masons solicitors presented the proposed resolution requiring the Trust Board's approval. The resolution requested that the Trust affixes its seal to and makes a Compulsory Purchase Order under section 25 of and paragraph 27 of schedule 4 to the National Health Service Act 2006 for the acquisition of the land and new rights within the areas identified on plan PA-2344-CPO-01, for the purpose of securing the provision of a new acute hospital together with a supporting education, research and administration centre, a multi storey car	

park, gym, crèche, car parking and means of access.

The resolution also requested that the Land Acquisition Group has authority to continue to manage all matters relating to the Order and voluntary acquisitions of land for the new acute hospital on the Trust's behalf and specifically (but not exclusively) be authorised to take all necessary steps to:

Secure the making, confirmation and implementation of the CPO including the publication and service of all notices and the presentation of the Trust's case at any public Inquiry;

Acquire interests in land and new rights within the CPO either by agreements or compulsorily; and

Approve agreements with land owners setting out the terms for the withdrawal of objections to the Order, including where appropriate seeking exclusion of land or new rights from the Order and/or making arrangements for rehousing or relocation of occupiers.

It was confirmed in discussion that final approval for all land transactions would remain a matter for the Trust Board itself.

Dr Sahota asked what measures were in place to ensure that the process is appropriately monitored. He was advised that the day-to-day matters will be handled by the LAG, which reports to the Acute Hospital Project Board. The minutes from the Project Board are then presented for consideration in the private session of the Trust Board meetings.

Mr Adler asked who was represented on the LAG. Mr Seager advised that the group consisted of himself together with Robert White, Finance Director, Rob Banks, Head of Estates, Richard Kinnersley, Head of Capital Projects. Also in attendance are local council and legal advisers and chartered surveyors. The Foundation Trust project manager and local authority representative (experienced in CPOs locally) were also to be invited to join the group.

The route for approvals for the purchase of individual premises was discussed. Mr Seager advised that a standard proforma would be completed for presentation to the Trust Board as necessary. For reasons of commercial confidentiality, the approvals would be sought in the private session of the Trust Board meetings.

Mr Cash asked what delay would be incurred should an objection be raised to the compulsory purchase process. Mr Riley advised that steps are to be taken to publicly advise that the compulsory purchase order has been made, which should reduce the number of last minute objections. In any event, the timescales for the process have incorporated a public inquiry, in anticipation of objections being raised.

Miss Akhtar asked whether the costs in the business case take into account any potential shift in the market value of properties over the timeframe of the land purchase. She was advised that the budget costs had been established based on benchmark norms and hence there is a risk that actual costs may deviate from the budget once the full picture had been established; to help manage this risk this had been factored into the contingency allocation. The OBC/LBC approval is conditional on capital costs outturn being within10% of approval figure

The Trust Board was asked to support the resolution proposed and unanimously agreed.	
AGREEMENT: The Trust Board resolved to affix the Trust seal to and make a Compulsory Purchase Order for the purpose of securing the provision of a new acute hospital together with supporting facilities	
8 Maternity services review	**SWBTB (9/09) 174** **SWBTB (9/09) 174 (a)** **SWBTB (9/09) 174 (b)** **SWBTB (9/09) 174 (c)**
Mr Adler reminded the Trust Board that since the concerns about the care provided by Sandwell Hospital maternity services, a risk mitigation plan has been implemented. A medium term review of services has been undertaken, particularly in the light of the sustainability issues in connection with the current arrangements. The review was led by Sandwell PCT as the lead commissioner and has generated a shortlist of options for the future configuration of services, on which there is to be public consultation. Giving final approval for public consultation and the future medium term configuration rests formally rests with Sandwell PCT but the PCt is working closely with HoB PCT and the Trust. There has been much discussion around potential options and although there is no preferred option put forward, all options result in a considerable change to the way in which services are delivered from Sandwell Hospital. Mrs Jayne Dunn joined the meeting and advised that a clinical case for change had been developed locally, however a review by the National Clinical Advisory Team (NCAT) was needed in accordance with the Department of Health regulations. The outcome of the review supported the locally developed clinical case for change. A long list of reconfiguration options had been developed and a process for short listing the options then developed, involving a scoring system which was applied by the steering group and by stakeholders and user representatives. A wider reference group was also given the opportunity for comment on the options. Pre-engagement work with users had been undertaken through a series of focus groups and questionnaires, which highlighted the importance of the provision of local antenatal care. A series of Listening into Action style workshops with staff working in maternity and related services had also been undertaken at an early stage with the feedback from these being used to help develop the service models and short listing criteria. The three options were outlined to be, in summary: to transfer all births and consultant activity to City Hospital and retain low risk Midwifery-led antenatal services at Sandwell Hospital, including routine scans; Relocate all births and inpatient maternity care to City Hospital, with a small number of consultant antenatal clinics at Sandwell Hospital, together with a full range of midwifery antenatal services including routine screening; and Transfer all consultant-led care and all inpatient services and temporarily, all births to City Hospital, whilst a standalone midwifery-led birth centre is developed within Sandwell and once operational, some midwifery-led low risk births would be	

relocated to the new centre.

Mrs Dunn reported the public consultation process rests with Sandwell PCT and if it progresses as planned, a full business case will be taken to the Trust Board in February 2010, with an implementation plan submitted in April/May 2010. The project management aspect of the process requires oversight by the Office of Government Commerce (OGC), which is responsible for conducting Gateway Reviews. The first Gateway Review reported an amber–green status, with the next review planned for March/April 2010.

The Chair highlighted that the proposals are radical and are likely to generate interest from the public. Miss Bartram asked whether the implications of the plans on other Black Country providers of maternity services had been considered. She was advised that a loss of market share is assumed, where 500-600 births are likely to be lost to other providers. The establishment of the standalone centre is however, likely to recapture a portion of this market share. The Chair noted that there is already a year on year loss of women giving birth at Sandwell Hospital and again, a number of these losses may be attracted back to the area when the services are reconfigured. Mr Adler added that a survey of those women delivering elsewhere is being undertaken and initial results show perceptions of the quality of the services as well as geographical considerations are affecting women's choices.

Mr Adler advised that while the delivery of the options is financially viable, the effect on catchment and therefore income is not certain and more detailed work will continue on this as part of developing the business case.

Dr Sahota remarked that the operational issues would involve increased capacity at the City site and asked how this would be achieved. Mrs Dunn advised that the additional capacity will be provided from the co-located midwifery centre, previously approved by the Trust Board, together with a number of service changes. As the changes to the Sandwell Hospital services will mean the closure of 21 beds at this site, it is planned to open this amount of beds at City Hospital.

Mr Kirby asked whether the initial equality impact assessment undertaken had revealed any issues. Mrs Dunn advised that the equality impact assessment had considered all strands of equality and diversity and highlighted that the options provide a positive impact for all groups. The work did however suggest that further work was needed to take into account the needs of teenage mothers and some of the smaller ethnic groups.

Miss Bartram suggested that the placements from universities need to be considered as part of the plans.

Mr Cash asked what would happen should the outcome of the consultation reveal that Sandwell was the preferred choice for the maternity services. Mrs Davis highlighted that this was an issue for the Board and Sandwell PCT to handle, although initial screening has suggested that City Hospital is the preferred location. None of the shortlisted options included concentrating services at Sandwell.

The Trust Board gave its unanimous support to initiating the public consultation on maternity services.

AGREEMENT: **The Trust Board agreed that a public consultation of the shortlisted options for maternity services is undertaken**

AGREEMENT: The Trust Board agreed the case for change to the configuration of maternity services in the medium term **AGREEMENT: The Trust Board agreed the consultation framework** **AGREEMENT: The Trust Board agreed the consultation document** **AGREEMENT: The Trust Board agreed the decision-making process to identify an approved option**	
9 Statement of readiness for the swine 'flu pandemic	**SWBTB (9/09) 178** **SWBTB (9/09) 178 (a)** **SWBTB (9/09) 178 (b)** **SWBTB (9/09) 178 (c)**
Mr Kirby reported that a detailed plan was in place for handling any further stages of the swine 'flu pandemic. The Department of Health has also mandated that these plans are presented to the Trust Board for approval. Mr Kirby thanked Mr Matthew Dodd and Mr Andy Dunn for the work that they had undertaken with developing the plan. The action plan centres on three aspects: firstly, ensuring that robust links are in place with other organisations to ensure that all plans fit together. If these links are not in place there are potential risks around indemnity agreements. Secondly workforce planning, such as ensuring that FIT testing of masks for medical staff is completed, arranging return to work packages for recently retired staff and training for staff moving from one clinical area to another. Finally, actions needing to be taken if decisions are required regarding the prioritisation of treatment. The plans have been tested internally and exercises have been undertaken by the Strategic Health Authority (SHA) looking at cross-organisational links. The Chair noted that there had been no confirmation of additional funding in the event of a further wave of infections. Mr White added that there would potentially be a big impact on achieving the 18-week target. The Chair asked whether swine 'flu made patients more susceptible to *C difficile* and MRSA bacteraemia infections. Mr O'Donoghue advised that work is underway to determine the extent of any link, however any patient debilitated will have an increased risk of such infections. He asked whether the ethical group planned would override the clinicians' decisions about individual patients. Mr Kirby responded that this was not the intention and the remit of the group would be for policy decisions only. Mr Adler remarked that because of the surge of cases in the summer, the Trust has good experience of handling an outbreak, although the peak in the summer is still minor compared to the predicted possible level of cases. There are forecast to be critical care capacity issues and serious prioritisation considerations. Mr Kirby advised that the plan included the doubling of critical care capacity if required. It was agreed that an update on the status of actions should be considered at the next meeting. Mr Adler advised that the Department of Health had urged the Trust to encourage	

staff to take up vaccinations. There has been some testing of public views which has revealed that there may not be a huge uptake of the vaccine, although this position could change should the number of cases escalate. Dr Sahota asked whether there were similar vaccination plans for other Health bodies. Mrs Kinghorn advised that there is a meeting planned shortly to discuss the communications requirements around vaccinations. Mrs Hunjan asked how CRB checks would be managed in the event that recently retired staff would be asked to return to work. Mr Kirby advised that the process for ensuring such checks are completed would be followed as far as possible, although there would need to be a relative-risk test if the situation demands. The Trust Board approved the state of readiness for a further wave of H1N1 infections.	
AGREEMENT: The Trust Board approved the state of readiness for a further wave of H1N1 infections	
10 Permanent Injury Benefit to a former employee	**SWBTB (9/09) 179** **SWBTB (9/09) 179 (a)**
Mr Holden provided the background to the proposal to settle a permanent injury benefit for an ex employee of City Hospital NHS Trust. He advised that the employee had left the NHS in 1996 due to ill health and ten years later a claim was made under the NHS Injury Benefits Scheme which was successful on appeal. There is no right of appeal for the Trust against the decision. There has however been some doubt as to the liability for the payment of arrears and ongoing payment. The Trust initially contested liability on legal advice, but the Pensions Agency has stated that this is the responsibility of the Trust. The payment arrears is £383k plus an ongoing payment of £24k per annum, which has been accrued in the accounts and therefore has no implications for the current year financial position. The Trust Board was recommended to approve the payment being made. Dr Sahota asked for how long the individual had been employed. He was advised that the employee had been a member of the NHS since 1982, although only two years of this had been in City Hospital. Mr Adler asked the Board to note that the Department of Health had stated that a direction would be issued from the Secretary of State to make the payment if the Trust Board did not approve it. Mrs Hunjan asked for confirmation that the injury had been sustained. Mr Holden advised that the individual had been judged as permanently incapable of employment by the relevant medical representatives. Mr O'Donoghue asked whether there were any more cases pending, bearing a similar liability. He was advised that there was no way of knowing if a member of staff had left the Trust under such circumstances, whether a claim would be made. Given that there was little alternative, the Trust Board unanimously agreed to accept the liability for the payment and settle the claim immediately.	

AGREEMENT: The Trust Board agreed to accept the liability for the permanent injury benefit payment and to settle the claim immediately	
11 Strategy and Development	
11.1 'Right Care Right Here' programme: progress report	**SWBTB (9/09) 175** **SWBTB (9/09) 175 (a)** **SWBTB (9/09) 175 (a)**
The Trust Board was asked to receive and note the latest version of the 'Right Care, Right Care' programme progress report. Mr Kirby highlighted that there had been three new areas of work started in relation to outpatient services, emergency care pathways; and the systematic approach to care. Mr Cash asked whether the delay with the use of the Norman Power Centre had been resolved. Mr Kirby assured him that the linkage with the Power Centre was now working well.	
12 Performance Management	
12.1 Monthly performance report	**SWBTB (9/09) 180** **SWBTB (9/09) 180 (a)**
Mr White presented a summary of the Trust's performance against a number of key targets and indicators for the period April - August 2009. Performance against the stroke care target was noted to be a concern, given that the expected increase in the number of patients spending their majority of the hospital stay had not increased as expected. The good performance against the Accident and Emergency waiting times target was noted to have been maintained. In terms of performance against the CQUIN targets, it was noted that performance with the smoking cessation target is good, although further work is due to be undertaken to ensure that the referrals reported are those awaiting elective surgery, as it is these that the CQUIN target relates to. Patient activity remains high, although this performance is spread against a number of commissioners. There has been a drop in the number of shifts covered by agency staff, resulting in a decline in expenditure associated with agency and bank staff. There has been a continued increase in the number of PDRs submitted. Mr Trotman reported that a presentation on progress with addressing theatre utilisation issues had been considered by the Finance and Performance Management Committee at its last meeting and the discussions will be reflected in the minutes of the meeting due for presentation at the next Trust Board meeting. Miss Bartram asked for clarification on the position regarding sickness following the recent negative press article. Mr Holden reported that the article had not provided	

a truly reflective picture and that the Trust's sickness absence rates were one of the lowest in the region. Mr Kirby suggested that consideration should be given to changing some of the information in the report that is currently presented on a separate site basis.	
12.2 Monthly finance report	**SWBTB (9/09) 171** **SWBTB (9/09) 171 (a)**
Mr White reported an in month surplus of £177k against a target of £7k. Year to date however, the position remains adverse at £186k below plan. The stabilised position is attributable to additional income received in month. There has not been any need to call on uncommitted contingency. There has been some budgetary pressure in some divisions due to the income issues, however recovery plans have been received from these areas which will be worked through and actions agreed. The summary of the plans has been considered by the Finance and Performance Management Committee. A number of data challenges have been received in month however the Trust is engaged with the PCTs to resolve these disputes.	
12.3 NHS Performance Framework monitoring report	**SWBTB (9/09) 172** **SWBTB (9/09) 172 (a)**
Mr White presented the NHS Performance Framework monitoring report. The Board was pleased to note that the score for July was 2.94, classifying the Trust as a 'performing' organisation. It was noted that the performance against the 'stay on a stroke unit' target was at amber status. Mr Adler reported that overall status for all Trusts had now been published and a significant number of Trusts are classified as 'performance under review' and 'underperforming'.	
13 Governance and Operational Management	
13.1 Progress with delivering single sex accommodation	**SWBTB (9/09) 173** **SWBTB (9/09) 173 (a)** **SWBTB (9/09) 173 (b)**
Mr Kirby presented an update on the Trust's progress with delivering single sex accommodation, following the Department of Health guidance to ensure mixed sex accommodation is eliminated from hospitals. Following a visit from the national support team, the final report has been received, which Mr Kirby offered to circulate. The report recognises that there is commitment by the Trust to achieve the single sex requirements, however there are difficulties in achieving this due to the constraints posed by the configuration of the estate. The broader issues on privacy and dignity are being resolved but require further work. The recommendations from the report will be developed into an action plan which will be regularly monitored. A mechanism is now in place to formally report occasions when the single sex requirements are breached, which will be included within the October	

performance monitoring report to be considered at the November meeting. Partitioning work is nearly complete and the majority of bays within the Medical Assessment Unit at City Hospital are now operating on a single sex basis. The assessment unit at Sandwell Hospital will have one bay operating on a mixed sex basis as this is to be dedicated to high technology procedures. A series of engagement activities have occurred which included the local LINK teams and shadow FT members and have generated a set of issues for consideration. Various options are to be considered to resolve the single sex accommodation difficulties on the City Hospital site, with thought needing to be given to the clinical implications. Miss Bartram suggested that it was difficult to compare the Trust's position with that of other Trusts. Mr Kirby acknowledged that a direct comparison was not possible, although reminded the Board that the local patient survey and auditing of progress had been previously reported to the Board. Mr Cash asked whether the plans had been discussed with clinicians and in particular the proposal to establish mixed speciality wards. Mr Kirby reported that the surgeons are comfortable with the plans, however the physicians have a concern that the plans may present difficulties. Mr O'Donoghue added that technically the mixed speciality wards were a reversion to previous configuration. There are clinical safety issues and working practice considerations that need to be fully thought through. Mr Cash highlighted that the current nightgowns present a significant dignity issue. Miss Overfield advised that although work is being done to address this matter, the Trust is currently bound by a national contract. Mr Adler reminded the Board that the forthcoming core standards declaration would feed into the new registration with the Care Quality Commission. Miss Dhami added that in its last declaration, the Trust had declared that it would not be compliant with the core standard regarding single sex accommodation until December 2009.	
ACTION: **Mr Kirby to circulate the national support team's report into single sex accommodation**	
13.2 Mortality update	**SWBTB (9/09) 183** **SWBTB (9/09) 183 (a)** **SWBTB (9/09) 183 (b)**
Mr O'Donoghue reminded the Board that following the Heathcare Commission's review of Mid Staffordshire NHS Foundation Trust, a recommendation arose to ensure that mortality is reviewed on a systematic basis. An action to investigate the same had arisen from a meeting of the Governance and Risk Management Committee. Current assurance regarding the mortality trend is linked to the standardised mortality rate (SMR), which tracked over four years, has shown a steady decline. A further strand of assurance concerns the Trust's incident reporting system which captures any untoward mortality cases. The third means of assurance concerns the	

Dr Foster intelligence system which sends alerts should there be a deviation from expected mortality rates in a particular speciality. When such an alert is received, an audit of the cases involved is undertaken. At present, four alerts are in progress, all of which have audits underway. The Trust is also participating in a mortality review pilot organised by the Strategic Health Authority. The current tool used to review hospital deaths is due to be expanded shortly to enable more comprehensive monitoring of mortality. Dr Sahota asked how the Trust works with palliative care providers and was advised that although the Trust is in touch routinely with palliative care providers, the overall provision is outside the Trust's control. Dr Sahota suggested that the Trust should consider working with the PCTs to develop hospice home working. Mr Kirby advised that this work is being supported, particularly at Sandwell. The Chair suggested that as there is a lack of palliative care available, consideration should be given to the Trust providing this service. She was advised that this was underway and a joint working arrangement was probable. Miss Bartram asked what SMR was reported by Mid Staffordshire NHS Foundation Trust at the time of the investigation. She was informed that this was in excess of 120. In terms of the Dr Foster alerts, Mr O'Donoghue reported that these are reported in detail at the Governance Board meeting and a summary is considered by the Governance and Risk Management Committee. Miss Dhami reminded the Board that an outcome of the Heathcare Commission's investigation was that any mortality outliers would be reported to the Trust Board. This is planned within the next few months. Mrs Hunjan asked what level of detail is to be provided. She was advised that this would be considered by the Mortality Steering Group. Mr Trotman noted that accurate clinical coding is important to ensure a representative view of hospital mortality. Mr O'Donoghue agreed that clinical coding could be improved but suggested that comfort should be taken from the downward trend in SMR. Mr Adler underlined the importance of ensuring a robust system for reviewing each hospital death is in place, however he also highlighted that further thought needed to be given to the level of information presented to the Trust Board, particularly in the light of a declining SMR position.	
13.3 Annual report on complaints handling	**SWBTB (9/09) 177** **SWBTB (9/09) 177 (a)**
Miss Dhami presented the annual report into complaint handling, highlighting that this had been considered in detail by the Governance and Risk Management Committee. The complaints team had been an early adopter of the revised NHS complaints procedures, therefore a direct comparison with performance in 2007/08 was not possible. Compliance with the core standards concerning the handling of complaints had been declared as maintained in the last submission. The Board was advised that 834 complaints had been received in 2008/09, 715 of	

which were answered within 25 days. Some of these complaints had been fast tracked as part of the early adopter scheme. The Board noted that there had been a rise in complaints from the previous year although a number of these were multiple complaints about a single issue. The main categories of complaints have remained the same, with all aspects of clinical care remaining as the top category. The decline in the number of reported thank you letters was noted, however the Board was assured that this was reflective of poor reporting of letters, rather than a decline in the number of letters received. Mr Adler remarked that it was good to see the long term trends in complaints around staff attitude declining. The Chair asked what progress was being made to arrange for the Board to hear from individuals who had had cause to complain. She was advised that a handling strategy for this was being developed.	
13.4 Annual report on risk	**SWBTB (9/09) 176** **SWBTB (9/09) 176 (a)**
Miss Dhami presented the annual report on risk, highlighting that this had been considered in detail by the Governance and Risk Management Committee. In terms of the patient safety development programme, a number of actions from 2008/09 have been rolled forward to the 2009/10 plan. The preparation for the NHS Litigation Authority assessments has taken up much of the risk team's resources during the past few months. Three patient safety walkabouts have been piloted and have involved Dr Sahota as the non-executive with an interest in patient safety. Miss Dhami was asked to check the reasons behind the rise in security incidents.	
ACTION: Miss Dhami to determine the reason behind the rise in security incidents	
13.5 Quarterly integrated risk, complaints and claims report	**SWBTB (9/09) 181** **SWBTB (9/09) 181 (a)**
Miss Dhami presented the latest quarterly integrated risk, complaints and claims report. The complaints data was noted to be in relation to the new reporting guidelines, which allow greater flexibility to negotiate the response times. The Board noted the analysis of the instances when the agreed deadlines for reporting were not met. Mr Adler expressed concern over the rise in complaints reported. Miss Dhami advised that there had been a decline in the number of complaints concerning nursing care, although a rise in the number of operational and systems issues was evident. Miss Dhami offered to prepare an analysis of the increase against the national picture.	

ACTION: **Miss Dhami to prepare an analysis of the rise in complaints against the national trends data**	
14 Update from the Committees	
14.1 Finance and Performance Management	**SWBFC (8/09) 079**
The Board noted the minutes of the Finance and Performance Management Committee meeting held on 20 August 2009.	
15 Any other business	**Verbal**
There was none.	
16 Details of the next meeting	**Verbal**
The next meeting is scheduled for Thursday 29 October 2009 at 14.30pm in the Churchvale/Hollyoak Rooms, Sandwell Hospital.	
17 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: 29 October 2009, Churchvale/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

24 September 2009 - City Hospital

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

In Attendance: Mr C Holden (CH), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Mr J Cash (JC)

Apologies: Professor D Alderson (DA)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 23 October 2009

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 096	Sustainability	Presentation	25-Jun-09	Present the sustainability strategy at the November meeting of the Trust Board	GS	26-Nov-09	**ACTION NOT YET DUE**	Review next meeting	
SWBTBACT. 106	Annual report	SWBTB (9/09) 176 SWBTB (9/09) 176 (a)	24-Sep-09	Determine the reason behind the rise in security incidents	KD	26-Nov-09		Review next meeting	
SWBTBACT. 107	Quarterly integrated risk, complaints and claims report	SWBTB (9/09) 181 SWBTB (9/09) 181 (a)	24-Sep-09	Prepare an analysis of the rise in complaints against national trend date	KD	26-Nov-09		Review next meeting	
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 a future meeting. Suggest revisiting in December	Future	17-Dec-09
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	Update to be provided within next SES update	Future	17-Dec-09
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. 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	01-Jan-10		Future	
SWBTBACT. 105	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 the outcome of the work of the Accident and Emergency Action Team at the October meeting of the Trust Board	DOD	29-Oct-09	Included on agenda of private Trust Board session	Completed Since Last Meeting	
SWBTBACT. 107	Policy on the development, approval and management of policies	SWBTB (8/09) 158 SWBTB (8/09) 158 (a) SWBTB (8/09) 158 (b) SWBTB (8/09) 158 (c)	27-Aug-09	Circulate the full list of policies to the Trust Board	KD	29-Oct-09	Circulated as requested	Completed Since Last Meeting	

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 094	Patient Experience update	Hard copy papers	28-May-09	Present an update on progress against the Patient Experience Action Plan at a future meeting of the Trust Board	RO	24-Sep-09	Included on agenda	Completed Since Last Meeting	
SWBTBACT. 104	Chair's opening comments	Verbal	24-Sep-09	Communicate the Trust Board's congratulations to Dr Cadigan on his recent appointment in the Royal College of Physicians	SGP	29-Oct-09	Letter written to Dr Cadigan as requested	Completed Since Last Meeting	
SWBTBACT. 105	Progress with delivering Single Sex accommodation	SWBTB (9/09) 173 SWBTB (9/09) 173 (a) SWBTB (9/09) 173 (b)	24-Sep-09	Circulate the national support team's report into single sex accommodation	RK	29-Oct-09	Circulated as requested	Completed Since Last Meeting	

Next Meeting: 2

Sandw

Members:	Mrs S Davis (SD), Mr R Trotman (RT). Ms I Bartram (IB), Mrs G Hur Overfield (RO)
In Attendance:	Mr C Holden (CH), Miss K Dhami (KD), Mr G Seager (GS), Mrs J
Apologies:	Professor D Alderson (DA)
Secretariat:	Mr S Grainger-Payne (SGP)

Reference No	Item	Paper Ref	Date
SWBTBAGR.107	Minutes of the previous me	SWBTB (8/09) 166	24-Sep-09
SWBTBAGR.108	Initiation of a CPO	SWBTB (9/09) 168 SWBTB (9/09) 168 (a) SWBTB (9/09) 168 (b) SWBTB (9/09) 168 (c)	24-Sep-09
SWBTBAGR.109	Maternity Services review	SWBTB (9/09) 174 SWBTB (9/09) 174 (a) SWBTB (9/09) 174 (b) SWBTB (9/09) 174 (c)	24-Sep-09
SWBTBAGR.110	Maternity Services review	SWBTB (9/09) 174 SWBTB (9/09) 174 (a) SWBTB (9/09) 174 (b) SWBTB (9/09) 174 (c)	24-Sep-09
SWBTBAGR.111	Maternity Services review	SWBTB (9/09) 174 SWBTB (9/09) 174 (a) SWBTB (9/09) 174 (b) SWBTB (9/09) 174 (c)	24-Sep-09
SWBTBAGR.112	Maternity Services review	SWBTB (9/09) 174 SWBTB (9/09) 174 (a) SWBTB (9/09) 174 (b) SWBTB (9/09) 174 (c)	24-Sep-09
SWBTBAGR.113	Maternity Services review	SWBTB (9/09) 174 SWBTB (9/09) 174 (a) SWBTB (9/09) 174 (b) SWBTB (9/09) 174 (c)	24-Sep-09
SWBTBAGR.117	Statement of readiness for swine 'flu pandemic	SWBTB (9/09) 178 SWBTB (9/09) 178 (a) SWBTB (9/09) 178 (b) SWBTB (9/09) 178 (c)	24-Sep-09

SWBTBAGR.118	Permanent injury benefit to a former employee	SWBTB (9/09) 179 SWBTB (9/09) 179 (a)	24-Sep-09

9 October 2009, Churchvale/Hollyoak Rooms @ Sandwell Hospital

ell and West Birmingham Hospitals NHS Trust - Trust Board

24 September 2009 - City Hospital

njan (GH), Dr S Sahota (SS), Miss P Akhtar (PA), Mr J Adler (JA), Mr D O'Donoghue (DO), Mr R White (RW), Mr R Kirby (RK), Miss F

Kinghorn (JK), Mr J Cash (JC)

Last Updated: 23 October 2009

Agreement
The minutes of the previous meeting were approved as a true and accurate record of discussions held
The Trust Board resolved to affix the Trust Seal to and make a Compulsory Purchase Order for the purpose of securing the provision of a new acute hospital, together with supporting facilities
The Trust Board agreed that a public consultation of the shortlisted options for maternity services is undertaken
The Trust Board agreed the case for change to the configuration of maternity services in the medium term
The Trust Board agreed the consultation framework
The Trust Board agreed the consultation document
The Trust Board agreed the decision-making process to identify an approved option
The Trust Board approved the state of readiness for a further wave of H1N1 infections

The Trust Board agreed to accept liability for the permanent injury benefit payment and to settle the claim immediately

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	New Hospital Project-Compulsory Purchase Order
SPONSORING DIRECTOR:	Graham Seager, New Hospital Project Director
AUTHOR:	Graham Seager, New Hospital Project Director
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

At its September meeting the Trust Board resolved to make a Compulsory Purchase Order in respect of land for the new acute hospital. Following the meeting but prior to making the order the trust's legal advisor recommended amendments to the Order. The amendments related to:

CRANE OVER SAILING RIGHTS
All crane over sailing rights have been removed from the CPO. Further consideration of crane over sailing has lead to the conclusion that this can be adequately dealt with by the contractor acquiring these rights under licence from the Highways Authority if they are required.

BOUNDARY AMENDMENTS
Those plots containing the bridge links and access road to those links have been converted from rights to full title plots.

Following site inspection of the bridge links and discussions with our advisors, it is possible that the works required to the bridge links may be more extensive than first thought. Maximum flexibility is therefore required. Freehold title for the bridge links and access strip rather than tightly defined rights have been included so that if it transpires that more extensive works are required the CPO provides sufficient powers to authorise these. It is being stressed to the owners, however, that our aim is to obtain temporary rights only and for the avoidance of doubt that remains our clear intention

A revised map is enclosed as appendix 1.

To maintain project timescales and to maintain the relevance of land referencing work the issue was considered and approved within the framework of the Trusts SO/SFIs as an emergency action.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

Note the amendments made and ratification of agreed action.

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		
Communications & Media		
Risks		The Trust's legal adviser confirms that: (a) the removal of the crane oversailing rights reduces the scope for the Compulsory Purchase Order to be objected to and therefore makes it more likely to be confirmed. We are also advised that local highway authorities negotiate crane oversailing licences routinely with developers and contractors. We will pursue this for the benefit of the future contractor in parallel with plot acquisitions within the site; (b) the treatment of the boundary plots where work needs to be carried out is consistent with an approach the principle of which has been endorsed by senior personnel dealing with CPO issues on behalf of the Secretary of State on other CPOs.

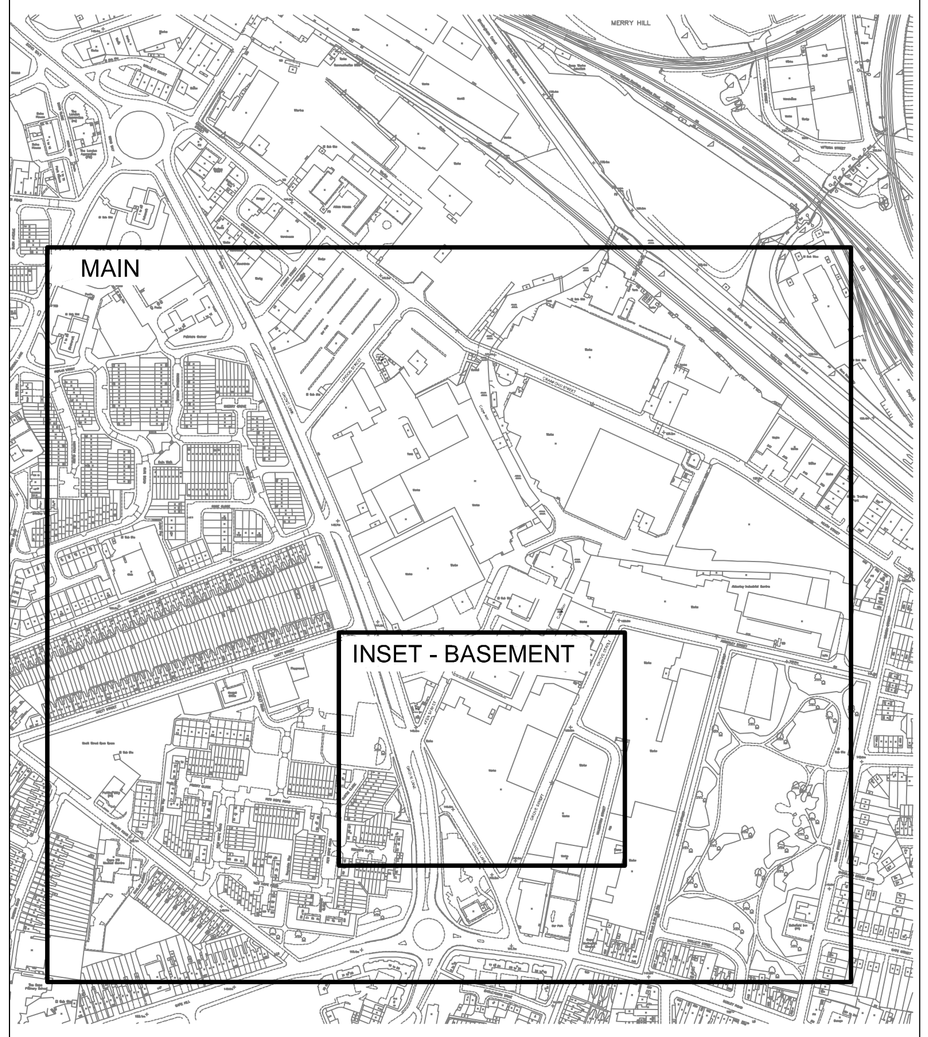
PREVIOUS CONSIDERATION:

Discussion with members of the Board involved with agreeing the emergency action.

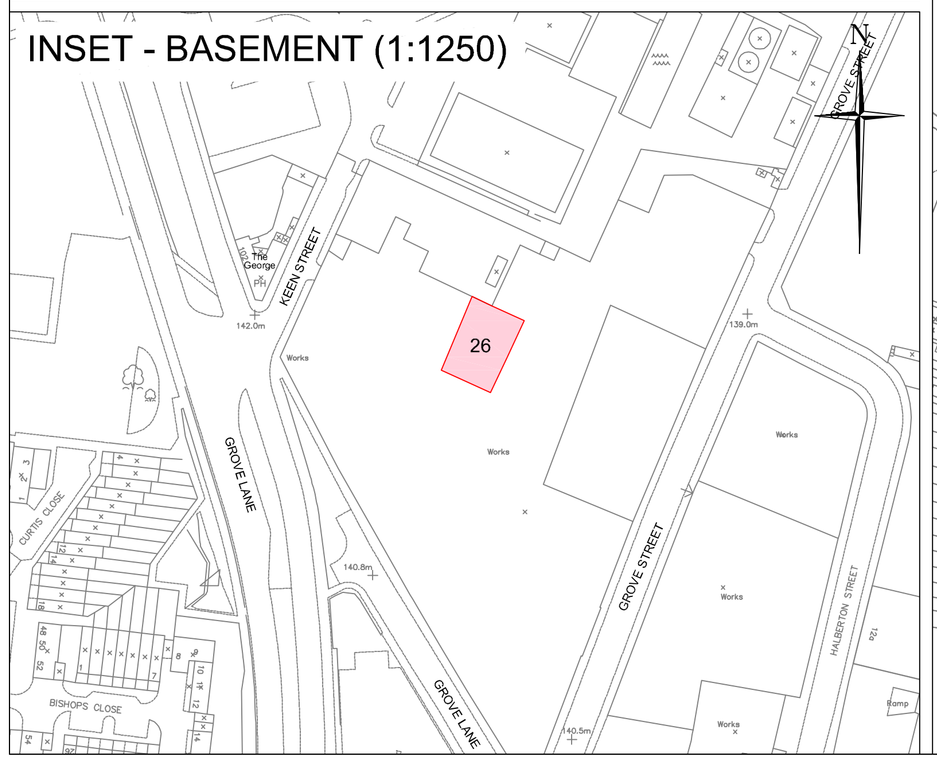
MAP REFERRED TO IN THE SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST (GROVE LANE, SMETHWICK) COMPULSORY PURCHASE ORDER 2009

SWBTB (10/09) 187 (a)

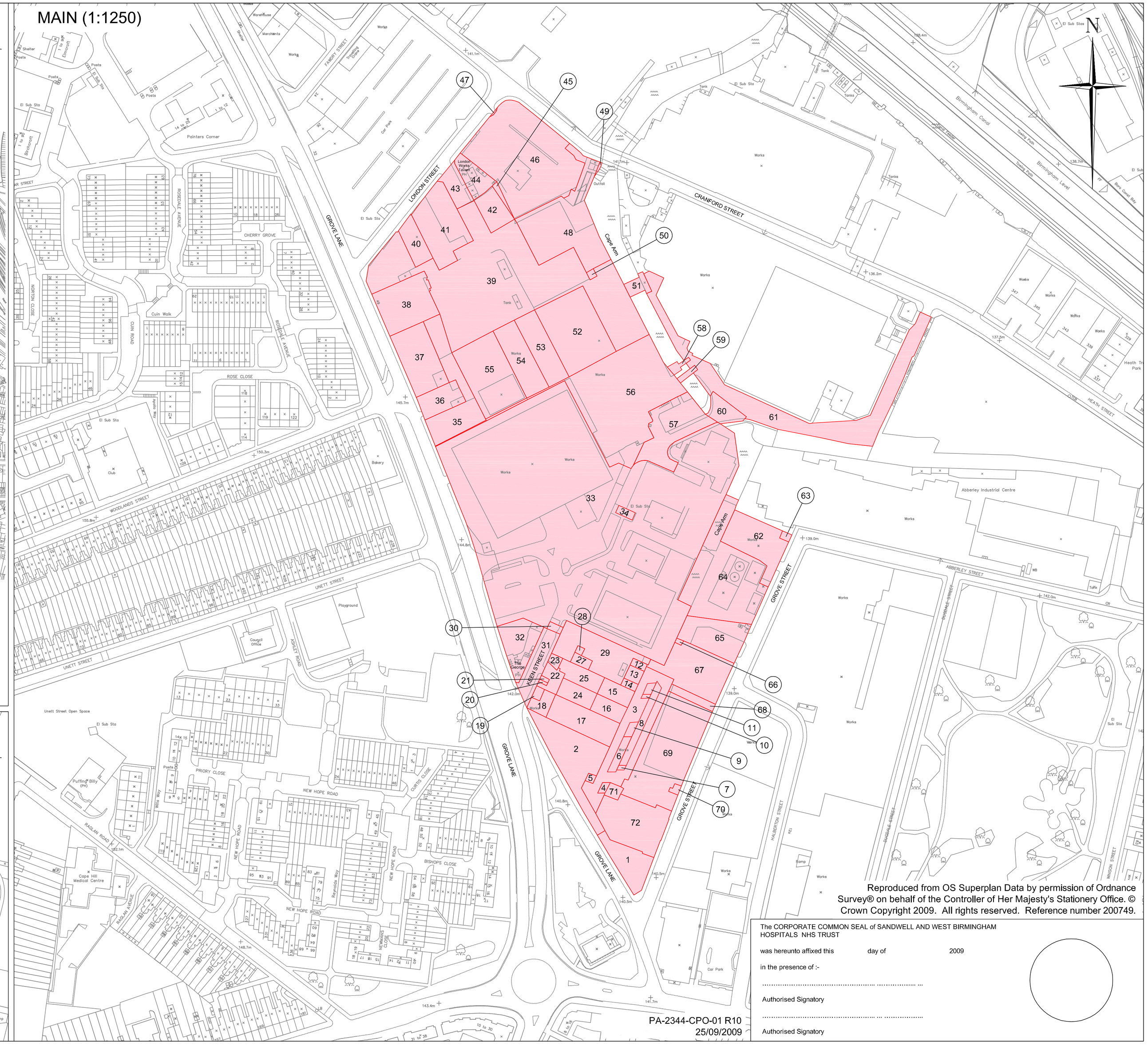
KEY PLAN (NOT TO SCALE)



INSET - BASEMENT (1:1250)



MAIN (1:1250)



Reproduced from OS Superplan Data by permission of Ordnance Survey® on behalf of the Controller of Her Majesty's Stationery Office. © Crown Copyright 2009. All rights reserved. Reference number 200749.

PA-2344-CPO-01 R10
25/09/2009

The CORPORATE COMMON SEAL of SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

was hereunto affixed this day of 2009

in the presence of :-

....

Authorised Signatory

....

Authorised Signatory

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Estates Strategy Annual Review 2009/10
SPONSORING DIRECTOR:	Graham Seager, Director of Estates/New Hospital Project
AUTHOR:	Rob Banks, Head of Estates
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

This report provides an annual update of the Estates Strategy to identify the current position in relation to the Estates Management Issues listed below. This layout is consistent with the Executive Summary of the Main Estates Strategy document approved by the Trust Board in October 2008.

- Existing Estate;
- Estates Performance;
- Risk Management and Governance;
- Environmental Performance;
- Estates Returns and Information Collection (ERIC) and Performance Indicators;
- Patient Perceptions and Patient Environment Action Team (PEAT);
- Summary Disposal and Proceeds of Sale;
- Development Control Plans;
- Strategic Options for Estate change.

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 consider and approve this Estates Strategy Annual Review 2009/10.

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	**X**	
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Usual annual review of estates strategy. Last considered at Trust Board meeting held in September 2008.

SWBTB (10/09) 196 (a)

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Estates Strategy Annual Review 2009/10

October 2009

ESTATES STRATEGY ANNUAL REVIEW 2009/10

LIST OF TABLES

ESTATES STRATEGY ANNUAL REVIEW 2009/10

1.0 INTRODUCTION

The Estates Strategy for the period 2008/09 to 2017/18 was approved by the Trust Board at the meeting in October 2009.

The objectives of the Estates Strategy are as follows:

1. To analyse the estate condition and its performance;

2. To identify costs to achieve Estatecode condition 'B' for key facets of Condition Survey;

3. To prioritise capital investment in estate statutory compliance issues;

4. To maintain/improve compliance with Annual Health Check Core standards;

5. To achieve improvement year on year in NHS Environmental Assessment Tool (NEAT) assessment;

   NEAT now replaced by the 'Building Research Establishment Environmental Assessment Method' for Healthcare, (BREEAM);

6. To operate all estate and facilities services at a benchmark between the lower and upper quartiles of the Estates Return Information Collection (ERIC) returns of comparable Trusts and demonstrate value for money;

7. To achieve green status for all operational related performance indicators by March 2016.

This report provides an annual update of the Estates Strategy to identify the current position in relation to the Estates Management Issues listed below. This layout is consistent with the Executive Summary of the Main Estates Strategy document.

- Existing Estate;
- Estates Performance;
- Risk Management and Governance;
- Environmental Performance;
- Estates Returns and Information Collection (ERIC) and Performance Indicators;
- Patient Perceptions and Patient Environment Action Team (PEAT);
- Summary Disposal and Proceeds of Sale;
- Development Control Plans;
- Strategic Options for Estate change.

2.0 EXISTING ESTATE

Sandwell and West Birmingham Hospitals (SWBH) estate property portfolio consists of a variety of buildings with a very diverse range of ages and conditions.

The total value of the Trusts building assets is shown in Table 1 below:

Table 1 – Total Value of Trusts Building Assets at 31/03/09

Sandwell	£87,311,411
City	£104,778,555
Rowley	£13,684,785
Total Value of Building Assets	**£205,777,000**

The valuation of the Estate is due to be updated in line with Department of Health guidance by 1st April 2010. There have no material changes to the portfolio during this review period.

3.0 ESTATE PERFORMANCE

No further condition surveys have been carried out during the last twelve months. However, backlog maintenance figures have been updated following Capital Investment during 2008/09, inflation and outputs from revised risk assessments of key estates elements.

Table 2 below identifies costs to achieve Estate Code Condition 'B'.

Definition of Condition 'B':

'B' Sound, operationally safe and exhibits only minor deterioration

Table 2 – Cost to Achieve Condition 'B'

High Risk	**£205,000**
Significant Risk:	**£2,710,000**
Moderate Risk:	**£86,275,847**
Low Risk:	**£9,123,900**
Total backlog: (to achieve condition 'B')	**£98,314,747**
Risk Adjusted:	**£6,163,026**

An investment commensurate with the high and significant risk elements of backlog has been approved by the Strategic Investment Review Group (SIRG) from 2009/10 Capital Programme.

The Trusts current backlog maintenance position when benchmarked against other large acute Trusts outside of London using Estates Return Information Collection (ERIC) data, is as shown in Table 3.

Table 3 – Total Backlog Cost per Occupied Floor Area (£/m^2)

LOWER QUARTILE	MEDIAN	UPPER QUARTILE	SWBH POSITION
£36.80	£122.40	£245.85	£608.90

Trust Total Backlog Cost per occupied floor area - well above upper quartile position.

Table 4 – Total Risk Adjusted Cost per Occupied Floor Area (£/m^2)

LOWER QUARTILE	MEDIAN	SWBH POSITION	UPPER QUARTILE
£17.57	£37.92	£38.17	£102.55

Risk Adjusted Backlog – marginally above median position. This is an indication that high and significant risks are being addressed within 12 months.

The 2009/10 financial programme includes £3.6 million allocated to statutory standards and estates related improvement schemes the breakdown of which is as shown in Table 5 below:

Table 5 – Statutory Standards and Estates Related Budget Allocation

Capital	£2,265,000
Non- Recurrent Revenue	£650,000
Sub Total	**£2,915,000**

Table 6 - Additional Estates Related Budget Allocation

Security	£300,000
Healthcare Commission	£370,000
Sub Total	**£670,000**

Total SIRG Approved Expenditure £3,585,000

Other notable schemes for Capital Investment during 2009/10 are as follows:

- Urgent Care Centre, City Hospital
- Medical Records Relocation, City Hospital
- City Hospital MRI Scanner
- D16 Refurbishment, City Hospital
- City Hospital Maternity Block Refurbishment
- Neurophysiology Outpatients Move
- D20/D25 Refurbishments
- Mixed Sex Privacy and Dignity

Further investment in the existing estate will be required as the Trust moves towards the development of the new acute hospital. This investment will be required in order to maintain compliance with statutory standards, impending standards and the need to achieve high levels of business continuity. The Trusts 10 year Capital Plan Forecast reflects this need for continuing investment in the existing estate.

4.0 RISK MANAGEMENT and GOVERNANCE

The Estates and Capital Projects Directorate continues to follow the robust well developed risk management and governance structure:

Governance meetings are held monthly with quarterly reports to Trusts Governance Board. Risk assessments across many elements of Estates Management are undertaken annually and continually monitored and reviewed by the Head of Estates and appropriate Estates Operational Manager. All Red risks relating to the Estates are incorporated into the Trusts risk register in order that an informed corporate view is adopted to the process of Pro-active Risk Management.

The Directorate has achieved compliance/partial compliance with the related core requirements for the following:

- Care Quality Commission(CQC) Annual Health Check
- CQC Hygiene Code (January 2009) partial compliance
- National Health Service Litigation Authority (NHSLA)Standard 3 level 1– Safe Environment

The Estates Risk Register is a statutory requirement and an aid to determining the prioritisation of funding for capital investment using the principles as laid down in Estates and Facilities Management Standard "a risk based methodology for establishing and managing backlog 2007.

Annual Health Check Core Standards relating to estates and facilities issues are as shown in Table 7 below. The Directorate has achieved compliance with these core standards with the exception of standard C20b which was declared as partial compliance due to the single sex accommodation issues.

To improve single sex sleeping accommodation across the trust significant investment has been made on many of the trust's wards. This investment has improved Standard compliance. More work is being undertaken to find ways of improving the remaining inpatient accommodation at the City Site.

Table 7 – Annual Health Check Core Standards relating to Estates and Facilities

C4b	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised
C4c	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.
C4e	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.
C15a	Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet.
C15b	Where food is provided, healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.
C20a	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation.
C20b	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality
C21	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

The Hygiene Code 2009 relating to estates and facilities issues are as shown in Table 8 below. The Directorate has been working towards compliance with CQC report following Hygiene Code inspection November 08.

Table 8 – Hygiene Code 2009 relating to Estates and Facilities Issues

Criterion 2	Provide and maintain a clean and appropriate environment that facilitates the prevention and control of HCAI
Criterion 5	Gain the co-operation of staff, contractors and others involved in the provision of health care in preventing and controlling infection
Criterion 6	Provide or secure adequate isolation facilities

The NHSLA Standard 3 (level 1) which relate to estates and facilities issues are as shown in Table 9 below. The Directorate has compliance to level 1 and working with colleagues in Risk Management to collate data for level 2 application and assessment in December 09.

Table 9 - The NHSLA Standard 3 (level 1)

Criteria 1.3.1	The organisation has approved documentation which describes the process for managing the risks associated with the physical security of premises and other assets.
Criteria 1.3.2	The organisation has approved documentation which describes the process for managing the risks associated with sickness absences
Criteria 1.3.3	The organisation has approved documentation which describes the process for managing the risks associated with safeguarding adults.
Criteria 1.3.4	The organisation has approved documentation which describes the process for managing the risks associated with moving and handling.
Criteria 1.3.5	The organisation has approved documentation which describes the process for managing the risks associated with slips, trips and falls involving patients, staff and others
Criteria 1.3.6	The organisation has approved documentation which describes the process for managing the risks associated with inoculation incidents
Criteria 1.3.7	The organisation has approved documentation which describes the process for managing the risks associated with the maintenance of reusable medical devices and equipment
Criteria 1.3.8	The organisation has approved documentation which describes the process for managing the risks associated with the harassment and/or bullying of staff.
Criteria 1.3.9	The organisation has approved documentation which describes the process for managing the risks associated with the prevention and management of violence and aggression.
Criteria 1.3.10	The organisation has approved documentation which describes the process for managing the risks associated with work-related stress.

Many issues require a programme of strategic capital investment. The current Risk Assessment process is all based around the long term strategic objective to move to a new acute hospital within the timeframe identified in this strategy. Should the new acute hospital not come to fruition in this timescale Risk Assessments will need to be completely reassessed.

5.0 ENVIRONMENTAL PERFORMANCE

As from 1st October 2008 all public buildings over 1000m² needed to display their energy performance/efficiency rating on a scale of A to G by use of Display Energy Certificates (DEC's). The Trust has complied with this directive. Plans are currently in place to update these for 2009/10. The display energy certificates are displayed at main entrances to all buildings to which the directive applies.

The Trust has received funding from the DoH's Energy and Sustainability Fund in the sum of £430k to implement three Energy Saving Schemes as indicated below. These schemes are all underway and will be completed by 31/03/10 resulting in cost savings circa £200k/annum and Carbon Dioxide ($C0_2$) reduction of 2189 tonnes per annum.

Energy Saving Scheme	**Cost**	**$C0_2$ Reduction**
Improved Thermal Insulation	£123,000	668
Expansion of Trusts Building Management System	£196,000	709
Improved Condensate Recovery Systems to main boiler house	£111,000	812
Total	**£430,000**	**2189**

Overall Trust Energy Utility Performance: (No of Acute Trusts in Sample is 40)

Using the 2008/09 ERIC data the Trusts performance uses a range of energy/utility metrics as shown in tables 10 to 22 below:

Table 10 - Total Site Energy Consumed per Heated Volume (GJ/100m³)

Lower Quartile	Median	Trust Value	Upper Quartile
61.87	69.68	69.90	76.21

Table 11 - Total Electrical Energy Consumed per Occupied Floor Area (GJ/m²)

Trust Value	Lower Quartile	Median	Upper Quartile
0.48	0.49	0.57	0.68

Table 12 - $C0_2$ Emission per Occupied Floor Area (Kg/m²)

Lower Quartile	Median	Trust Value	Upper Quartile
123.72	134.34	139.40	146.60

Table 13 - Total Energy Cost per Occupied Floor Area (£/m²)

Trust Value	Lower Quartile	Median	Upper Quartile
24.78	24.85	28.26	29.81

Table 14 - Average Cost per Unit of Energy Consumed (Pence/KWh)

Trust Value	Lower Quartile	Median	Upper Quartile
4.45	4.48	5.09	5.65

Water Services:

Table 15 - Water Services Cost per Total Water Volume (£/m²)

Trust Value	Lower Quartile	Median	Upper Quartile
0.76	0.91	1.40	1.81

Table 16 - Water Services Cost per Occupied Floor Area (£/m²)

Trust Value	Lower Quartile	Median	Upper Quartile
1.10	1.54	2.14	2.97

Table 17 - Water Volume per Occupied Floor Area (m³/m²)

Trust Value	Lower Quartile	Median	Upper Quartile
1.46	1.48	1.63	1.88

Table 18 - Total Water Volume per Occupied Bed (Ltrs/Bed/Day)

Lower Quartile	Trust Value	Median	Upper Quartile
662.67	711.28	739.18	858.81

It is evident from the tables above that the Trust energy/utility performance and water usage is generally at median level or below. This is confirmation that investment in energy savings over the last few years is paying dividends. However, this is not to say that further efficiency savings cannot be achieved.

A 'Building Research Establishment Environmental Assessment Method' (BREEAM) Assessment has been undertaken on the New Acute Hospital Public Sector Comparator and an Excellent rating achieved. An Excellent rating is a requirement for Business Case Approval by the Department of Health.

A presentation on sustainability was delivered to and well received by the Trust Board in June 2009.

An LiA event is arranged for 22 October 2009 to launch sustainability into the organisation. The event will cover the three key strands of sustainability relating to the NHS those being:

- Procurement;
- Transport;
- Energy.

Output to establish a Sustainability Steering Group and produce a Sustainability Management Action Plan to Trust Board in November. There is a statutory requirement for the Trust to comply with Carbon Reduction Commitment (CRC), work is in hand to ensure compliance is achieved in the appropriate timescale.

6.0 ESTATES RETURN INFORMATION COLLECTION (ERIC) RETURNS

ERIC data for 2008/09 was submitted to the Department of Health on 30th June 2009, this is a mandatory requirement from the Department of Health.

An overview of Trust Performance for a range of Estates/Facilities criteria for 2008/09 compared to other large acute Trusts outside of London is shown below:

Estate Maintenance:

Table 19 - Total Building and Engineering maintenance Cost per Occupied Floor Area (£/m²)

Trust Value	Lower Quartile	Median	Upper Quartile
17.70	22.00	24.91	32.15

Cleanliness:

Table 20 - Total Cost of Cleaning per Occupied Floor Area (£/m²)

Lower Quartile	Median	Trust Value	Upper Quartile
27.38	31.62	31.90	36.06

Food Services:

Table 21 - Gross Cost of Patient Services per Main meals requested (£/meal)

Trust Value	Lower Quartile	Median	Upper Quartile	No. in Sample
2.47	2.47	3.10	4.06	37

A detailed analysis of the Performance Indicators will be undertaken when the Indicators are available from the Department of Health later this year and presented to the Executive Team within the Divisional Review process.

7.0 PATIENT PERCEPTION and PEAT

PEAT 2009

- **External Audits**

  All the PEAT scores have been submitted to the National Patient Safety Agency (NPSA). The confirmed PEAT results for environment, food and privacy and dignity for the Trust have now been received, see Table 22 below.

Table 22 – PEAT Results for the Trust for 2008/09

Site Name	Environment Score	Food Score	Privacy & Dignity
Sandwell Hospital	Good	Excellent	Good
City Hospital	Good	Excellent	Good
Eye Hospital	Good	Excellent	Good
Rowley Hospital	Good	Excellent	Good

- **Internal Audits**

A revised PEAT audit system has been introduced with the implementation of environmental self-assessments undertaken by the wards. The main change is that the responsibility for the audit of the standards now rests with the relevant ward/departmental manager. The basis for the audits is the same with all wards and clinical departments inspecting on a quarterly basis, any rectification action plans will be either dealt with at a local level or forwarded to the PEAT Coordinator, they will then be actioned accordingly subject to manpower and funding.

8.0 SUMMARY DISPOSAL and PROCEEDS OF SALE

The situation in relation to disposal of surplus land remains as the Estates Strategy in that there is planned to be significant land disposal from the City and Sandwell sites after once the community facilities have been established.

9.0 DEVELOPMENT CONTROL PLANS

The Development Control Plans (DCR) for 2009/10 have been agreed following discussion with the Director of Estates, Head of Estates, Head of Capital Projects and Chief Operating Officer and approved through the Strategic Investment Review Group (SIRG). DCP's for Sandwell and City sites can be seen in Appendix 1 and 2.

Main areas for development are shown in Section 3.0.

The approved Capital Programme for 2009/10 can be seen in Appendix 3.

10.0 STRATEGIC OPTIONS FOR ESTATE CHANGE

The 'Right Care, Right Here' (RCRH) Programme (formerly Towards 2010 Partnership) continues to make progress, Sandwell and West Birmingham's major component being the construction of a New Acute Hospital in Grove Lane.

Progress in the last twelve months has included Department of Health approval of the Outline Business Case and Sandwell MBC's approval of the Outline Planning Application. Land acquisition of the Grove Lane site is critical to the delivery of the New Acute Hospital and work has continued with much work being done in relation to land referencing to determine owners and tenants. Discussion has taken place with limited numbers of interested parties regarding

voluntary acquisitions. However Compulsory Purchase is essential to ensure all interests can be acquired within the appropriate timescale of this project.

The Trust has received Secretary of State approval to make The Compulsory Purchase Order (CPO) in relation to the acquisition of land and property on Grove Lane site and the Trust Board resolution was approved at the September 09 Meeting.

The key new acute hospital programme dates are as follow:

- OJEU Notice – November 2010
- PFI Financial Close – 2012/2013
- Construction Complete – 2015/2016

11.0 POSITION STATEMENT IN RELATION TO ESTATES STRATEGY OBJECTIVES

Objective	Position Statement	Current Status RAG Rating
1. To analyse the estate condition and its performance 2. To identify costs to achieve Estatecode condition B for key facets of Condition Survey 3. To prioritise capital investment in estate statutory compliance issues	Backlog maintenance figures updated on 31/3/09 in line with investment made during 2008/09 and revised risk assessments for 2009/10. Capital Programme agreed by SIRG for 2009/10 and Statutory Standards expenditure approved commensurate with high and significant risks identified.	
4. To maintain/improve compliance with Annual Health Check Core standards	More work needs to be undertaken to achieve compliance with Core Standard C20b	
5. To achieve improvement year on year in NHS Environmental Assessment Tool (NEAT) assessment NEAT now replaced by the 'Building Research Establishment Environmental Assessment Method' for Healthcare, (BREEAM)	BREEAM assessment for New Acute Hospital – excellent rating achieved. For Public Sector Comparator. Display Energy Certificates (DEC's) produced and displayed by 31 December 2008 as required for compliance. Energy Savings Schemes implemented (DH funding £430,000) In relation to the Trust energy/utility performance, most metrics fall within the median or lower quartiles of the ERIC benchmarking data. Plans in place to promote sustainability and carbon reduction and the development of a Sustainability Development Management Plan is in progress.	
6. To operate all estate and facilities services at a benchmark between the lower and upper quartiles of the Estates Return Information Collection (ERIC) returns of comparable Trusts and	Key Estates and Facilities Services are operated between the lower and upper quartiles of the ERIC benchmarking data. Where Services lie outside these parameters action will be taken to identify reasons and develop plans for corrective action.	

demonstrate value for money		
7. To achieve green status for all operational related performance indicators by March 2016	With the approval of the New Acute Hospital Outline Business Case and Secretary of State approval to make Compulsory Purchase Order in relation to land acquisition for Grove Lane, it is still on programme for compliance to be achieved for all performance indicators by 2016.	

12.0 CONCLUSION

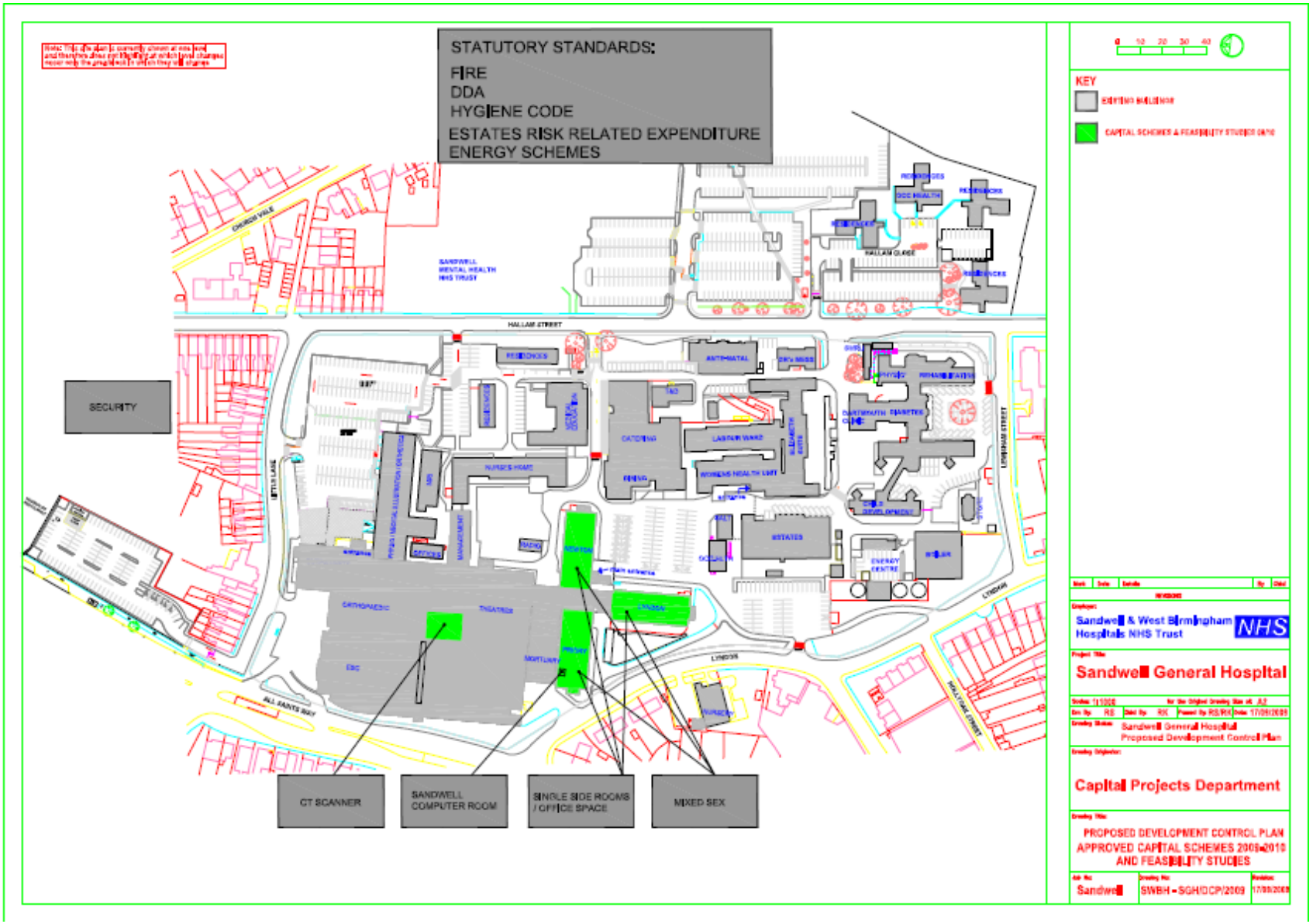
As can be seen from the position statement in section 11.0 above, good progress is being made to ensure compliance with the objectives of this Estates Strategy. From an operational perspective the risk management and governance arrangements in place are robust and the estate in being effectively managed to maintain risk to an absolute minimum in a cost effective manner. Year on year capital investment to address the high and significant risks is essential to maintain this position. The Estates Directorate continues to provide the necessary support to the Trust to ensure appropriate standards are achieved across a range of performance standards, Care Quality Commission, NHSLA etc. Improvements are being made in relation to environmental issues and the push towards sustainability should see even greater benefits for the future.

The long term strategic objective, to move to a single acute hospital site on Grove lane remains on schedule for completion by 2016.

ESTATES STRATEGY ANNUAL REVIEW 2009/10

APPENDIX 1

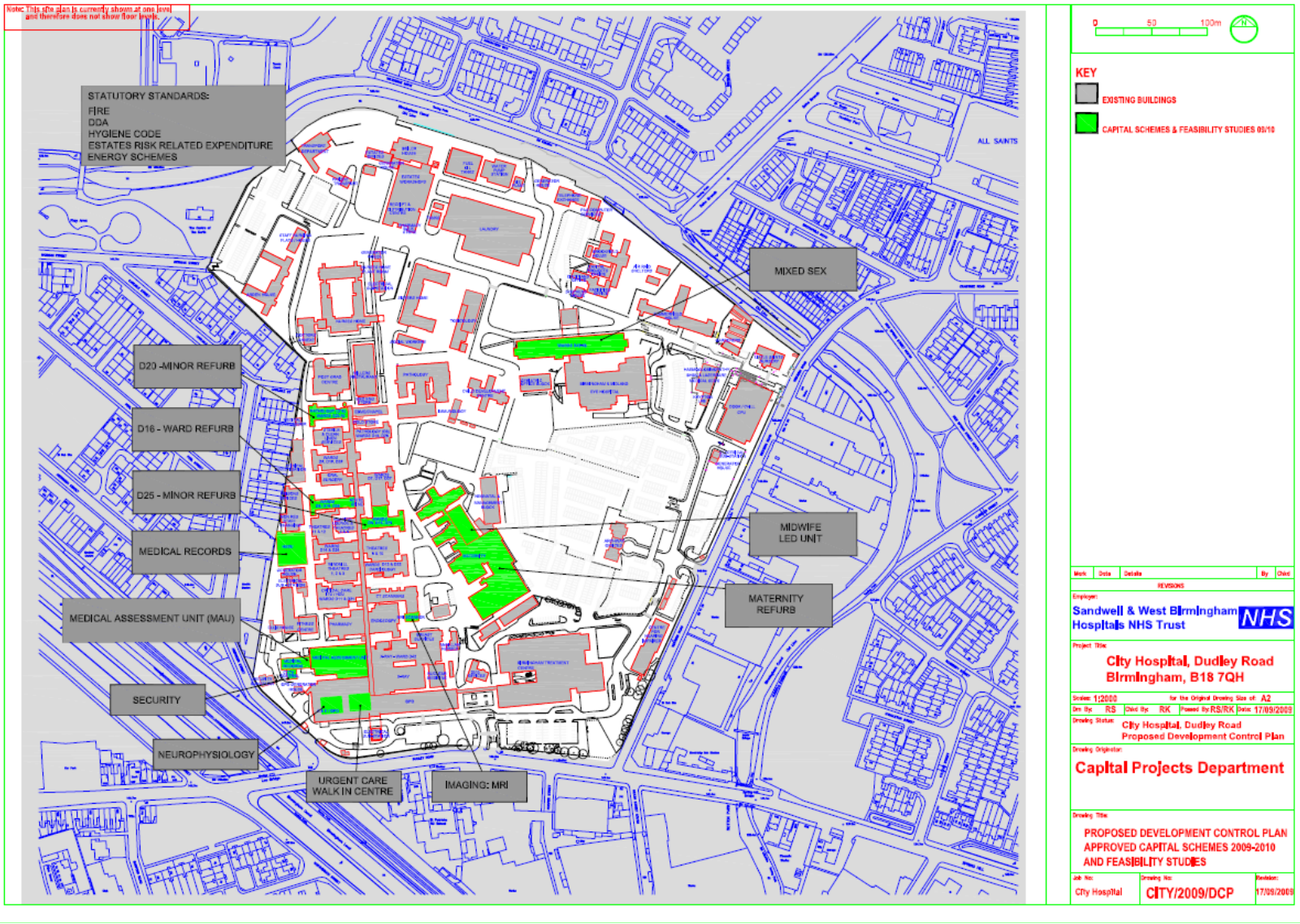
Development Control Plan – Sandwell Hospital


STATUTORY STANDARDS:
FIRE
DDA
HYGIENE CODE
ESTATES RISK RELATED EXPENDITURE
ENERGY SCHEMES
SECURITY
CT SCANNER
SANDWELL COMPUTER ROOM
SINGLE SIDE ROOMS / OFFICE SPACE
MIXED SEX
KEY
Sandwell & West Birmingham Hospitals NHS Trust
NHS
Sandwell General Hospital
Capital Projects Department
PROPOSED DEVELOPMENT CONTROL PLAN
APPROVED CAPITAL SCHEMES 2009-2010
AND FEASIBILITY STUDIES
SWBH - SGHDCP/2009

ESTATES STRATEGY ANNUAL REVIEW 2009/10

APPENDIX 2

Development Control Plan – City Hospital


Note: This site plan is currently shown at one level and therefore does not show floor levels.
STATUTORY STANDARDS:
FIRE
DDA
HYGIENE CODE
ESTATES RISK RELATED EXPENDITURE
ENERGY SCHEMES
D20 -MINOR REFURB
D16 - WARD REFURB
D25 - MINOR REFURB
MEDICAL RECORDS
MEDICAL ASSESSMENT UNIT (MAU)
SECURITY
NEUROPHYSIOLOGY
URGENT CARE WALK IN CENTRE
IMAGING: MRI
MIXED SEX
MIDWIFE LED UNIT
MATERNITY REFURB
ALL SAINTS
0 50 100m
KEY
EXISTING BUILDINGS
CAPITAL SCHEMES & FEASIBILITY STUDIES 09/10
REVISIONS
Employer:
Sandwell & West Birmingham Hospitals NHS Trust
NHS
Project Title:
City Hospital, Dudley Road
Birmingham, B18 7QH
Scales: 1:2000
for the Original Drawing Size of: A2
Drn By: RS
Chkd By: RK
Passed By:RS/RK
Date: 17/09/2009
Drawing Status:
City Hospital, Dudley Road
Proposed Development Control Plan
Drawing Originator:
Capital Projects Department
Drawing Title:
PROPOSED DEVELOPMENT CONTROL PLAN
APPROVED CAPITAL SCHEMES 2009-2010
AND FEASIBILITY STUDIES
Job No:
City Hospital
Drawing No:
CITY/2009/DCP
Revision:
17/09/2009

ESTATES STRATEGY ANNUAL REVIEW 2009/10

APPENDIX 3

2009/10 CAPITAL PROGRAMME

Sandwell & West Birmingham Hospitals NHS Trust

CAPITAL PROGRAMME 2009/2010: PROPOSED ADJUSTMENTS

	Col E = July Board Report	Capital Programme 2009/10 per July Board Report	August SIRG Adjustments	Effect of Capital Programme Review	Revised 09/10 Plan		Capital Programme 2010/11
		£000	£000	£000	£000		£000
Capital Resources							
	Internally Generated Cash (depreciation)	15,250			15,250		15,250
	New Energy Schemes PDC Funding	430			430		386
	M3 Confirmation of CRL (post IFRS)	386			386		
	Loan Proceeds						4,098
Total Resources		**16,066**			**16,066**		**19,734**
Capital Expenditure							
Estates Schemes	Statutory Standards and Estates Risk Related Expenditure	1,940			1,940		1,940
	Security Provision	300			300		
	HC Commission	370			370		
	New Energy Schemes	430			430		
					0		
Equipment	Medical Equipment	750			750		750
	Imaging Equipment (including MRI and enabling)	2,345			2,345		
	Nasoendoscopes	300		-50	250		
					0		
IT	IT Programmes	610			610		700
	Sandwell Computer Room	200		-13	187		
	Telecoms Equipment - *** B/F	220			220		
					0		
Mixed Sex	Mixed Sex - undefined contingency	150		-50	100		
	Mixed Sex as per plan sent to SHA	650			650		500
	Priory 2 Linked Works (Medical Gases)	14			14		
					0		
Other Building Work	Urgent Care Centre	1,000			1,000		
	Sandwell Capacity Changes	540		-540	0		
	D20/D25 Refurbishment	60			60		
	SGH - creation of clincial space/office relocations				0		500
	MAU Redevelopment (including statutory standards element)	1,000		-645	355		1,645
	D16 Full Refurbishment	500			500		
	MLU @ City	800			800		
	Capitalisation of Salaries	300			300		300
					0		
Other Schemes	Ophthalmology Clinics (Remaining x 2)	200			200		
	City CBRN Facility	60			60		
	HSSU/Medical Records Racking	45			45		
	General Slippage Brought Forward	500		-250	250		
	SIRG Earmarked Allocations	2,782		-2,782	0		
					0		
Other Building Work	MAU Redevelopment (including statutory standards element)		-645	645	0		
	Refurbishment of City Maternity Block		400		400		
	Pathology Sample Reception		120		120		
	Rowley Hospital Out-Patient Facilities		150		150		
	Sandwell ESC 2nd Triage Room		17		17		
					0		
Estates Schemes	Security Provision *** B/F		200		200		
					0		
Equipment	Additional Medical Equipment (including Pathology) *** B/F		1,500		1,500		
	Sandwell Replacement CT Scanner *** B/F		800		800		1,000
					0		
					0		
Other Schemes	Decontamination - Cardiology		240	-145	95		
Other potential Schemes	Cardiology - IT expansion			70	70		
	Neurophysiology Outpatients			300	300		200
	Hygience initiatives			300	300		
	Clean Air Theatres at Sandwell						200
	RRH - modifications OP lower floor/Beds upper						500
	Ward refurbishment related capitalised equipment						400
	Allocation for final maternity improvements						600
	Pharmacy Automation				50		
	Slippage Management				-1,700		
Land	Land purchases with Loan proceeds				2,028		10,499
					0		
Total Expenditure (Excluding 09/10 Schemes)		**16,066**	**2,782**	**-3,160**	**16,066**		**19,734**

*** Expenditure brought forward from later years

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Safeguarding Declaration
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

In August the Trust Board received a report on Safeguarding which advised the Trust Board of progress to date against Safeguarding Adults and Children standards. It also outlined the main points from the published CQC national report and the expectations that the CQC places on TB's.

A further letter from the NHS Chief Executive David Nicholson (16/07/09) underlined the need for Trust Boards to ensure the following:

- The organisation meets the statutory requirements in relation to Criminal Records Bureau checks.
- Child protection policies and systems are up to date and robust, including a process for following up children who miss outpatient appointments and a system for flagging children whom there are safeguarding concerns.
- All staff have received level 1 training and a review of other training has been undertaken.
- Designated/named professionals are clear about their roles and are adequately resourced.
- There is a Board Level Director in place.

In addition, Boards are now required to publish a declaration on their websites when they are satisfied that these arrangements are in place. These declarations should be shared with the SHA and PCTs.

A declaration was submitted by the Trust to the SHA/PCTs on 8th October (see attached) regarding compliance against the above standards. The Trust declared compliance, but is outstanding a Trust Board declaration that is published on the Trust website.

The following form of words is proposed for the Trust declaration:

> *"The Trust considers it is and will continue to be in compliance with the requirement to operate in a way that ensures the recognition of vulnerability in children and adults and the action to safeguard vulnerable individuals".*

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 agree the declaration described above.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Improve the quality of care provided to vulnerable adults and children – to include Safeguarding Childrens' Standards
Annual priorities	
NHS LA standards	2.3.3 – Safeguarding adults
Core Standards	C2 - Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.
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**	▪ The Trust is required to meets the statutory requirements in relation to Criminal Records Bureau checks ▪ Child protection policies and systems are required to be up to date and robust
Equality and Diversity		
Patient Experience		
Communications & Media		

Risks		

PREVIOUS CONSIDERATION:

Trust Board received a report on Safeguarding in August 2009, which advised the Trust Board of progress to date against Safeguarding Adults and Children standards.

(Declaration to the SHA/PCTs submitted 8th October):

Safeguarding Children – Template A

Name of Trust/PCT:	Sandwell & West Birmingham Hospitals NHS Trust
Contact details for person completing form:	Rachel Overfield rachel.overfield@swbh.nhs.uk 0121 507 4795
Name of Board Level Exec Director lead for Safeguarding	Rachel Overfield
Has the Trust/PCT published a declaration on safeguarding arrangements? (As a minimum the declaration should be accessible within 3 clicks from the homepage of the Trust's website). If not, when will this be available?	Yes, but revised for October 09 Trust Board approval.
Using information provided in your Trust's declaration please describe briefly how your Board is assured that:	
1. Your Trust/PCT meets statutory requirements in relation to CRB checks:	Yes – CRB checks are conducted for all staff including bank staff and via SLA with agencies.
2. Child protection policies and systems are up to date and robust:	Yes, all policies and systems have been reviewed within the past year and agreed via the Trust's Governance process.
3. Child protection policies include a process for following up children who miss OP appointments:	Yes, include in the Trust DNA policy and the Children's Discharge Planning Policy.
4. Child protection policies include a system for flagging children for whom there are safeguarding concerns:	Yes, included in the Trust policy.
5. All eligible staff have undertaken and are up to date with safeguarding training at level 1.	Yes, completed for the whole Trust in 2009.
6. Either a review of other training arrangements has been carried out or will be carried out by the end of 2009, taking account of the emerging messages from the national review of safeguarding:	There has been considerable focus on training this year and a review of the content of training is planned and will be complete by the end of 2009. Level 3 provided by PCT.
7. Designated and/or named professionals are clear about their role and have sufficient time and support to undertake it:	Yes, although we are reviewing the time given to the named nurse and doctor.

8. There is a Board level Executive Director lead for safeguarding:	Yes – Chief Nurse.
9. The Board reviews safeguarding across the organisation at least once a year and has robust audit programmes to assure it that safeguarding systems and processes are working:	The TB receive regular reports on safeguarding. Internal audit are undertaking a review of all systems and processes and will report by March 2010.

To be completed by Trusts and PCTs and returned to mandy.knowles@westmidlands.nhs.uk by 8.10.09

Safeguarding Children – Template B

To be completed by PCTs only and returned to mandy.knowles@westmidlands.nhs.uk by 8.10.09

Name of PCT:	
Contact details for person completing form:	
Has the PCT scrutinised the declarations on safeguarding arrangements for all providers from whom services are commissioned?	
If no, please describe the timescales for achieving this:	
Please briefly describe the PCT's arrangements for monitoring the performance of all providers, including the independent sector, in relation to safeguarding. Please send any additional documentation that may be helpful:	
Do you ensure GP Practises have systems in place to fulfil their safeguarding role?	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Grievance and Disputes Policy
SPONSORING DIRECTOR:	Lesley Barnett, Acting Director of Workforce
AUTHOR:	Nick Bellis, HR Manager
DATE OF MEETING:	22 October 2009

SUMMARY OF KEY POINTS:

The purpose of this policy is to ensure that a robust system is in place to ensure employees have the right to raise concerns and for these to be resolved as quickly as possible.

Main revisions to the previous policy procedure include:

- Definitions as to where exceptions to this policy may occur and how they may be dealt with, for example, regarding National Terms and Conditions and issues that are already subject to staff consultation.
- It also clarifies which issues should be progressed via the Trust's Dignity at Work Policy as opposed to Grievance.
- The ideal time for an informal issue to be discussed with the employee raising the Grievance and their Manager has been reduced to 3 days.

Grievance hearing details and outcomes will be recorded and annual monitoring reports will be provided by the Director of Workforce on an annual basis.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

It is requested that the Board approves this policy.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	2.5.2 Raising concerns
Core Standards	C8a - having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services
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		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Staff side consultation has been completed at JCNC (October 09). PPAC consultation was sought prior to this.

The policy was approved by the Trust Management Board on 20 October 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

GRIEVANCE AND DISPUTES POLICY

PROFILE	
REFERENCE NUMBER:	HR/007
VERSION:	5
STATUS	
ACCOUNTABLE DIRECTOR:	Director of Workforce
AUTHOR:	Human Resources Manager
DATE OF LAST REVIEW/ ORIGIN DATE:	July 2007
DATE OF THIS REVIEW:	July 2009
APPROVED BY:	
DATE OF APPROVAL	
IMPLEMENTATION DATE:	October 2009
DATE NEXT REVIEW DUE:	October 2011
REVIEW BODY:	Trust Management Board
CATEGORISATION:	Human Resources
DATE OF EQUALITY IMPACT ASSESSMENT:	July 2009
APPLICATION:	Trust-wide
PRINCIPAL TARGET AUDIENCE:	All staff employed by the Trust
ASSOCIATED TRUST DOCUMENTS:	Disciplinary Policy Equal Opportunities In Employment Capability Procedure Sickness Absence Policy Recruitment and Selection Procedure

Grievance and Disputes Policy

CONTENTS

1. Introduction

1.1 The Trust recognises that from time to time employees may have individual grievances relating to a range of matters, which affect their working situation. The Trust encourages full and free communication between managers and employees and anticipates that this approach will lead to problems being resolved quickly and as near to their source as possible.

1.2 This procedure specifies how individual and collective grievances will be handled within the Trust. It also outlines how matters of dispute may be progressed beyond the Trust.

2. Objectives

The Sandwell and West Birmingham Hospitals NHS Trust maintains that all staff have the right to raise grievances relating to their working conditions, environment and contractual terms and conditions of employment. This policy is designed to support the resolution of grievances as swiftly as possible.

3. Scope

This policy applies to all employees of the Trust.

4. Definitions

Grievance - for the purposes of the procedure this means: 'a complaint by an employee (or employees) about an action which their employer has taken or is contemplating taking in relation to him/her' (The Employment Act 2002 (Dispute resolutions) Regulations 2004). It also applies to matters of equal opportunities, new working practices and organisational change. Such claims involve questions relating to the interpretation or application of the rules concerned.

4.1 Dispute - If a collective grievance is not resolved at the final stage, i.e. a failure to accept the decision of the panel at stage 4, then the grievance – being taken outside the organisation – becomes a dispute.

4.2 Status Quo - Means the working and management arrangements, which applied before the grievance, will operate until the grievance procedure has been exhausted. The aggrieved party may invoke the Status Quo, if appropriate.

5. Roles and Responsibilities

5.1 Chief Executive

Overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant

legislation.

5.2 Trust Board

a) To create an environment and culture in which staff feel enabled to raise any issues about which they have concerns and to have a right for their concerns to be addressed and responded to in a timely fashion.

b) To ensure that all concerned are aware of this policy and of sources of available support; that managers and employees are aware of the expectations, which flow from the policy, and what to do if these are not met.

c) To oversee the policy and ensure that managers deal with grievances informally wherever possible and that any formal grievances are heard in a timely manner with a view to resolution, wherever possible.

5.3 Policy Author

a) Ensure appropriate review of the documents, either in line with the review timescale set at the time of approval or as a result of changes to practice, organisational structure or legislation.

b) Ensure appropriate consultation has taken place with the relevant individuals or groups during the policy development process.

5.4 Ensure the necessary equality impact assessment is carried out prior to the document entering the approval process.

5.5 Line Managers

To treat all complaints, sensitively and confidentially and take timely action, as appropriate.

5.6 All Staff

To take responsibility for attempting to resolve issues informally wherever possible and to follow this policy if this is not possible.

5.7 Trade Unions

To support and represent employees as appropriate and to treat all grievances confidentially as well as support informal or formal resolution, where appropriate.

6. Equality Requirements

The Trust recognises the diversity of the local community and those in its employ. Our aim is therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day to day operations and has produced an Equality Policy Statement to reflect this. All policies will be assessed in accordance with the equality initial screening toolkit, the results of which are monitored centrally.

7. References/ Legal Framework

7.1 Trust Policies and Procedures

Disciplinary Policy
Equality Statement

The legal framework that supports this policy includes the following:

7.2 **Legislation** Employment Act 2002 (Dispute Resolution) Regulations 2004

7.3 **Codes of Practice**

ACAS Code of Practice (April 2009) – Disciplinary and Grievance Procedures
Resolving Disputes at Work (DTI)
Disciplinary, Dismissal and Grievance Procedures – Guidance For Employers (DTI)

8. Informal Resolution of Problems

8.1 The ACAS code of practice recommends that employees should aim to settle most grievances informally either with their immediate line manager or the next level of management. For this reason and the swifter resolution of grievance issues, the informal process constitutes step 1 of the Trust's Grievance and Disputes Procedure.

8.2 It is expected that unless there are highly exceptional circumstances all grievances should be considered at Stage 1 before a formal grievance is considered.

8.3 A decision to proceed without an informal stage of the grievance procedure will require the authorisation of the Director of Workforce or their Deputy.

9. Representation

An employee has the right to be accompanied by a Trade Union/Professional representative or a work colleague from Step 2 of this procedure. However, with the agreement of both parties, trade union involvement may be sought at Step 1 of this process to help facilitate the process and achieve a speedy resolution.

10. Time Limits

It is in the interest of both the Trust and its employee(s) that grievances are resolved quickly, ideally within one month of them being raised informally and within two months of them being raised formally, see Section 12 for further guidance on time limits. Where possible, dates for hearings should be agreed in consultation with the employee and their representative. Any changes to the hearing date or time should be agreed within five

working days of the initial date being set. An extension of the time limit may be permitted by mutual agreement.

11. Exceptions

It is important that matters relating to bullying and harassment are raised in accordance with the Trust's Dignity at Work Procedure and in line with Agenda for Change Terms and Conditions. It is also important that such issues are raised in this manner to avoid harassment or bullying issues being under recorded or under reported.

Grievances will not be accepted where they relate to agreed Terms and Conditions of Employment. Matters of interpretation in relation to these terms and conditions should be progressed via recognised members of the Trust's Agenda for Change Terms and Conditions group.

Wherever possible grievances raised regarding ongoing consultation/negotiation processes will be heard and considered in tandem with this process. Grievances regarding matters which have already been agreed via a recognised collective consultation process such as Joint Negotiating Consultation and Committee or Policies and Procedures Advisory Committee will need to be considered by these groups as to how the Grievances are heard and addressed

12. Status Quo

12.1 Upon submission of a grievance/dispute the individual(s) is entitled to request that the status quo applies until the successful resolution of the grievance or conclusion of Stage 4 of this procedure.

12.2 In such circumstances the Director of Workforce may override the right to the status quo in the event that its application: -

- Is considered to present a health and safety concern.
- May have a detrimental affect on quality of care.

13. Steps in the Procedure

13.1 Step 1 – Informal Resolution with Immediate Manager/Manager at an appropriate level

Grievances must be discussed between the employee(s) and the immediate manager/next level of management in the first instance, ideally within 3 days of the issue being raised. The manager will endeavour to resolve the matter informally, taking into account the issues involved and the employee's preferences for outcome. If the employee's immediate manager is closely involved with the issue relating to the informal grievance then it may be appropriate for the next level of management to assist in the informal resolution.

13.2 Step 2 – The Employee sets out the nature of the grievance in writing

If a grievance has not been resolved informally, the employee(s) or their representative may lodge a formal grievance by informing the relevant manager (normally at Divisional General Manager level) in writing by completing the Grievance and Disputes Form (Appendix 1) The individual lodging the grievance should state that they are lodging a grievance in writing using the appropriate form, identify the full nature of and the reason for the Grievance together with the desired outcome. The manager receiving the grievance is entitled to request further details or explanation in order to progress matters.

13.3 Step 3 – The Hearing of The Grievance

The Manager hearing the grievance will convene a meeting to discuss the grievance without unreasonable delay but ideally within 10 working days, of receipt of the written grievance. At the meeting the employee should have the chance to explain the nature of their grievance and the manager involved in the informal resolution of the grievance should outline their attempts to resolve the grievance informally. After the meeting the Manager may undertake whatever investigation is felt appropriate and should communicate their decision in writing within 10 working days. If the employee is dissatisfied with the outcome and remains aggrieved they will have the opportunity to appeal in line with Step 4 of the procedure.

13.4 Step 4– Appeal to Chief Executive (or Nominated Deputy – Executive Director Level)

If the employee remains aggrieved they should write without unreasonable delay but ideally within 10 working days of receipt of the written decision following Step 3 to the Chief Executive outlining their grievance and the grounds for appeal. The Chief Executive will nominate either an Executive Director or Non Executive Director to convene a hearing, ideally within 10 working days, to consider the grievance. The nominated Chairperson will decide the appropriate constitution of the panel to consider the appeal.

A written statement of case should be provided by the individual raising the grievance and the Senior Manager involved at stage 3 no later than 7 working days prior to the hearing.

The appeal panel will consider the views of both the parties who heard the grievance at Step 3. After considering the matter, the Appeal Chairperson will confirm their decision in writing within five working days.

The procedure for hearing the appeal is outlined in Appendix 2.

14. Vexatious Grievances

If an investigation confirms that an employee has made a Grievance for malicious or vexatious reasons this could lead to disciplinary action.

15. Grievances In Relation To Other Procedures

Where a grievance is raised during another process (e.g. Disciplinary Policy, Capability Policy and Sickness Absence Policy) and is related to the issues which are being managed via another Trust policy, then the Director of Workforce (or Deputy) will decide on the most appropriate process to be followed taking into account specific guidance contained within the relevant policy.

16. Collective Grievances

Collective Grievances will apply when the grievance applies to a number of staff. In order that the Grievance may be resolved swiftly, the group in question should be represented at hearings and meetings by no more than 3 staff from the group The Grievance and Disputes Form (Appendix 1) should be used and should be signed by all parties to the collective Grievance.

17. Resolution of Disputes

17.1 A dispute will only be recognised in the event where all internal procedures have been exhausted and the Collective Grievance is supported by a recognised trade union.

17.2 If either party fails to accept the decision of the Sub-Committee of the Trust Board, the matter may be referred to the Advisory, Conciliation and Arbitration Service:

- by either party to the dispute for conciliation, or
- by joint agreement of the parties to the dispute for arbitration.

18. Policy Review

This policy will be reviewed in 2 years time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

19. Training and Awareness

19.1 Awareness about this Policy will be included in all Induction and mandatory training and will form an integral part of all Management Development training.

19.2 Managers are responsible for raising awareness of this policy amongst their staff via internal staff communication meetings.

19.3 Copies of this policy should be made available to all staff via the Trust's intranet and locally in a designated policies folder.

20. Monitoring

All formal grievance hearing outcomes will be recorded on the Trust's centralised workforce information system and annual monitoring reports will be prepared to ensure that the policy is being applied fairly and consistently and is not adversely affecting any particular staff in accordance with the Trust's Equal Opportunities Policy.

21. Appendices

Appendix 1: Grievance and Disputes Form

Appendix 2: Grievance and Disputes Hearing Procedure

22. Further Enquiries

Further information relating to this policy can be obtained from the Department of Human Resources.

Sandwell and West Birmingham Hospitals NHS Trust

GRIEVANCE AND DISPUTES FORM

Name:

Grade:

Department:

Representative:

Nature of the Grievance:

Summary of attempts at informal resolution:

Desired Outcome:

Signature: Date:

CC: Human Resources Department

Sandwell and West Birmingham Hospitals NHS Trust

GRIEVANCE AND DISPUTES HEARING PROCEDURE

a) The purpose of the hearing is to ensure that the case is fully heard.

b) The approach will be that the employee/representative states the case and accepts questions of fact or detail from the representatives of the Management side, and from the members of the panel.

c) Similarly the representatives of the Management side will state the Management case and accept questions of fact or detail from the Staff side, and from the members of the panel.

d) The Management side will be asked to sum-up first, with the Staff side having the final say.

e) Whenever either side feels that brief adjournments may be necessary, these will be allowed at the discretion of the chair of the hearing.

f) If information, additional to that supplied in the written submissions, is presented at the hearing then either side may seek an adjournment to deal with this.

g) Either side may call witnesses.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Initial Equalities Screening Checklist

POLICY TITLE/SERVICE:	Grievance and Disputes Policy
ACCOUNTABLE DIRECTOR:	Director of Workforce
MANAGER RESPONSIBLE FOR COMPLETION:	Nick Bellis, HR Manager
DATE:	September 2009

Public service organisations are required to take concerted action to identify and eliminate inequality. Undertaking equality impact assessment in relation to all relevant policies provides the means for doing this.

This checklist should be completed to determine if the proposed policy is relevant to the Trust's General Duty under race, gender and disability equality.

CHECKLIST

Step 1 – What is the purpose of the policy/service proposal?

To enable the swift resolution of grievances raised by staff and their unions.

How will the outcomes be measured?

- Via annual monitoring.
- Any grievances complaint received

Who are the key stakeholders?

- All employees.

Step 2 – Gather information and data (evidence)	**YES**	**NO**
Will the proposed policy/service involve or have consequences for the patients or staff of the Trust on racial grounds in the context of their gender, disability, sexuality, age, religion and language?		√
Is there any reason to believe that people from the different equality strands, taking into account of interaction between strands, could be affected differently, by the proposed policy/service • If yes, please state reason and those likely to be affected and evidence sources...		√
Is there evidence to suggest that any part of the proposed policy/service could discriminate unlawfully, directly or indirectly? • If yes, please specify, If no, please explain		√ No evidence available to suggest proposed policy will discriminate.
Is there any evidence that some people may have different expectations of the policy/service in question due to their race, gender, disability, sexuality, age, religion and language? • If yes, please specify • If no, please explain		√ No evidence to suggest some people may have different expectations
Is the proposed policy/service likely to affect relations between some		√

people due to their race, gender, disability, sexuality, age, religion and language, for example if is seen as favouring a particular group or denying opportunities for another? • If yes, please state reason/evidence and information on those likely to be affected.	

Step 3 – Impact of the Policy, process or service

If any of the questions are answered 'yes' then the proposed policy/service is likely to be relevant to the Trust's legal duties in relation to race, gender and disability. The relevant manage should proceed to complete a full Equalities Impact Assessment (see appendix 2).

A copy of the completed form must accompany the policy/service when it is presented to the relevant body for approval.

This initial quality impact assessment checklist has been completed by (*please sign below):*

Name of EIA Lead : Nick Bellis, HR Manager
Signed: _____

SWBTB (10/09) 198 (c)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

GRIEVANCE AND DISPUTES POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Grievance and Disputes
ACCOUNTABLE DIRECTOR:	Colin Holden, Director of Human Resources
POLICY AUTHOR:	Nick Bellis, Human Resources Manager
APPROVED BY:	
DATE OF APPROVAL	

An implementation plan must be developed for all policies. This will ensure that a systematic approach is taken to the introduction of policies in order to secure effective working practices.

The following template provides a checklist to be used as a starting point for thinking about implementation in a systematic manner.

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
Co-ordination of implementation • How will the implementation plan be co-ordinated and by whom? *Clear co-ordination is essential to monitor and sustain progress against the implementation plan and resolve and issues that may arise.*	That a new policy has been introduced that is different to the previous version. This key message needs to be communicated to all Trust managers and all staff responsible for training managers.	Communication timescale to be developed in line with date for Trust Board approval.	Human Resources Manager	From date of Trust Board approval
Engaging staff • Who is affected directly or indirectly by the policy? • Are the most influential staff involved in the implementation? *Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made.*	This policy applies to all Trust employees. Senior Managers within the Trust will be invited to comment on the revised draft of the policy, prior to its submission to the Trust's JCNC.	Consultation has taken place with the following: - Staff Side - PPAC JCNC Executive Directors, Divisional Directors, DGM's	Human Resources Manager	 PPAC September 2009 JCNC October 2009 October 2009
Involving service users and carers • Is there a need to provide information to service users and carers regarding this policy? • Are there service users, carers, representatives or local organisations who could contribute to the implementation? *Involving service users and carers will ensure that any actions taken are in the best interests of the service users and carers and that they are better informed about their care.*	N/A	N/A		
Communication • What are the key messages to communicate to the different stakeholders?	• That the policy has been amended and is now different to the current	Communication via: - • Team Brief • Staff comms – email system.	Human Resources Manager	To coincide with Trust Approval (proposed date is November 2009)

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
• How will these messages be communicated? *Effective communication will ensure that all those affected by the policy are kept informed thus smoothing the way for any changes. Promoting achievements can also provide encouragement to those involved.*	version. • Itemise some key areas of change. • Up to date information is available on the intranet or directly from the HR Department. Proposed to communicate the above via team brief and by use of HR intranet site.	• Policy to be placed on Intranet. Learning and Development Department to be fully informed of all key changes and implications to training provision.		
Training • What are the training needs related to this policy? • Are the people available with the skills to deliver the training? *All stakeholders need time to reflect on what the policy means to their current practice and key groups may need specific training to be able to deliver specific requirements.*	All line managers need to be aware that the policy has changed and where they can access information in the event that they have to deal with a matter that where the Grievance process has been invoked.	Provision of on-going training and induction programmes and Divisional support via the Learning and Development and HR Department.	Human Resources Manager	From November '09 onwards.
Resources • Have the financial impacts of any changes been established? • Are other resources required to enable the implementation of the policy e.g. new documentation, increased staffing? *Identification of resource impacts is essential at the start of the process to ensure action can be taken to address issues that may arise at a later stage.*	The new policy has been designed to streamline the grievance process in order that informal staff concerns are resolved more promptly than is our current practice. It is therefore anticipated that the new arrangements will support improvements in staff productivity within the organisation.	N/A	-	-

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
Securing and sustaining change • Have the likely barriers to change and realistic ways to overcome them been identified? • Who needs to change and how do you plan to approach them? • Have arrangements been made with service managers to enable staff to attend briefing and training sessions? • Are arrangements in place to ensure the induction of new staff reflects the policy? *Initial barriers to implementation need to be addressed as well as those that may affect the on-going success of the policy.*	• Advice and support will be available from the HR Department alongside on-going training provision from Learning and Development.	Learning and Development team fully briefed on new policy requirements. HR team fully understand the implications and requirements of the new policy and process. The staff side have been engaged with the policy development during the consultation process.	Human Resources Manager	November '09 onwards.
Evaluation • What are the main changes in practice that should be seen from the policy? • How might these be evaluated? • How will lessons learned from implementation of this policy be fed into the organisation? *Evaluating and demonstrating the benefits of new policy is essential to promote the achievements of those involved and justify changes that have been made.*	Improvements in timescales to manage a grievance process due to reduced stages. All grievance outcomes are monitored by the HR Department on an annual basis.	Develop improved monitoring arrangements via the use of ESR.	Human Resources Manager	November '09 onwards.
Other consideration •				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Board Committees – Terms of Reference
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	22 October 2009

SUMMARY OF KEY POINTS:

The Trust Board Committees' terms of reference are presented for ratification, having been amended since the Board last ratified them in September 2006.

There have been no significant changes to the terms of reference for the Finance & Performance Management, Charitable Funds and Remuneration & Terms of Service Committees, although they have been updated to reflect that the Trust Secretary provides the required administrative support to the Committees. No further amendments have been identified at present.

Amendments to the terms of reference for the Audit Committee were agreed at its meeting in May 2008 to reflect that the debtors report is now considered periodically by the Committee and to reflect the change in name of the Governance Committee to the Governance and Risk Management Committee. The terms of reference were again reviewed by the Committee in May 2009, in line with its cycle of business and no further amendments were proposed.

Amendments to the terms of reference for the Governance and Risk Management Committee were agreed at its meeting in March 2009, including a change to the paragraph relating to the oversight of the Governance Board by the Governance and Risk Management Committee to strengthen arrangements for reviewing the key discussions and decisions made at the Governance Board. The requirement for a clinician to be present at all meetings was also built into the attendance section. Evidence of the approval of the Committee's terms of reference by the Board is required to support the forthcoming assessment by the NHS Litigation Authority.

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 ratify all Committees' Terms of Reference.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	2.1.3 – Risk Management Committees. Evidence of the approval of the Committee's terms of reference by the Board is required to support the forthcoming assessment by the NHS Litigation Authority.
Core Standards	
Auditors' Local Evaluation	Internal control

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		Failure to ratify the terms of reference of the Governance and Risk Management Committee may jeopardise achievement of standard 2.1.3

PREVIOUS CONSIDERATION:

Terms of Reference for the Committees were last ratified by the Trust Board at its meeting in September 2006.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

AUDIT COMMITTEE - TERMS OF REFERENCE

Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (The Committee). The Committee is comprised of non-executive directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

Membership

The Committee shall be appointed by the Board. The Committee shall be formed by at least one half of the Non Executive Directors, with a quorum of two members. One of the members will be appointed Chair of the Committee by the Board. The Chair of the organisation shall not be a member of the Committee.

Attendance

The Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings. However at least once a year the Committee should meet privately with the External and Internal Auditors.

The Chief Executive and other executive directors should be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control.

The recording of minutes and appropriate support to the Chair and committee members shall be provided by the Trust Secretary.

Frequency

Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Duties

The duties of the Committee are as follows:

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the Standards for Better Health), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board

- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organization as identified in the Assurance Framework

- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organization

- annual review of the effectiveness of internal audit

External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor, as far as the Audit Commission's rules permit

- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy

- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

- review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Healthcare Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Governance and Risk Management Committee.

In reviewing the work of the Governance and Risk Management Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- major judgemental areas
- significant adjustments resulting from the audit

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

Other Duties

- To review and make recommendations to the Trust Board in respect of all proposed changes to Standing Orders, Standing Financial Instructions, Powers Reserved to the Board, Scheme of Delegation, and other financial procedures as appropriate.
- To review schedules of losses and compensations.
- To review every reported breach of Standing Orders.
- To consider the Director of Finance's Annual Opinion Statement on the adequacy of Internal Audit.
- To monitor the progress against the data quality action plans.
- To review the Trust's outstanding debtors report on a periodic basis

Reporting

The minutes of Audit Committee meetings shall be formally recorded and submitted to the Board. Specifically, following each committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. Subject to reporting timetables, a set of agreed draft minutes will be presented to the next immediate public Trust Board meeting for information. The draft minutes will then be presented at the next Audit Committee meeting. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Standards for Better Health.

Other Matters

Administrative support from the Trust Secretary will include:

- agreement of agenda with Audit Committee Chair and attendees and preparation of papers
- taking the minutes & keeping a record of matters arising and issues to be carried forward
- advising the Committee on pertinent matters

Director of Finance & Performance Management
April 2009

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

GOVERNANCE AND RISK MANAGEMENT COMMITTEE

Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Governance and Risk Management Committee (the Committee).

2. Membership

The Committee will comprise of:

- Three Non-Executive Directors
- Chief Executive
- Director of Finance & Performance
- Medical Director
- Chief Nurse
- Director of Governance

A quorum will be 3 members, of which there must be at least one Non-Executive Director and one Executive Director. In the event that either the Medical Director or Chief Nurse cannot attend, an appropriate deputy will attend on their behalf.

The Chair of the Committee will be a Non-Executive Director and will be appointed by the Trust Chair.

The Trust Secretary will administer meetings of the Governance and Risk Management Committee.

3. Attendance at meetings

Trust Board members, who are not members of the Committee, may attend for all or part of the meeting by prior agreement with the Chair of the Committee.

The following specialist advisers will attend meetings when invited:

- Director of Occupational Health & Safety
- Trust Control of Infection Lead
- Trust Clinical Effectiveness Lead
- Trust Clinical Risk Lead
- Head of Risk Management
- Head of Complaints & Litigation
- Head of Health & Safety
- Head of Clinical Effectiveness
- Trust Security Adviser

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

4. Chair of the Meeting

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

5. Frequency of meetings

Meetings shall be held bi-monthly.

6. Required Attendance at meetings

To ensure the Committee is able to function effectively, it is expected that members will attend at least two thirds of the meetings in any 12-month period. Failure to do so will result in escalation to the Trust Chair or Chief Executive, who will take action as appropriate.

7. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee may act with such authority delegated to it by the Trust Board from time to time.

The Committee will operate independently of other Committees that the Board creates, but will work to avoid duplication of issues.

8. Function

The Governance and Risk Management Committee will set the strategic direction for governance and risk management within the Trust. It will ensure that the Trust has the structures, systems and processes it needs in order to achieve its key clinical and other objectives, and that they perform well. It will take an overview of the arrangements and identify where service delivery, quality and performance falls below acceptable standards, to take steps to bring it back in line with expectations, and to promote improvement and excellence.

9. Accountabilities and Reporting arrangements

The Governance and Risk Management Committee is accountable to the Board, which will expect the committee to demonstrate that it has met its objectives and has delivered its work plan and annual reporting cycle. This will be monitored by regular presentation of minutes and an Annual Report to the Board.

The Governance Board is accountable to the Governance and Risk Management Committee, which will monitor the delivery of the Governance Board workplan through reviewing the minutes of the Governance Board on a regular basis. The delivery of objectives and workplans of the other governance committees, such as that with responsibility for Heath and Safety, will be monitored by the Governance Board.

10. Duties

10.1 Reporting regularly to the Board and giving advice on matters relating to the quality of clinical care, governance arrangements and risk management.

10.2 Developing and monitoring implementation of the Trust's Governance and Risk Management Strategies.

10.3 Assessing and monitoring the standard of clinical care offered to patients.

10.4 Ensuring that all risk, including financial risk, within the Trust is known, properly assessed and managed.

10.5 Developing the Trust's Corporate Risk Register and Assurance Framework.

10.6 Ensuring that the Trust develops, maintains and reviews the effectiveness of systems and mechanisms that are able to achieve rapid and effective responses to risks and hazard alerts.

10.7 Developing a positive risk awareness culture and an open, self critical and thorough approach to investigating and learning from adverse events.

10.8 Ensuring that governance and risk management is embedded in training and education and human resources management.

10.9 Ensuring that effective mechanisms develop and operate across the Trust to involve service users, carers, the public and partner organisations in improving clinical governance and risk management.

10.10 To ensure that the Trust has taken appropriate action in response to relevant independent reports, government guidance, statutory instruments and ad hoc reports from enquiries and independent reviews.

10.11 To compare the Trust's clinical performance against available national and local data.

10.12 Producing an annual report on progress against meeting its objectives and its annual reporting cycle.

11. Minutes

The minutes of the Governance and Risk Management Committee shall be recorded and submitted to the Board.

Following each committee meeting, the minutes shall be drawn up and submitted to the Chair in draft format. Subject to reporting timetables, a set of agreed draft minutes will be presented to the next immediate public Trust Board meeting. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board. The draft minutes

will then be presented at the next Governance and Risk Management Committee meeting where the person presiding at it will sign them.

12. Monitoring

The Governance and Risk Management Committee will monitor its effectiveness by assessing progress against its objectives on an annual basis and reporting this to the Trust Board.

Ratification by:	
Date ratified:	
Review:	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

FINANCE & PERFORMANCE MANAGEMENT SUB COMMITTEE

Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Finance & Performance Management Sub Committee (the Committee).

2. Membership

The Committee will comprise of all Non-Executive Directors (including the Trust Chair), the Chief Executive and the Director of Finance.

A quorum will be 3 members, of which there must be at least one Non-Executive Director and one Executive Director.

The Chair of the Committee will be a Non-Executive Director and will be appointed by the Trust Chair.

3. Attendance at meetings

The Hospital Directors, Director of Human Resources (or a representative) and the Head of Performance Management will attend the meetings.

Trust Board members, who are not members of the Committee, may attend for all or part of the meeting by prior agreement with the Chair of the Committee.

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

The Trust Secretary will attend as secretary to the Committee and will maintain minutes of the meetings.

4. Chair of the Meeting

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

5. Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where the person presiding at it will sign them.

6. Frequency of meetings

Meetings will be held monthly, but there will normally be no meeting in August and January.

7. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee may act with such authority delegated to it by the Trust Board from time to time.

The Committee will operate independently of the Trust's Audit, Remuneration and such other Committees that the Board creates, but will work to avoid duplication of issues.

8. Duties

Financial Statements

To consider regular financial reports and forecasts including prime statement of accounts and supporting analyses and forecasts, focusing particularly on:

- Any changes in accounting and policies and practices
- Major judgmental areas
- The going concern assumption and underlying recurrent performance
- Compliance with NHS accounting standards
- Compliance with other legal requirements

To discuss financial issues arising from interim and final audits.

To commission and consider various financial reporting and analyses, as appropriate.

To consider explanations of significant variances/deviations from budget by Directorates and Departments on a regular basis and to consider proposals for remedial action.

To review the calculation adequacy and deployment of financial provisions for clinical negligence; doubtful debts; inflation etc.

To consider other topics or matters as directed by the Trust Board.

Strategic & Business Planning

To consider processes for the preparation and the content of Strategic and Business Plans and Annual Revenue and Capital Budgets.

To review the Trust Business Plan and Annual Budgets before submission to the Trust Board.

To monitor performance compared with the Annual Business Plan and Budgets.

To consider financial aspects of Business Cases for significant revenue or capital expenditure prior to submission to the Board.

To retrospectively review business cases for benefits realisation.

Financial Accounting

To consider the likely impact of technical changes to accounting policy or practices.

To consider detailed cash flow and working capital forecasts.

Service Agreements and Contracts

To review proposals to enter into material contracts for the supply or services from financial and legal perspectives.

To review the financial outcome of material contracts.

To consider regular reports of the Trust and Directorate Performance in respect of service agreements agreed with Commissioners and to note findings.

To monitor the Local Delivery Plans (LDPs) with Commissioners.

Performance Management

To monitor the financial performance of individual Directorates and Departments. To consider regular management performance reports from individual Directorates and Departments.

To consider performance against external performance targets set from time to time by the Department of Health and Strategic Health Authority, e.g. waiting lists/times, management costs, etc.

To consider performance against a range of internally developed clinical, financial and operational indicators.

Business Risk

To consider business risk management processes in the Trust.

To review arrangements for risk pooling and insurance.

To consider the implications of pending litigation against the Trust.

9. Reporting

The minutes of the Finance Sub Committee shall be recorded and submitted to the Board. Following each sub committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. Subject to reporting timetables, a set of agreed draft minutes will be presented to the next immediate public Trust Board meeting for information. The Chair of the Committee shall draw to the attention of the Board any issues that require

disclosure to the full Board. The draft minutes will then be presented at the next Finance & Performance Management Sub Committee meeting (see ‘Minutes’ above)

Copies of the agenda will be provided for all Trust Board members.

Ratification by:	Trust Board
Date ratified:	September 2006
Review:	To meet Trust Board approval in September 2007

Changes to the Terms of Reference for the Finance & Performance Management Committee

The changes are outlined below.

Membership

The Committee will comprise of ***all Non-Executive Directors (including the Chair of the Trust)***, the Chief Executive and the Director of Finance.

Replacing:

…the Chairman of the Trust, two Non-Executive Directors (to be appointed by the Chairman of the Trust)…

Attendance at meetings

The ***Hospital Directors***, Director of Human Resources (or a representative) and the Head of Performance Management will attend the meetings.

Replacing:

…Director of Operations…

The ***Head of Performance Management*** will attend as secretary to the Committee and will maintain minutes of the meetings.

Replacing:

…Secretary to the Board…

Frequency of meetings

Meetings will be held monthly, but there will ***normally*** be no meeting in August and January.

Service Agreements and Contracts

To monitor the ***Local Delivery Plans (LDPs) with Commissioners.***

Replacing:

…preparation of Service and Financial Frameworks and Service Agreements with Purchasers…

Performance Management

To consider performance against external performance targets set from time to time by ***the Department of Health and Strategic Health Authority, e.g.*** waiting lists/times, management costs, etc.

Replacing:

…NHSE and others…

To consider performance against a range of internally developed clinical, ***financial and operational*** indicators.

Reporting

The minutes of the Finance Sub Committee shall be recorded and submitted to the Board. ***Following each sub committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. Subject to reporting timetables, a set of agreed draft minutes will be presented to the next immediate public Trust Board meeting for information. The draft minutes will then be presented at the next Finance & Performance Management Sub Committee meeting (see 'Minutes' above)***

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

CHARITABLE FUNDS SUB COMMITTEE
TERMS OF REFERENCE

Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Charitable Funds Sub Committee (the Committee).

Membership

The Committee will comprise of all the voting members of the Trust Board (the Trustees).

The quorum will be 3 members, of which there must be at least one Non-Executive Director and the Director of Finance.

The Chairman of the Committee will be a Non-Executive Director and will be appointed by the Chairman of the Trust.

Attendance at meetings

Other Directors, who are not members of the Committee, may attend for all or part of the meeting by prior agreement with the Chairman of the Committee.

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

The Trust Secretary will attend as secretary to the Committee and will maintain minutes of the meetings.

Chairman of the Meeting

At any meeting of the Committee, the Chairman if present shall preside. If the Chairman is absent from the meeting then another Non-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 where the person presiding at it will sign them.

Frequency of meetings

Meetings will be held four times a year.

Charitable Funds Committee - Terms of Reference

continued

Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee may act with such authority delegated to it by the Trust Board from time to time.

Duties

On behalf of all Members of the Trust Board (being the Trustees in law under the terms of the Charities Acts) the Committee will:

- Monitor the safeguarding of those assets donated or bequeathed, in cash or other form, to the Trust's Charitable Funds.
- Ensure, as far as is practicable, that the expressed or intended wishes of donors or benefactors are met in the deployment of funds.
- Monitor and review the banking, accounting and audit arrangements made in respect of charitable funds.
- Advise on the appointment of Investment Brokers to provide professional advice on the investment of charitable funds.
- Together with such Brokers, recommend the investment strategy for such funds.
- To receive and consider regular reports on income to and expenditure from the Trust's Charitable Funds, prior to submission and to review the regular investment reports supplied by the Trust's brokers.
- Monitor Standing Orders, Standing Financial Instructions and operating procedures in so far as these cover the use of charitable funds within the Trust and, as far as practicable, ensure compliance.
- Ensure, as far as practicable, that the Trust complies with relevant legislation and formal Department of Health guidance on charitable funds.

To consider all business cases involving the use of Charitable Funds prior to consideration by the Trust Board.

Charitable Funds Committee - Terms of Reference

continued

Reporting

The minutes of the Charitable Funds Sub Committee shall be recorded and submitted to the Board. Following each sub committee meeting, the minutes shall be drawn up and submitted to the Chairman in draft format. Subject to reporting timetables, a set of agreed draft minutes will be presented to the next immediate public Trust Board meeting for information. The draft minutes will then be presented at the next Charitable Funds Sub Committee meeting (see 'Minutes' above)

Copies of the agenda will be provided for all Trust Board members.

Last Reviewed: **September 2007**

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REMUNERATION AND TERMS OF SERVICE SUB COMMITTEE

Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Remuneration and Terms of Service Sub Committee (The Committee).

2. Membership

The Committee will comprise of all the Non-Executive Directors of the Trust and a quorum will be either the Trust Chair or the Vice Chair and two other Non-Executive Directors.

3. Attendance

The Chief Executive will attend for all relevant discussions of the Committee other than those relating to the Chief Executive's own remuneration and terms and conditions of employment.

Other Executive Directors may be in attendance to provide appropriate advice as required by the Committee.

The Trust Secretary will attend as secretary to the Committee and will maintain minutes of the meetings.

4. Chair of Meeting

At any meeting of the Committee, the Trust Chair if present shall preside. If the Chair is absent from the meeting then the Vice Chair shall preside.

5. Minutes

The minutes of the proceedings of meetings shall be drawn up and submitted for agreement at the next ensuing meeting where the person presiding at it will sign them.

6. Frequency

The Committee shall meet at least once annually. The Trust Chair will call additional meetings when considered necessary.

7. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee may act with such authority delegated to it by the Trust Board from time to time.

8. Duties

The purpose of the Committee is to advise the Trust Board on the terms and conditions of employment, including the remuneration packages, for the Chief Executive and the Executive Directors. The Committee will take due account of any National policy and/or guidance.

The main duties of the Committee are as follows:

8.1 To recommend the remuneration and terms of conditions of employment for the Chief Executive and the Executive Directors.

8.2 To recommend the remuneration and terms and conditions of employment for any employees who are not subject to national terms and conditions of service.

8.3 To scrutinise and agree any termination payments made to the Chief Executive and Executive Directors.

8.4 To ensure the consistent application of the Trust policy on remuneration and terms and conditions of employment for the Chief executive and the Executive Directors.

8.5 To ratify the recommendations of the Clinical Excellence Awards Committee.

9. Reporting

The minutes of the Committee will be recorded and submitted to the Trust Board.

Following each meeting of the Committee, the minutes will be drawn up and submitted to the Chair in draft format. Subject to reporting timetables, a set of agreed draft minutes will be presented to the next immediate in-committee Board meeting. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board. The draft minutes will be presented at the next Remuneration and Terms of Service Sub Committee (see ‘Minutes’ above).

Ratification by:	Trust Board
Date ratified:	September 2006

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Care Quality Commission: Annual Health Check
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	John Adler, Chief Executive
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

Following its report released on 15 October, the Care Quality Commission has awarded the Trust **'Good'** for the quality of its services and **'Good'** for use of its resources in its annual ratings. This is the third year running that this rating has been maintained for our services and the second for our resources.

The Care Quality Commission has rated our achievement of national targets as "excellent/fully met" and our core standards as '"almost met" In 2008/09 we declared non compliance with one of the core standards - relating to single sex accommodation. This is the subject of an ongoing action plan. Non compliance with three others core standards was resolved by the end of the year (March 09).

The minority of areas where there was under-achievement on national targets are the subject of ongoing improvement work and monitoring through the performance management system.

A full copy of the CQC's report is attached in the appendix.

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 annual performance ratings awarded by the Care Quality Commission.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to achieve Annual Healthcheck Core Standards
Annual priorities	
NHS LA standards	
Core Standards	All
Auditors' Local Evaluation	ALE score equates to Use of Resources score

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

Financial	**X**	Use of resources
Business and market share		
Clinical	**x**	Includes clinical quality standards
Workforce		
Environmental		
Legal & Policy		Incorporates various statutory requirements
Equality and Diversity		Includes E&D standards
Patient Experience	**x**	Includes patient experience measures
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

All staff have been advised of the performance ratings awarded by the CQC in a communication from the Chief Executive on 15 October 2009

Performance rating 2008/09 - Sandwell and West Birmingham Hospitals NHS Trust

Overall performance

The overall performance rating is made up of two parts: 'quality of financial management', which looks at how effectively a trust manages its financial resources; and 'quality of services', which is an aggregated score of performance against national standards, existing commitments and national priorities. The below tables summarise the four years of the performance assessment.

	2008/09	2007/08	2006/07	2005/06
Quality of Services				
Quality of Financial Management				

Based on our assessment for 2008/09, the quality of services provided by Sandwell and West Birmingham Hospitals NHS Trust for its local population was 'good'. The financial management rating for this organisation is 'good', as this organisation has been assessed as performing well and financial targets have been met for at least the past two years.

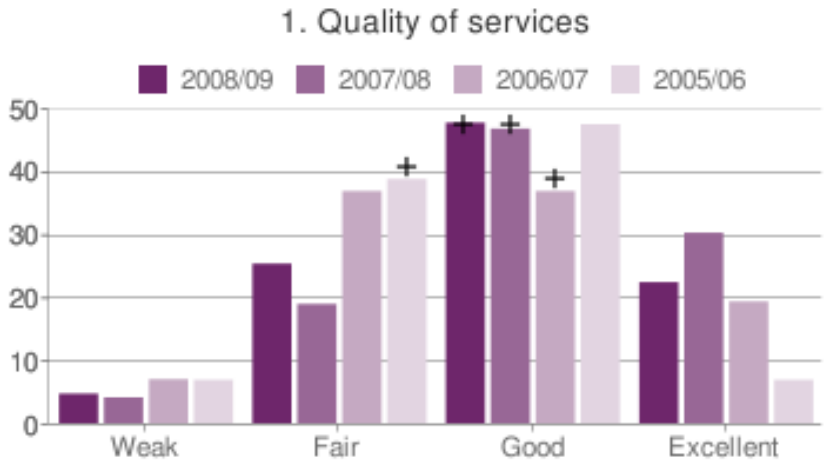
The trust was not one of those chosen to receive an inspection over the summer.

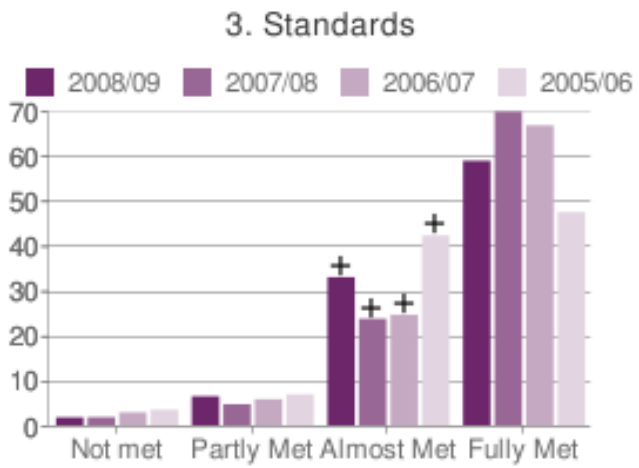
Components of quality of services:

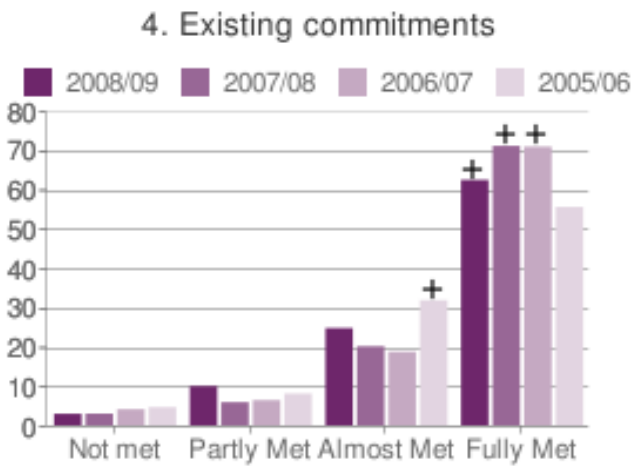
	2008/09	2007/08	2006/07	2005/06
Meeting core standards	NOT MET · PARTLY MET · **ALMOST MET** · FULLY MET	ALMOST MET	ALMOST MET	ALMOST MET
Existing commitments	NOT MET · PARTLY MET · ALMOST MET · **FULLY MET**	FULLY MET	FULLY MET	ALMOST MET
National priorities	WEAK · FAIR · GOOD · **EXCELLENT**	EXCELLENT	GOOD	FAIR

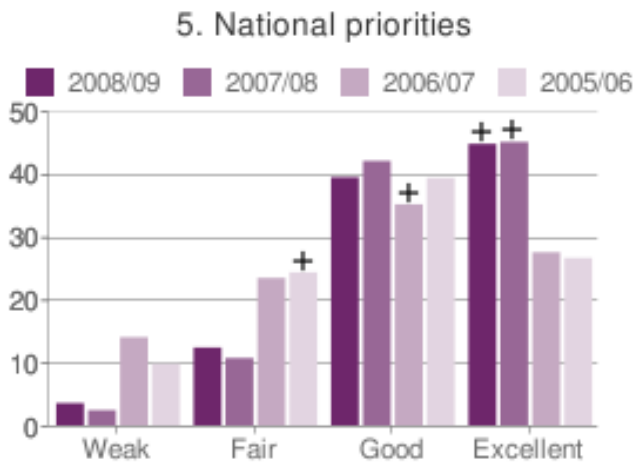
Overall performance of acute trusts

The graphs below show the percentage spread of results for all acute trusts for quality of services and quality of financial management, as well as for the three components of quality of services, over all four years. The performance of Sandwell and West Birmingham Hospitals NHS Trust is indicated by +.









Standards performance

Every NHS trust in England is responsible for ensuring that it is complying with the Department of Health's core standards. As part of the performance assessment, we ask all trusts to assess their performance against the core standards and to publicly declare the information. The tables below present Sandwell and West Birmingham Hospitals NHS Trust's performance in the seven key areas of health and healthcare over the last four years.

Safety	2008/09	2007/08	2006/07	2005/06
C01a - incidents - reporting and learning	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C01b - safety alerts	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C02 - safeguarding children	NOT MET	COMPLIANT	COMPLIANT	COMPLIANT
C03 - NICE interventional procedures	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C04a - infection control	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C04b - safe use of medical devices	COMPLIANT	NOT MET	NOT MET	NOT MET
C04c - decontamination	COMPLIANT	COMPLIANT	COMPLIANT	NOT MET
C04d - medicines management	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C04e - clinical waste	COMPLIANT	COMPLIANT	COMPLIANT	NOT MET

Clinical and cost effectiveness	2008/09	2007/08	2006/07	2005/06
C05a - NICE technology appraisals	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C05b - clinical supervision	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C05c - updating clinical skills	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C05d - clinical audit and review	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C06 - partnership	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT

Governance	2008/09	2007/08	2006/07	2005/06
C07a and c - governance	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C07b - honesty, probity	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C07e - discrimination	NOT MET	NOT MET	COMPLIANT	COMPLIANT
C08a - whistle-blowing	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C08b - personal development	NOT MET	NOT MET	COMPLIANT	COMPLIANT
C09 - records management	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C10a - employment checks	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C10b - professional codes of conduct	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C11a - recruitment and training	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C11b - mandatory training	COMPLIANT	COMPLIANT	COMPLIANT	NOT MET
C11c - professional development	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C12 - research governance	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT

Patient focus	2008/09	2007/08	2006/07	2005/06
C13a - dignity and respect	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C13b - consent	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C13c - confidentiality of information	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C14a - complaints procedure	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C14b - complainants discrimination	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C14c - complaints response	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C15a - food provision	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C15b - food needs	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C16 - accessible information	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT

Accessible and responsive care	2008/09	2007/08	2006/07	2005/06
C17 - patient and public involvement	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C18 - equity, choice	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT

Care environment and amenities	2008/09	2007/08	2006/07	2005/06
C20a - safe, secure environment	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C20b - privacy and confidentiality	NOT MET	COMPLIANT	COMPLIANT	NOT MET
C21 - clean, well designed environment	COMPLIANT	COMPLIANT	NOT MET	NOT MET

Public health	2008/09	2007/08	2006/07	2005/06
C22a and c - public health partnerships	COMPLIANT	COMPLIANT	COMPLIANT	COMPLIANT
C22b - local health needs	COMPLIANT	NOT APPLICABLE	COMPLIANT	COMPLIANT
C23 - public health cycle	COMPLIANT	COMPLIANT	COMPLIANT	NOT MET
C24 - emergency preparedness	COMPLIANT	COMPLIANT	COMPLIANT	NOT MET

Key: COMPLIANT | INSUFFICIENT ASSURANCE | NOT MET | NOT APPLICABLE

Existing commitments performance by indicator

Our existing commitments assessment looks at performance against long-standing targets that were mostly set during the Department of Health's 2003-2006 planning round. All NHS trusts should be meeting these commitments, which are mainly concerned with waiting times and access to services.

Performance against these indicators is detailed below.

Indicators	2008/09	2007/08	2006/07	2005/06
Total time in A&E: four hours or less	ACHIEVED	ACHIEVED	ACHIEVED	ACHIEVED
Waiting times for rapid access chest pain clinic	ACHIEVED	ACHIEVED	ACHIEVED	ACHIEVED
Revascularisation waiting times	ACHIEVED	ACHIEVED	ACHIEVED	ACHIEVED
Cancelled operations	UNDER ACHIEVED	UNDER ACHIEVED	UNDER ACHIEVED	UNDER ACHIEVED
Time to reperfusion	ACHIEVED	DATA NOT AVAILABLE	UNDER ACHIEVED	ACHIEVED
Delayed transfers of care	UNDER ACHIEVED	NOT APPLICABLE	UNDER ACHIEVED	FAILED
Inpatient waiting times	ACHIEVED	ACHIEVED	ACHIEVED	ACHIEVED
Outpatient waiting times	ACHIEVED	ACHIEVED	ACHIEVED	ACHIEVED
Access to GUM clinics	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
Data quality on ethnic group	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE

Note: Data from the last four years has been presented in the table above. However, annual amendments to indicator constructions and scoring thresholds have sometimes taken place.

National priorities performance by indicator

Our national priorities assessment looks at performance against priorities set during the Department of Health's 2008-2011 planning round. These include goals for the whole of the NHS, such as reducing health inequalities and improving the health of the population.

Performance against these indicators is detailed below.

Indicators	2008/09	2007/08	2006/07	2005/06
Infant health: smoking & breastfeeding	ACHIEVED	ACHIEVED	UNDER ACHIEVED	ACHIEVED
Experience of patients	SATISFACTORY	SATISFACTORY	SATISFACTORY	SATISFACTORY
Incidence of C. difficile	ACHIEVED	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE
Incidence of MRSA	ACHIEVED	UNDER ACHIEVED	ACHIEVED	FAILED
Stroke care	UNDER ACHIEVED	NOT APPLICABLE	UNDER ACHIEVED	NOT APPLICABLE
18 Week referral to treatment times	ACHIEVED	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE
Maternity HES: data quality	UNDER ACHIEVED	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
All cancers: one month wait	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
All cancers: two week wait	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
All cancers: two months wait	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
Participation in heart disease audits	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
Engagement in clinical audits	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
NHS staff satisfaction	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE

Note: Data from the last four years has been presented in the table above. However, annual amendments to indicator constructions and scoring thresholds have sometimes taken place.

Key: ACHIEVED, SATISFACTORY, UNDER ACHIEVED, BELOW AVERAGE, FAILED, POOR, DATA NOT RETURNED, DATA NOT AVAILABLE, NOT APPLICABLE

Glossary of terms:

Core standards

Fully met: This score means that a trust met all of the core standards set by Government by the end of the assessment year. A trust can only receive this score if it declares no more than four failings during the year. These failings must have been corrected by the end of the year.

Almost met: This score means that a trust met almost all of the core standards set by Government.

Partly met: This score means that a trust met many of the core standards set by Government. However, it was not able to demonstrate that it had met a number of standards.

Not met: This score means that a trust did not meet several of the core standards set by Government.

Compliant: This score means that a trust's board determined that it had met a standard during the assessment year, without any significant lapses.

Insufficient assurance: This score means that a trust's board was unclear as to whether there had been one or more significant lapses during the assessment year in relation to a standard.

Not met: This score means that a trust's board was clear that there had been one or more significant lapses in relation to a standard during the assessment year.

Declaration adjusted / Qualification: This score means that a trust received a follow up inspection at the end of the assessment year and had its declared compliance level adjusted, or qualified, based on the findings of our inspection.

Existing commitments and national priorities

Fully met: This score means that a trust performed consistently well for the existing commitments assessment.

Almost met: This score means that a trust performed well for many aspects of the existing commitments assessment.

Partly met: This score means that a trust performed poorly for some aspects of the existing commitments assessment.

Not met: This score means that a trust generally performed poorly for the existing commitments assessment.

Excellent: This score means that a trust performed consistently well for the national priorities assessment.

Good: This score means that a trust performed well for many aspects of the national priorities assessment.

Fair: This score means that a trust performed poorly for some aspects of the national priorities assessment.

Weak: This score means that a trust generally performed poorly for the national priorities assessment.

Achieved: This score means that a trust performed to a high level for this performance indicator.

Underachieved: This score means that a trust performed below the required level for this performance indicator.

Failed: This score means that a trust performed poorly for this performance indicator.

Not applicable: This score means that this performance indicator did not apply to this trust.

Data not available: This score means that this performance indicator did apply to this trust, but the relevant data were not available. This was not the fault of the trust.

Data not returned: This score means that this performance indicator did apply to this trust, but the relevant data were either not returned or were of insufficient quality for the purpose of this assessment. As a result, this trust was awarded the lowest score.

Indicator: This is what we use to measure performance.

Indicator construction: This is the detailed information that we publish about an indicator, which outlines the data and the method we will use to assess performance.

Scoring threshold: This is what we use to determine the required level of performance for an indicator. For each indicator, we use thresholds of performance to decide whether an organisation has 'achieved', 'underachieved' or 'failed'.

Quality of services / Quality of commissioning assessment

Excellent: This score means that a trust received the highest score for all applicable assessments that contribute to the overall quality score.

Good: This score means that a trust received at least the second highest score for all applicable assessments that contribute to the overall quality score.

Fair: This score means that a trust performed adequately in terms of the overall quality score.

Weak: This score means that a trust performed poorly in terms of the overall quality score.

Quality of financial management assessment

Excellent: This score means that a trust performed very well. Management arrangements operated effectively, and financial targets were met for at least the last two years.

Good: This score means that a trust performed well in regard to its financial arrangements, and met its financial targets for at least the last two years.

Fair: This score means that a trust performed adequately in regard to its financial arrangements.

Weak: This score means that a trust performed poorly in regard to its financial arrangements.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The New Registration System for Health and Adult Social Care
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

This paper summarises the new CQC registration process and the impact this will have on the core standards declaration for 2009/10.

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 NOTE the introduction of a new regulatory framework for health and adult social care from 1st April 2010 and the changes to the current core standards declaration process for 2009/10.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality of care
Annual priorities	6.2 Continue to achieve Annual Health check Core Standards
NHS LA standards	
Core Standards	All
Auditors' Local Evaluation	

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

Financial	**X**	The CQC will have a range of new powers to enforce compliance with the registration requirements including: ▸ Prosecutions (with fines up to £50,000) ▸ Issuing penalty notices ▸ Suspending services
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	**X**	Under the Health and Social Care Act 2008 and the Health and Social Care Act (Registration Requirements) Regulations 2009 it will be unlawful to provide regulated activities without being registered with the CQC
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Discussed at the Executive Team meeting on Tuesday 13 October 2009

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

The New Registration System for Health and Adult Social Care

1. Introduction

1.1 From April 2010, the regulation of health and adult social care will change. Legislation is bringing in a new system that applies to all regulated health and adult social care services.

1.2 All health and adult social care providers, who provide regulated activities, will be required by law to register with the Care Quality Commission (CQC). New registration comes into effect on 1st April 2010 for NHS trusts (including primary care trusts) and 1st October 2010 for adult and social care and independent health care providers.

1.3 This paper summarises the new CQC registration process and the impact this will have on the core standards declaration for 2009/10.

2. The new regulatory framework

2.1 With the introduction of the Health and Social Care Act 2008 and the Health and Social Care Act (Registration Requirements) Regulations 2009, Standards for Better Health for the NHS are being replaced by registration requirements. The new regulations are due to be laid before Parliament in autumn 2009.

2.2 From April 2010 all regulated health and adult social care providers will be required by law to register with the CQC and to do so they must show they are meeting essential common quality standards.

2.3 Regulated activities that require registration will be described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009. They will include, for example:

- personalised care;
- surgical procedures;
- diagnostic procedures;
- treatment of disease, disorder or injury.

The regulated activities that may also be provided within an acute trust include maternity and midwifery services, accommodation for persons who require treatment for substance misuse and management and supply of blood and blood derived products.

Providers are required to list all of the locations where the regulated activity will be provided. It is, therefore, necessary to determine which regulated activities the Trust provides, and the locations from which they are provided. For each regulated activity, providers will also need to produce a "statement of purpose" about the services they provide. The precise nature of this statement has yet to be published by the CQC.

It will be a serious offence to carry out a regulated activity without being registered.

2.4 The CQC, by law, is required to produce guidance about compliance to make clear to providers what they need to do to be compliant with the new regulations. The guidance will focus primarily on outcomes, such as what constitutes a quality experience for people who use services, rather than primarily on policies, systems and processes. It will include guidance on:

- Respecting and involving people who use services;
- Personalised care, support and nutritional needs

Unlike the Standards for Better Health, the guidance about compliance has an enhanced legal status. It can be used as evidence in criminal or civil proceedings and in the CQC's enforcement action.

The final guidance about compliance is expected to be published in December 2009.

3. Involving people who use services in registration

3.1 The views and experiences of representative groups of people who use services will be used by the CQC to inform decisions about whether a service provider should be registered, including:

- Local Involvement Networks (LINks);
- Overview and Scrutiny Committees;
- Local Safeguarding Childrens' Boards.

3.2 The CQC will expect providers to involve, consult and engage with people who use services in order to comply with regulations and have evidence of their compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009, including the views of people who use services.

4. Timescales for registration

4.1 2009/10 is a transitional year between the previous system and our new system of registration and performance ratings. Subject to legislation, the key dates for NHS providers are:

- At the **beginning of December 2009**, the CQC will publish final guidance about compliance and the judgement framework (the judgement framework sets out how the CQC will judge compliance with the regulations). During the first two weeks in December the CQC will hold regional workshops with NHS trusts to help them to understand how to register with CQC.

- **Between 4th and 29th January 2010**, NHS trusts apply for registration by submitting applications using online forms accessed via the CQC's website. The CQC will then assess registration applications, comparing them against data held

- In **February and March 2010**, the CQC may talk to trusts about their application and may ask them to supply more evidence to support them. The CQC will make a decision for each provider on whether to accept the application and will register providers accordingly.

- From **1st April 2010**, the results of the NHS trusts applications for registration will be made public.

  After registering a provider, the CQC will check and monitor its services to ensure that they go on meeting the standards. The focus will be on areas where it is believed that there is a risk of standards not being met.

  In the Autumn 2010 the CQC will launch a consultation on registration fees for all providers.

4.2 It will be unlawful to provide regulated activities without being registered with the CQC. In order to gain and maintain registration providers will need to demonstrate an ongoing ability to meet the registration requirements.

4.3 The CQC will have a range of new powers to enforce compliance with the requirements including:

- Prosecutions (with fines up to £50,000)
- Issuing penalty notices
- Suspending services

5. Assessment in 2009/10

5.1 2009/10 is a transitional year between the previous system of the Annual Health Check in 2008/09 and the CQC's new registration systems of registration and periodic review. The CQC's review of NHS trusts and primary care trusts as providers will have three components of assessment:

- compliance with core standards;
- performance against the Government's national priorities and existing commitments; and
- quality of financial management.

5.2 To avoid confusion with providers' applications for registration for 2010/11, which start in January 2010, the CQC has requested a core standards declaration mid year. Trusts are, however, required to comply with the core standards for the entire assessment year 1st April 2009 to 31st March 2010. The Trust is required to make a declaration by the 7th December of its performance against core standards in the first seven months of the year from 1st April 2009 to 31st October 2009. Information received as part of the core standards declarations will be used as part of the cross-check of information to inform the CQC's decision on trusts' registration status in April 2010, where appropriate.

5.3 In November, the Board will receive a report on the current position of the Trust on compliance with the core standards for 2009/10 for approval.

6. Recommendation

The Board is asked to NOTE the introduction of a new regulatory framework for health and adult social care from 1st April 2010 and the changes to the current core standards declaration process for 2009/10.

Kam Dhami
Director of Governance October 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Assurance Framework 2009/10: Quarter 2
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	29 October 2009

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	RED	1.1 (b), 6.2
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	1.3 (b), 1.4 (b), 1.5, 2.1, 2.4, 2.5, 2.9, 3.2, 4.2, 4.36, 5.1, 5.3, 6.1
YELLOW	1.2, 1.4 (a), 1.4 (b), 4.1, 6.3, 6.5, 6.7	YELLOW	1.1 (a), 1.2, 1.4 (a), 2.3, 2.6, 2.7, 2.8, 2.10, 3.1, 3.3, 4.1, 4.4, 5.2, 6.3, 6.5, 6.6, 6.7
GREEN	None	GREEN	1.3, 2.2, 6.4

Following proposed mitigating treatment, risks around the delivery of objectives 1.1 (b) (ensure achievement of national access targets) and 6.2 (achievement of Core Standards) remain as red.

Progress against delivery of the corporate objectives is discussed in a separate item on the Trust Board agenda.

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 2

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

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

October 2009

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		Progress report			
				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* Probability	Severity	Risk score	*What controls / systems we have in place to assist in securing delivery of our objective*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*Where are we failing to put controls/systems in place? Where are we failing to in making them effective?*	*We have evidence that we are reasonably managing our risks and objectives are being delivered*	*Where are we failing to gain evidence that our controls / systems, on which, we place reliance, are effective?*	*What needs to be done to address the identified gaps in control and assurance*	*Executive Lead and due date*	*Outline of progress to date on actions taken to minimise risk and/or progress with addressing the gaps in control and assurance*	*Post-mitigation* 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	2	3	6 ▶

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan		Progress report			
• 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	• Initial stages of flu pandemic plan delivered successfully during Q1 • State of readiness and flu plan presented to Trust Board in September • Update planned for October • Winter bed capacity plans updated in the light of flu planning	4	4	16 ▶
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		Progress report			
• 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 made on development of action plan for City Hospital. Reported to September Trust Board • Further progress report including decision on future ward configuration to be reported to Trust 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									2	5	10 ▶
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	2	5	10 ▶

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan		Progress report			
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 ▼
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	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 consultation commences October 2009.	3	3	9 ▶

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan		Progress report			
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 ▶
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	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		Progress report			
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 assessment dates are being arranged and will feed into final decision around assessment level at the end of October 2009 Ward reviews to establish compliance/raise awareness under way NHSLA leaflet published with August payslip. Further leaflets being produced for October/November	2	4	8 ▶
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		Progress report			
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 Monitoring of junior doctors' hours to take place in September and October 2009	2	3	6 ▼

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan		Progress report			
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 200910. • Progress on individual projects reviewed at RCRH Implementation Board. Most making good progress.	2	3	6 ▶
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.	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		Progress report			
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	None identified	None required	DFPM	Income volatility present but Trust balanced overall. Exercise underway to determine if mid-year income budget adjustment is warranted given the improved clarity of changes between v3.5 and v.4 HRGs	2	3	6 ►
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 to below £200k as at September with replacement schemes delivering	3	3	9 ►

Principal risks				Controls: Key controls	Controls: Assurances on controls	Controls: Gaps in controls	Assurances: Positive assurances	Assurances: Gaps in assurance	Action plan		Progress report			
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	• Good progress made with issues arising from Outpatient Action Plan. Beginning to address Outpatient scheduling issues. • Theatre utilisation work showed some improvement in Quarter 2 but now slowed. Further stage of activity planned for the rest of the year.	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	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/ NHP D	Affordability review initiated. Quarterly risk review completed	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		Progress report			
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.	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	Recommendation to trust Board to revise the objective in the light of the RCRH review,	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		Progress report			
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. The Trust is required to make a declaration at the end of November 2009 of their performance against core standards in the first seven months of the year from 1 April 2009 to 31 October 2009. The self-assessment process to establish continued compliance with the core standards will follow the same approach as in previous years.	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		Progress report			
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.	2	3	6	Monthly reporting will allow managers to keep track of individuals status	Corporate level reports will be available	Too early to tell. 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	Too early to accurately determine post mitigation scores	2	3	6 ▶
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	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	Too early to accurately determine post mitigation scores	4	1	4 ▶

Principal risks				Controls			Assurances		Action plan		Progress report			
				Key controls	Assurances on controls	Gaps in controls	Positive assurances	Gaps in assurance						
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/ NHP D	Fact finding for strategy content commenced	2	2	4 ▶

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Corporate Objectives 2009/10 – Progress Report (Quarter 2)
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Anne Charlesworth, Head of Corporate Planning
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

The report contains a summary of progress, at the end of Quarter 2, 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 Q2 and the proposed amendment to objective 6.1 regarding the application for NHS Foundation Trust status.

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**	
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 20 October 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ANNUAL PLAN 2009/10
CORPORATE OBJECTIVES PROGRESS REPORT (QUARTER TWO)

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 TWO PROGRESS

A summary of the position on each objective at the end of Quarter 2 is set out in the table that accompanies this report. An overview of the Q2 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 Achieve 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 second quarter, just under half of the objectives are assessed as green. Objective 4.4, which relates to the introduction of routine service line reporting, has been changed from green to amber as a result of issues that have arisen with the computer software. Following progress on delivery of the new hospital project which has moved objective 5.1 to amber, the only objective now rated red is 6.1 the application for NHS Foundation Trust status which is addressed in the proposed revision below.

REVISION TO OBJECTIVES

As members of the Trust Board will be aware the Right Care Right Here programme is currently being reviewed to ensure that it is sustainable during a period of constrained finances for the NHS. This work is progressing well but will not be finalised for some time. Because of the integrated nature of planning across the health economy, this has knock-on effects on the Trust's application for NHS Foundation Trust status in particular the Long-Term Financial Model and Integrated Business Plan.

The new timetable for the FT application is likely to be clearer in mid 2010, which means that the Trust will not achieve NHS FT status during 2009/10. This revised timetable is fully supported by the West Midlands Strategic Health Authority.

In the light of these developments, it is proposed to amend objective 6.1 to:

> *6.1 Continue to pursue NHS Foundation Trust status and explore complementary approaches to further increasing patient, public and staff engagement.*

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 Q2. The Trust Board is recommended to:

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

2. AMEND objective 6.1 to "*Continue to pursue NHS Foundation Trust status and explore complementary approaches to further increasing patient, public and staff engagement".*

Richard Kirby
October 2009

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
TRUST OBJECTIVES 2009/10: QUARTER TWO PROGRESS REPORT

PROGRESS REPORTING

Progress with many of the corporate objectives will be reported to the Board monthly through for example the monthly performance and finance reports (e.g. progress with 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 Two (Sept 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) = 99.05% 6/12 YTD, 98.9% in Q2 • Cancer targets (Mths 4&5): 2 Weeks = 93.6% 31 Days = 99.7% 62 Days = 87.4% (Assessed against revised national definitions for which thresholds not yet determined) • 18 weeks (Month 05): Admitted RTT = 96.5% Non-Adm. RTT = 98.0% • Max. Waits: IP = max wait 19 weeks (Month 05) OP = max wait 12 weeks (Month 05) Cardiac = max wait 5 weeks (Month 05) Diagnostics = 14 greater than 6 weeks, none >13 weeks (Month 05) • Rapid access chest pain = 100% (Q2) • GUM 48 hour access: Offered App't = 99.8% 6/12 YTD, 100% for Q2 Seen = 88.5% 6/12 YTD, 89.6% for Q2	**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 Two (Sept 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	Series of improvements now delivered including privacy screens on wards at Sandwell and improvements in separation of genders in assessment units and theatre recovery. New monitoring arrangements launched mid-September. Undertaking option appraisal for ward configuration for City – to be presented to December Trust Board.	**2**
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.	**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. No further progress made.	**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 Q2. MRSA Screening: • Elective Screens = 5895 • Non-Elec. Screens = 1484 C. Diff: • 39 cases (target trajectory <67) MRSA Bacteraemia: • 2 cases (target trajectory <9) Infection rates remain within target. Audits continue to show improvement. Some additional handwash stations are in place. TB reports continue.	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Two (Sept 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 05): • 67.3% patients spent >90% hospital stay on Stroke Unit Access to CT Scan (Q2): • 64.85% patients received Scan within 24 hours admission (72.58% Sept) 24/7 CT scanning 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. Remaining short term risks relate to midwifery staffing (particularly community). Trust and PCT Boards have agreed basis for medium term configuration review and formal consultation process starts mid-October. Timing slippage concerns have been resolved. Dashboard indicators continue positive trends. [Caesarean Section Rate 23.1% - Q2]	**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. 8 new wards have joined in October 09. Ward reviews were undertaken in June – the next round in November 09. Showed an improvement. Staff establishment review completed.	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Two (Sept 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. 1st cycle to complete Dec 09 Clinical Executive Team launched successfully. Extended to include Clinical Directors	**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. For Q2: Hip Fracture: • 88.2 received operation within 48 hours admission (target 79%) CT Scan Access: • 62.9% patients received Scan within 24 hours admission (target 72%) Major concerns about data quality. Caesarean Section Rate: • 22.3% (target 26.7%) OP Source of Referral Info: • 1.44% not stated (target <8.5%) Electronic referral system about to be deployed for smoking cessation	**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.	An interim visit to assess preparedness and advise on further action for both assessments took place on 2/3 September 2009. Induction and mandatory training remains the top 'hotspot' for the Level 2 NHSLA general risk management standards assessment. Two work	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Two (Sept 2009)**	**Red / Amber / Green Assessment**
			streams are running simultaneously to resolve the outstanding issues, which primarily relate to electronic data capture and dissemination. The Assessor's view was that, if the planned action is fully implemented, CNST maternity level one is achievable 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.	**2**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Two (Sept 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. Plan to expand capacity at Rowley agreed in outline at August SIRG. Update to be provided to November SIRG. Discussions with HoB have resulted in likelihood that future development will concentrate on Greet HC not Aston 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 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 where clearly budgetary pressure exists. Some of this is linked to additional activity but the situation is not helped by lower than anticipated income per spell, particularly in medical specialties. Strong performance in other areas is serving to maintain a balanced position overall.	**3**
4.2	Delivery of CIP of £15m. RW	• Achievement of CIP.	The position on CIP delivery is improving and is presently forecast to deliver in full. However, as there is still a year to date underperformance this indicator is being kept as Amber. Monitoring and management continues at FMB and reported to F&PMC.	**2**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Two (Sept 2009)**	**Red / Amber / Green Assessment**
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. Theatre improvement work concentrating on second wave of activity including planning for launch of Productive Operating Theatre programme. Bed management work continues to concentrate on development of real-time bed management system.	**2**
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.	Implementation issues associated with Ardentia have arisen and these are being addressed with the software supplier. This won't preclude the Trust from producing SLR positions in respect of the most recent year but may impact on the ability to make reporting more routine. Options for moving forward are being considered and incorporated into the work of the recently formed SLM (mgt) project.	**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**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Two (Sept 2009)**	**Red / Amber / Green Assessment**
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**
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	Achieve NHS FT status JA	• Authorised as NHS FT	Trust Board has considered options and agreed to hold FT application pending completion of RCRH Review and refresh of new acute hospital OBC. Proposal to revise objective (see main report text).	**1**
6.2	Continue to achieve Annual Healthcheck Core Standards KD	• Core standards achieved.	Only one of the core standards - C20b (compliance with single sex accommodation standards) - is currently declared by the Trust as 'not met'. The action plan to address the issues identified is due to be implemented by December 2009. Work is on-going to implement the action plan to achieve compliance with standard C20b – see 1.3 above. In order to avoid confusion with trusts' applications for CQC registration, which will start in January 2010, this year's core standards assessment will be based on a	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Two (Sept 2009)**	**Red / Amber / Green Assessment**
			mid-year declaration. The final date for submission of the 2009/10 declaration is 7th December 2009. The Trust's 2008/09 core standards declaration is being revisited to confirm that compliance has been maintained or improved.	
6.3	Deliver improved uptake of mandatory training and implement the LiA "Time to Learn" project. LB/GD	• Uptake of mandatory training	A revised MT policy has been issued. Additional training staff have been recruited Mandatory training provision has been reviewed and widely advertised. A robust booking system is in place and staff are actively booking onto the majority of the programmes. Critical issues to be resolved are: ▪ To improve update amongst medical staff, particularly consultants. ▪ To resolve I.T./System issues to enable robust reporting of mandatory training activity. Time to learn will be introduced as phase 2 before April 2010.	**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. Divisional reviews indicate good use of ward/dept specific data from staff survey. Planning now underway to use LiA techniques for major corporate programmes (e.g. clinical engagement, sustainability, QuEP).	**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	**2**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Two (Sept 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	A review of existing arrangements and an analysis of Trust requirements has been commissioned and a report with recommendations due to be received in November 2009. This needs further debate which will take place during the next 3 months.	**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 to be developed, initial plan developed November	**3**

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:	29 October 2009

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 September 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 – July 2009.
- The final review process for exemplar projects and the revised redesign structure.
- The intention to respond to an invitation from the Heart of Birmingham teaching PCT to put forward proposals for involvement in the further development of Greet Health Centre.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. NOTE the progress made with the Right Care Right Here Programme.
2. NOTE the Final Project Review Process for the first and second wave exemplar projects.
3. NOTE the revised structure for the service redesign elements of the Right Care Right Here Programme.
4. NOTE that the Heart of Birmingham teaching PCT have asked the Trust to put forward a proposal outlining options for the Trust's involvement in the further development of Greet Health Centre as an Outpatient and Diagnostic Centre.

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 SEPTEMBER 2009

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 September 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 – July 2009/10 (Appendix 2 – separate spreadsheet)
d) Right Care Right Here Revised Redesign Structure Diagram (Appendix 3)

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 – June 2009. There are four projects with 'Green' status – Urgent Care– HoB, Rehab Beds - Sheldon, Respiratory and ENT, all of which are exceeding targets.

The reasons for the six projects rated as 'Amber' are:
Rehab Beds - Rowley – step up provision is underperforming.
Musculoskeletal – the data changes previously reported has changed, with no explanation and there is no data on the primary care Rheumatology service.
Ophthalmology – while activity is underperforming no report has been submitted as the project lead has left and not been replaced.
Dermatology - clinics have been suspended owing to consultant vacancies, and importantly Soho clinics have been suspended June.
Gynaecology - no data report for July.
Diabetes – underperforming although the monthly totals for June and July have exceeded target so the underperformance is being recovered.

Two projects are rated 'Red':
Urgent Care Sandwell - owing to continuing underperformance and awaiting confirmation of the activity diverted to the Darzi GP Practice in Parsonage Street.
Cardiology - a replacement project lead is awaited and no reports have been received.

The issues relating to the projects rated as red and amber are being pursued by the Programme Delivery Group. In addition a process for placing the performance of the exemplar projects in the context of activity levels within the Acute Hospitals is being developed.

Exemplar Projects – In the context of the Programme Review and the revised service redesign priorities and structure, the Programme Delivery Group is establishing a Final Project Review Process for the exemplar projects. This will ensure that valuable lessons are learned, that progress made is

properly and fully recognised and that arrangements for continuation of service redesign activity are put in place wherever required. This process will take place in November and December.

There may be several potential outcomes for the existing projects including:

- Having reached a stage of development where it is sensible to mainstream redesigned services into the continuing relationship between commissioners and provider.
- The need for explicit arrangements to be put in place to continue effective clinical and professional dialogue.
- The requirement to be subsumed in whole or in part into the proposed future workstreams as part of a larger scale service redesign process.
- Having elements of the project closed as service redesign has been successfully concluded or service models have not worked well.

Service Redesign Activity - The Strategic Model Of Care Steering (SMOCS) Groups continue to make progress in developing the three key deliverables (Clinical Strategy, Overall Model of Care and Priorities for Service Redesign). Dates have now been agreed for the presentation of these to the Clinical Group through the autumn. Once approved by the Clinical Group the SMOCS deliverables will be presented to the Trust's Implementation Board.

Review of the Programme - A revised structure for the service redesign elements of the Programme has been agreed and is attached as Appendix 3. This shows how the three new areas for large scale redesign i.e. Demand Management Referrals/Outpatients, Demand Management Urgent/Emergency Care and Intermediate Care, will link to other work streams within the Programme.

Greet Health Centre - The Heart of Birmingham teaching PCT have asked the Trust to put forward a proposal outlining options for the Trust's involvement in the further development of Greet Health Centre as an Outpatient and Diagnostic Centre. This will include options for transferring clinical outpatient services to Greet Health Centre in line with the priorities of GPs for the local population and also options for developing 'front of house' clinical support services. The Trust views this as an important opportunity to develop redesigned patient pathways that closely integrate primary and secondary care and work towards the Right Care Right Here future vision and service models. The Trust has been working closely with local GPs in developing the initial proposal which will be submitted to the PCT by 26th October.

RECOMMENDATIONS

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.
2. NOTE the Final Project Review Process for the first and second wave exemplar projects.
3. NOTE the revised structure for the service redesign elements of the Right Care Right Here Programme.
4. NOTE that the Heart of Birmingham teaching PCT have asked the Trust to put forward a proposal outlining options for the Trust's involvement in the further development of Greet Health Centre as an Outpatient and Diagnostic Centre.

Jayne Dunn
Redesign Director – Right Care Right Here
20th October 2009

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, 28th September 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
- Agree a communications handling strategy for informing the stakeholders and public about the outcome of the Review (to be tabled at the meeting under Agenda Item 6)
- Agree to ensure all partners are invited to participate in the Partnership Board and all Programme Groups (Section 4.3.3)
- Debate and agree the proposed workstreams to be established to take forward the redesign of services (Section 4.4 and Figure 2)
- Debate and agree the proposed Delivery Principles (Section 4.5)
- Agree the recommendation for the Partnership Board to underwrite the additional expenditure required for the Programme Team to implement the outcome of the Review of the Programme (Section 4.6)
- Debate and agree the proposed changes to current governance arrangements to support the implementation of the Review of the Programme (Section 4.7)
- Note the proposed forward programme of work (Section 6)

2. Project Performance

2.1 April to July 2009

Given at Appendix 1 is the Project Performance report for April to July 2009.

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

The reasons for the six projects rated as 'Amber' are:
Rehab Beds - Rowley – step up provision is underperforming
Musculoskeletal – the data changes previously reported has changed, with no explanation and there is no data on the primary care Rheumatology service
Ophthalmology – while activity is underperforming no report has been submitted as the project lead has left and not been replaced
Dermatology - clinics have been suspended owing to consultant vacancies, and importantly Soho clinics have been suspended June but with no Programme involvement or formal notification from SWBH or the project lead
Gynaecology - no data report for July
Diabetes – underperforming although the monthly totals for June and July have exceeded target so the underperformance is being recovered

Two projects are rated 'Red':

Urgent Care Sandwell - owing to continuing underperformance
Cardiology - a replacement project lead is awaited and no reports have been received

These issues are being raised with the Programme Delivery Group.

As agreed at the last meeting, it is important to see this activity in the context of overall levels of activity in the acute hospitals, to ensure that transfer is taking place. A draft report format (see extract pages 3-5) has been developed to enable the information to be provided but it has not been possible to populate the full report for this month. It is recognised that the report attached is too detailed and the plan is to develop a dashboard, with graphical representation of performance, based upon key indicators that will be agreed by the Strategy Group. Comments from members of the Board on this format are welcomed.

3. Service Redesign Activity

3.1 SMOCS Update

Progress continues to be made with all the SMOCS Groups and they have now begun to present the three key deliverables (Clinical Strategy, Overall Model of Care and Priorities for Service Redesign) to the Clinical Group. The Maternity and Newborn SMOCS Group presented on 2nd September. This was well received and there were some issues of presentation, concerning the level of detail provided, which has been fed back to the other chairs who will be presenting in the next three months. A particular concern was the lack of reference to the role of GPs in the future proposed model of care. There will now be further debate with GP representatives from Heart of Birmingham and Sandwell to agree how this should be made more explicit. A revised document will then be received at the Clinical Group in October, with a view to signing off this SMOCS Group's report. A copy will then be provided to the Partnership Board in October and at the same time will be sent to partner organisations for them to sign the report at the appropriate level of governance within their organisations.

Given the time required for full discussion, the timetable for further presentations to the Clinical Group is being amended. The reports from the Planned Care and Children's SMOCS Groups will be presented in October, with the remaining reports to be made to the scheduled Clinical Groups in November and December, with an additional meeting being set up during November. This will ensure each SMOCS Group has their report properly considered and fully signed off by the Clinical Group by early December at the latest.

3.2 First and Second Wave Projects Final Review Process

With the emphasis from the Review of the Programme being concentrated on developing large scale service redesign, the Strategy and Programme Delivery Groups have debated the continuation of the existing first and second wave projects. The Groups have taken the view that it is imperative that the lessons to be learned from the service redesign and service transfers undertaken to date should be captured and their successes celebrated. There is also a clear recognition that arrangements to maintain the networks which have been established between clinicians and professionals across organisational boundaries should be maintained in some way.

The Programme Delivery Group is therefore establishing a Final Project Review Process, which will ensure that valuable lessons are learned, that progress made is properly and fully recognised and that arrangements for continuation of service redesign activity are put in place wherever required.
There may be several potential outcomes for the existing projects. They may:

- Have reached a stage of development where it is sensible to mainstream redesigned services into the continuing relationship between commissioners and provider
- Need explicit arrangements put in place to continue effective clinical and professional dialogue
- Require to be subsumed in whole or in part into the proposed future workstreams as part of a larger scale service redesign process (See Section 4.4 below)

- Have elements closed as service redesign has been successfully concluded or service models have not worked well.

The outcome of the Final Review process will be reported to the Partnership Board and circulated to partner organisations.

4. Review of Programme

4.1 General Update on Progress

This section provides a general update on progress and:

- summarises the agreements and progress made to date in the Review of the Programme
- identifies the major elements of work currently under way, with expected completion dates
- proposes the establishment of additional workstreams and changes to current workstreams in the Programme
- recommends the use of current Programme governance, with some amendments, for management of these workstreams
- identifies proposed principles to be used in the implementation of the Review of the Programme
- provides an update on discussions with the SHA on Tuesday 8th September
- outlines areas where decisions remain to be made

4.2 Agreements Made to Date

The partner organisations have made the following agreements, from discussions at the Joint Boards (both PCTs and SWBH) meeting on 20th July, the 'Think Tank' session on 19th August and the Partnership Board meetings on 27th July and 24th August:

4.2.1 Strategy

The strategy for all partner organisations is described as 'Improving Health Outcomes' with the Programme contributing to the achievement of this, by pursuing culture change, care redesign and appropriate infrastructure and systems. The relationship between these elements is shown in Figure 1.

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-July 09/10

Key: **CL OPs** Consultant Led Outpatients **NCL Ops** Non Consultant Led Outpatients

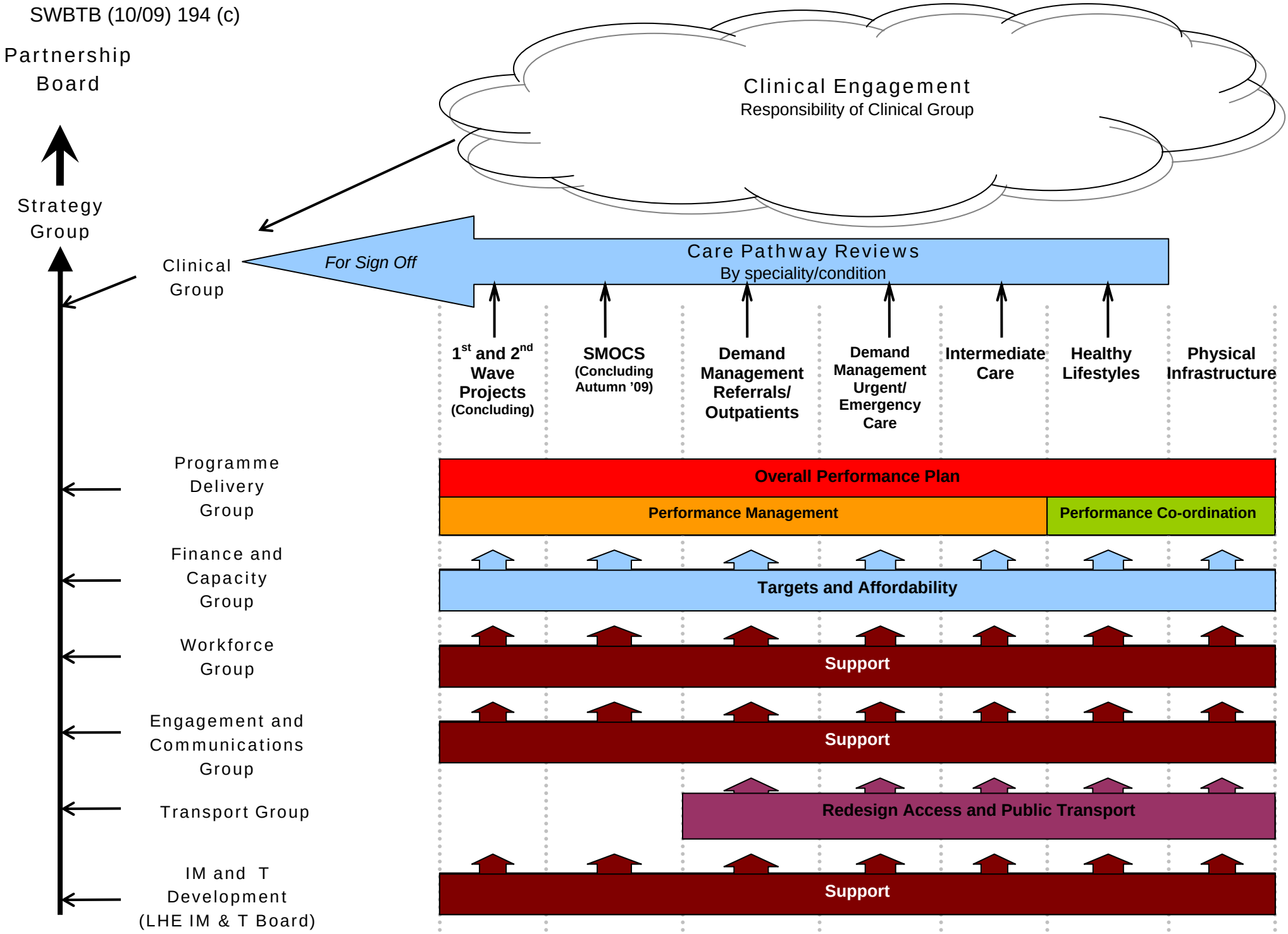
PROJECT	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2008/09 Yearend Target	Status	PROJECT LEAD	Comments
	MONTH (2009/10)																	
URGENT CARE - SANDWELL																		
Target (Attendances)	976	976	976	976	0	0	0	0	0	0	0	0	3,904		11,710		Gill Gadd	Activity below target. Project Lead has previously reported that the reduction in GP hours
Actual	842	855	972	862	0	0	0	0	0	0	0	0	3,531				SWBH	has reduced capacity resulting in the under performance.
Variance													**-373**	**-10**				
URGENT CARE - HoB																		
Targets (Attendances):																		
City	2,500	2,500	2,500	2,500	0	0	0	0	0	0	0	0	10,000		30,000		Mark Curran	Project just exceeding targets. HoBPCT have given SWBH notice to cease financial support
Actual	2,424	2,433	2,113	3,176	0	0	0	0	0	0	0	0	10,146				HOB PCT	for UCC GPs from 1st April 2010.
Variance													**146**	**1**				
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**				
	Note: July actual includes activity from additional GP in response to swine flu																	
REHAB BEDS - SHELDON																		
Targets:																		
Community - D43 (OBDs)	647	647	646	646	0	0	0	0	0	0	0	0	2,586		7,760		Angela Young	Project exceeding targets overall. Project closure report received, decision deferred by PDG.
Actual	638	783	631	643	0	0	0	0	0	0	0	0	2,695				HOB PCT	
Variance													**109**	**4**				
Care Centres (OBDs)	571	571	571	570	0	0	0	0	0	0	0	0	2,283		6,850			
Actual	595	657	592	662	0	0	0	0	0	0	0	0	**2,506**					
Variance													**223**	**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	0	0	0	0	0	0	0	0	1,167		3,500			
Actual	836	977	1,045	1,114	0	0	0	0	0	0	0	0	**3,972**					
Variance													**2,805**	**240**				
	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	0	0	0	0	0	0	0	0	1,267		3,800		Vacant	Step-up activity (Eliza Tinsley) below target. Significant overperformance for step-down
Actual	48	231	246	285	0	0	0	0	0	0	0	0	810				SPCT	element of the project.
Variance													**-457**	**-36**				
Community Step Down - Mc Ward (OBDs)	642	642	642	641	0	0	0	0	0	0	0	0	2,567		7,700			Project Lead is vacant. Chris Gibbs overseeing project on temporary basis.
Actual	1,526	1,663	1,611	1,627	0	0	0	0	0	0	0	0	6,427					
Variance													**3,860**	**150**				
STAR (Av Admits)	83	83	84	83	0	0	0	0	0	0	0	0	333		1,000			
Actual	60	77	75	91	0	0	0	0	0	0	0	0	303					
Variance													**-30**	**-9**				
MUSCULOSKELETAL (includes Orthopaedic beds & outpatients, Rheumatology outpatients & Pain Management																		
Targets:																		
HoB Orthopaedics Triage (NCL OPs)	545	545	545	545	0	0	0	0	0	0	0	0	2,180		6,535		Paul Hazle	Orthopaedic triage activity is exceeding target, as is Community Rheumatology.
Actual	641	556	902	884	0	0	0	0	0	0	0	0	2,983				SWBH	Reasons for Community Orthopaedics being significantly below target being explored with
Variance													**803**	**37**				the Project Lead. HoB community Pain Management Clinic start date postponed
Sandwell Orthopaedics Triage (NCL OPs)	574	574	574	574	0	0	0	0	0	0	0	0	2,296		6,885			indefinitely, contributing to activity for this element of the project being below target.
Actual	585	520	608	656	0	0	0	0	0	0	0	0	2,369					
Variance													**73**	**3**				Some of the actual data reported for previous months has changed - Project Lead asked for
Community Rheumatology (CL OPs)	381	381	381	381	0	0	0	0	0	0	0	0	1,524		4,564			explanation.
Actual	387	397	453	496	0	0	0	0	0	0	0	0	1,733					
Variance													**209**	**14**				
Primary Care Rheumatology (CL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		140			
Actual	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
Community Orthopaedics (CL OPs)	74	74	74	74	0	0	0	0	0	0	0	0	296		889			
Actual	50	4	43	47	0	0	0	0	0	0	0	0	144					
Variance													**-152**	**-51**				
Community Pain Management (CL OPs)	59	59	59	59	0	0	0	0	0	0	0	0	236		702			
Actual	11	13	15	20	0	0	0	0	0	0	0	0	59					
Variance													**-177**	**-75**				
	Note; Community Pain Management actual activity only includes Lyng activity																	

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-July 09/10

PROJECT	MONTH (2008/09) 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	0	0	0	0	0	0	0	0	5,091		15,274		Vacant	No report submitted, Project Lead vacant. Member of Project Team provided July data.
Actual	1,162	973	1,000	886	0	0	0	0	0	0	0	0	4,021				SPCT	
Variance													**-1,070**	**-21**				
DERMATOLOGY																		
Targets:																		
Community (CL OPs)	267	267	267	265	0	0	0	0	0	0	0	0	1,066		3,198		Kayode	Project exceeding target overall. No venue for Rowley identified. Consultant vacancies had
Actual	219	250	246	268	0	0	0	0	0	0	0	0	983				Odetayo	previously led to suspension of clinics at Tipton (Neptune) and Lyng - Project Lead has
Variance													**-83**	**-8**			HOB PCT	confirmed that a recent agreement has been made to suspend Soho clinics (no Programme
Community - GPwSI (OPs)	134	134	134	132	0	0	0	0	0	0	0	0	534		1,602			involvement).
Actual	178	187	260	275	0	0	0	0	0	0	0	0	900					
Variance													**367**	**69**				Project Lead vacant end September - request for final review report been made for submission prior to existing Lead taking up their new post.
RESPIRATORY																		
Targets:																		
Community - Nurse-led (OPs)	80	80	90	100	0	0	0	0	0	0	0	0	350		1,034		Sally Sandel	Actual activity has exceeded target (includes clinics being undertaken at Sandwell that have
Actual	276	281	258	248	0	0	0	0	0	0	0	0	1,063				SPCT	been redesigned).
Variance													**713**	**204**				
Primary Care - GP/Nurse/GPwSI (OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		432			Actual performance for April & June has decreased/increased respectively - Project Lead to
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					provide explanation.
Variance													**0**	**n/a**				
	Note: Primary Care service planned to commence in October																	
ENT																		Actual activity exceeding targets.
Target (CL Outpatients)	822	822	822	821	0	0	0	0	0	0	0	0	3,287		9,860		Jane Clark	
Actual	852	883	978	991	0	0	0	0	0	0	0	0	3,704				SWBH	
Variance													**417**	**13**				
CARDIOLOGY																		
Targets:																		
Community (CL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		782			No report submitted. Richard Young notified.
Actual - Rowley & Neptune	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0	0				Vacant	
Variance													**0**	**n/a**			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	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
GYNAECOLOGY																		
Target (CL OPs)	88	88	88	n/a	0	0	0	0	0	0	0	0	264		1,053		Therese	Narrative report submitted, data for July outstanding but Project Lead has stated that expects.
Actual	89	100	88	n/a	0	0	0	0	0	0	0	0	277				McMahon	activity to exceed target. Plans for a treatment and Diagnostic centre in Zone B unlikely to
Variance													**13**	**5**			HOB PCT	proceed. 15 GPs/1 Nurse applied for GPwSI/NwSI hysteroscopy training (6 places, starts December 2009. HoB-Sparkbrook PBC community clinic to commence October 7th.
DIABETES																		
Targets:																		
Community (CL OPs)	553	553	553	553	0	0	0	0	0	0	0	0	2,212		6,635		Olivia Amartey	Activity below target - Project Lead to provide explanation.
Actual	379	463	631	604	0	0	0	0	0	0	0	0	2,077				HOB PCT	
Variance													**-135**	**-6**				Project Lead to explain year to date underperformance.
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**				

SWBTB (10/09) 194 (c)



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	RCRH Acute Hospital Development: Project Director's Report
SPONSORING DIRECTOR:	Graham Seager, New Hospital Project Director
AUTHOR:	Andrea Bigmore, New Hospital Project Manager
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

The Project Director's report includes reference to:

- Compulsory Purchase Order
- Project Planning
- Due diligence
- Preparing for Competitive Dialogue
- The Design Vision

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to receive and note the update.

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	**X**	
Business and market share	**X**	
Clinical	**X**	
Workforce	**X**	
Environmental	**X**	
Legal & Policy	**X**	
Equality and Diversity	**X**	
Patient Experience	**X**	
Communications & Media	**X**	
Risks		Risks identified in project risk register and where appropriate included in Trust risk register

PREVIOUS CONSIDERATION:

Usual bimonthly update to Trust Board

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, Project Manager**
Subject:	**Acute Hospital Development Progress Report**
Date:	**16th October 2009**

1. Compulsory Purchase Order (CPO)

The CPO Order was made after Trust Board approval last month. Title owners were notified signalling the start of the period for them to raise objections. Work continues on voluntary acquisitions.

2. Project Planning

The successful initiation of the CPO means that the team is now able to update the project plan. The aim will be for the Trust to be ready to start the procurement process when a clear path to land title has been achieved. The plan will organise all of the work required to complete the procurement documentation, refresh the outline business case and secure approval to proceed with the procurement. The Project Board will oversee progress against the plan when it has been approved.

3. Due Diligence

A review of the departmental specifications and operational policies has been undertaken by a range of lead clinicians, managers and working groups across the Trust. This type of quality assurance process will be repeated at various stages of the project. It provides opportunities for checking and refining our brief to the Private Finance initiative (PFI) bidders. It also encourages a good level of engagement with key members of staff during the development process.

The outcome of this work has been positive so far showing that some work will be required to improve consistency across documents at the next version, but no serious issues have been identified.

4. Preparing for Competitive Dialogue

Competitive Dialogue is the approach we will be using to engage with the consortia who will bid for the Private Finance Initiative (PFI) contract. This process has been developed in response to fairly recent changes in European Union (EU) law and has only been undertaken by one other Trust to date.

The Core Team has been preparing a Competitive Dialogue (CD) strategy through a series of workshops over the last few weeks. A document is being developed to outline how we will work with bidders to ensure that design proposals are well developed and costed to a high level of certainty before selection of the preferred bidder.

The CD process involves:

- PFI bidders developing designs and solutions in response to the Trust's brief
- The team giving feedback on their proposals
- Formal submission and evaluation of proposals

The team is developing an approach to this that will minimise pressure on (and subsequent costs to) bidders. It will also allow proper clinical engagement in design and ensure that technical solutions are well worked up. There is considerable complexity in the process, but undertaking early planning will allow the team to prepare themselves and other participants in good time.

5. The Design Vision

A Design Vision Group was established early in the project to develop the vision that was used to develop the design brief. This group will be re-established in the New Year to review progress made. This group will be responsible for ensuring that the principles of the vision are maintained in the specification documents. The group will also be involved in the procurement process to ensure that the brief is interpreted into the best possible design solutions. The CD strategy will determine how this group will work during the procurement stage including detail about how public engagement can be facilitated.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Primary Care Trusts' Procurement Strategies
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White, Director of Finance and Performance Mgt
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

The Trust's two principal PCT partners have published procurement documents setting out a strategic view of how services are commissioned with some indication on how this shapes relationships with healthcare providers.

This reports summarises the procurement approaches adopted in the context of World Class Commissioning and the RCRH programme.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Full participation in the 'Right Care, Right Here' programme
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	Value for Money dimension

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

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

PREVIOUS CONSIDERATION:

Not previously considered.

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

PCT PROCUREMENT STRATEGIES

29 OCTOBER 2009

Introduction

The Trust's two principal PCT partners have published procurement documents setting out a strategic view of how services are commissioned with some indication on how this shapes relationships with healthcare providers.

Sandwell PCT

Sandwell PCT considered its procurement strategy in November of 2008. The policy context touches upon competition and choice as powerful levers to drive service quality, better value and reduce health inequalities. It also mentions the need to ensure alternative community provision which is one of the core aims of RCRH. The PCT summarised its document as follows:

"The longer term vision of healthcare delivery anticipates that procurement of services will be from a range of providers, which will inevitably call for the decommissioning of some existing providers, as a necessary step in this process.

As a commissioner of healthcare services, Sandwell PCT will need to demonstrate that it has robust commissioning and procurement processes that meet the 10 Principles and Rules of Competition and Cooperation (PRCC 2007):

As a World Class Commissioner, Sandwell PCT is required to commission services from providers who are best placed to deliver the needs of their patients and population, whilst co-operating with providers to ensure the experience of the patient is seamless.

The commissioning and procurement processes need to be transparent and non-discriminatory, with payment regimes being transparent and fair.

The attached strategy is a paper for discussion with / between respective groups across the organisation to ensure that the PCT is delivering against all of the World Class Commissioning competencies."

Sandwell plans to continue with its accountability agreements for PBC (practice based commissioners) to ensure objectives are aligned. In the main, it has grouped its commissioning activities into four dimensions.

Type 1 - Emergency Care. eg A&E, ambulance, out of area emergency care	**Type 2. Patient Choice.** eg secondary elective care, some aspects of primary care
Type 3 – Transformational Change eg RCRH, pooled budgets, APO services.	**Type 4 – Free Market Competition** eg out of area, third sector, some new services, some aspects of primary care

Under the 3rd type of service, the PCT recognises the potentially destabilising nature of allowing 'free market' or tendering processes to adversely affect patient access. Consequently, the Trust's status as the preferred provider is not endless, but does stay in place whilst the objectives of RCRH are pursued. Even with type 4 services, it is recognised that where these are provided by existing Acute providers, they may continue to do so but within a realigned model (i.e. more aligned to community based provision). Also of significance is reference to the 'fixed costs' of acute providers and this is consistent with the transitional financial framework.

The document goes on to discuss the development of the market and the legal framework for competitive procurement. There is a significant degree of discretion in terms of the extent of any market activity and this is useful as the document was written in the last half of 2008/09 when the activities associated with "plurality of provision" were perhaps wider than envisaged today. The pace at which tendering is used to modify the mix of service providers may be addressed in further WCC (work class commissioning) guidance given the Health minister's recent announcement that the NHS is the 'preferred provider'.

Electronic copies of the full document are available upon request.

Heart of Birmingham teaching PCT

More recently HoBtPCT published its strategy which can be found at http://www.hobtpct.nhs.uk/our_trust/public_meetings/ and then selecting Oct '09.

Like SPCT, the strategy is set in the context of WCC competencies. The relevent features of this include:

a. Competency 7 – Stimulate the market: Effectively stimulate the market to meet demand and secure required clinical and health and well-being outcomes. This will be delivered through the implementation of a procurement plan and a supplier development plan.

b. Competency 9 – Secure procurement skills: Secure procurement skills that ensure robust and viable contracts. The strategy sets out a proposal to develop and use external procurement resources through use of the

West Midlands Healthcare Purchasing Consortium (HPC). The HPC will advise on procurements and contribute to the development of the skills of key personnel to ensure contracts are managed effectively and deliver value for money.

c. Competency 10 – Manage the local health system: Effectively manage systems and work in partnership with providers to ensure compliance and continuous improvements in quality and outcomes. The strategy sets out how it will look at determining a range of preferred providers to ensure that the local system is managed during the significant change of the Right Care, Right Here programme.

Paragraph 26 captures the features of the RCRH principles.

26. HoB in conjunction with Sandwell PCT and Sandwell & West Birmingham NHS Trust have agreed a partnership programme (Right Care, Right Here) to support the local transformation of services and shift the balance away from acute hospital provision towards home and community based settings. As part of this programme a framework has been agreed that clearly maps out agreed activity volumes over the medium term. This is supported by a joint approach to the redesign of care pathways and a transitional financial framework. This process requires a high degree of collaborative working and within this context applying a purely competitive approach would undermine and destabilise the process in place.

The PCT refers to a contestability framework and highlights some of the benefits and risks of using such a powerful lever. Again, like SPCT it confirms there are no “hard and fast” rules of when to apply tendering.

Paragraph 53 addresses ‘preferred providers’ further and confirms SWBH as the preferred acute provider because:

a) A partnership approach is required to implement the Right Care Right Here (RCRH) strategy.
b) As part of that strategy a commitment to minimise destabilisation across the healthcare system has been made.
c) As part of that strategy an agreement of agreed activity volumes over a number of years has been made by all parties.
d) As part of the strategy a joint redesign of a range of care pathways working across acute, community and primary care settings.
e) As part of that strategy a transitional financial framework to manage respective parties’ risks has been made.

SWBHT remain the only acute provider with which we hold a contract that are willing to operate in this co-operative manner.

The other two entities include the Health Exchange (preventative care agenda) and the HoB provider services (again in part due to RCRH interfaces).

Summary & Recommendations

In summary, these two documents reinforce the benefits of partnership working and the need to ensure that stability and certainty of care provision is in place during a period of redesign. This remains as one of the key motivating factors for achieving RCRH partnership aims.

The Trust Board is asked to:

NOTE the PCT(s) approach to procuring services in the context of World Class Commissioning and the RCRH programme.

Robert White
Director of Finance & Performance Management

October 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance – Month 6
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert white/Tony Wharram
DATE OF MEETING:	22 October 2009

SUMMARY OF KEY POINTS:

The report is provided to update the Board on financial performance for the six months to 30th September 2009.

In-month surplus is £257k against a target surplus of £229k; £28k above plan.

Year to date surplus is £1,312k against a plan of £1,468k, £156k below plan.

In-month WTEs are 9 above plan, excluding the effect of agency staff.

Cash balance is in line with revised plan at 30th September.

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

Approval	Receipt and Noting	Discussion
X	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.
- To approve the amendments to the capital programme.

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 20 October 2009; Finance and Performance Management Committee on 22 October 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2009

EXECUTIVE SUMMARY

• In the period 1st April 2009 to 30th September 2009, the Trust has generated an overall I&E surplus of £1,312,000 which is £156,000 lower than the planned position. During the month of September, the Trust produced a net surplus of £257,000 exceeding the planned budget surplus by £28,000. This result continues the trend from the previous two months of meeting or slightly exceeding the planned surplus for the month.

• Fully coded and priced activity information is available for August 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 9 above plan and total pay expenditure for the month £249,000 above plan. This includes £442,000 of agency expenditure during September which is a significant fall compared with August levels.

• The month-end cash balance is almost exactly in line with the revised cash profile.

• The majority of operational divisions generated an in-month surplus but significant deficits were reported by Medicine A, Medicine B and Facilities. Again, this broadly continues the trend of previous months where the anticipated income per spell under HRGv4 fell below expectations.

Financial Performance Indicators

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	28	-156	> Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	34	-119	> Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	-249	-1,493	< Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	-117	-914	< Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	-9	89	< Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	-31	-31	> = Plan	> = 95% of plan	< 95% of plan
CIP Actual v Plan £000	-31	-294	> 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	1,468	1,312
Capital Resource Limit	3,925	2,307
External Financing Limit	---	10,043
Return on Assets Employed	3.50%	3.50%

2009/2010 Summary Income & Expenditure Performance at September 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	330,154	27,735	28,045	310	165,441	167,625	2,184	335,038
Other Income	37,271	3,118	3,208	90	18,440	18,544	104	37,375
Operating Expenses	(338,762)	(28,425)	(28,791)	(366)	(169,216)	(171,623)	(2,407)	(343,705)
EBITDA	28,663	2,428	2,462	34	14,665	14,546	(119)	28,708
Interest Receivable	150	13	7	(6)	75	38	(37)	65
Depreciation & Amortisation	(17,246)	(1,437)	(1,437)	0	(8,623)	(8,623)	0	(17,246)
PDC Dividend	(9,258)	(772)	(772)	0	(4,629)	(4,629)	0	(9,258)
Interest Payable	(40)	(3)	(3)	0	(20)	(20)	0	0
Net Surplus/(Deficit)	**2,269**	**229**	**257**	**28**	**1,468**	**1,312**	**(156)**	**2,269**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2009

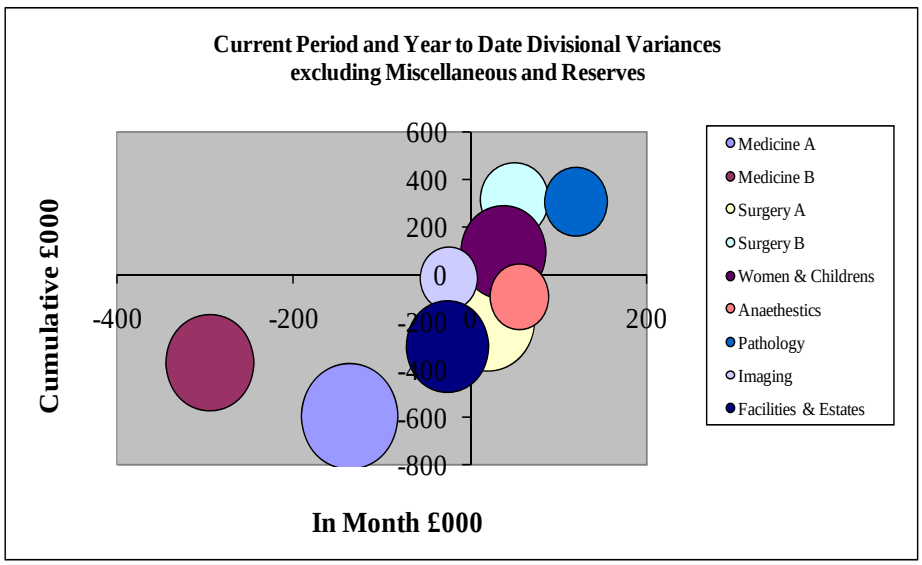
Divisional Performance

• Compared with the previous month, the overall position of the Trust has improved marginally with an in month bottom line performance £28,000 better than planned. This improvement is driven wholly by additional income, a combination of patient related SLA over performance, other non protected income (primarily ICR, road accident related insurance payments) and education & training. Pay costs continue to be significantly above plan with wte numbers, even excluding the impact of agency staff, now exceeding the plan. The non pay position is also generating budget deficits reflecting activity related pressures as patient treatment numbers exceed contracted levels.

•In month, Medicine A, Medicine B and Nursing - Facilities have generated significant deficits. The former two divisions are experiencing adverse income positions owing to the mix of patients attracting long and short stay tariff rates. Further analysis is being undertaken to understand the extent to which the current trend might continue. On the cost side, both Medicine divisions are experiencing high levels of pay expenditure, including ongoing significant spend on bank and agency staff. Nursing – Facilities performance is driven by high pay costs (a combination of substantive and agency staff) linked with ongoing environmental and cleaning programmes.

•The performance for the Trust overall is assisted by favourable budget positions within corporate divisions with a year to date performance of £342,000 better than plan and £84,000 in month.

• An additional £25,000 expenditure was incurred on specific pandemic flu related issues (primarily in Medicine A and Operations) bringing the year to date total to £408,000. To date this expenditure has been funded from Trust reserves.

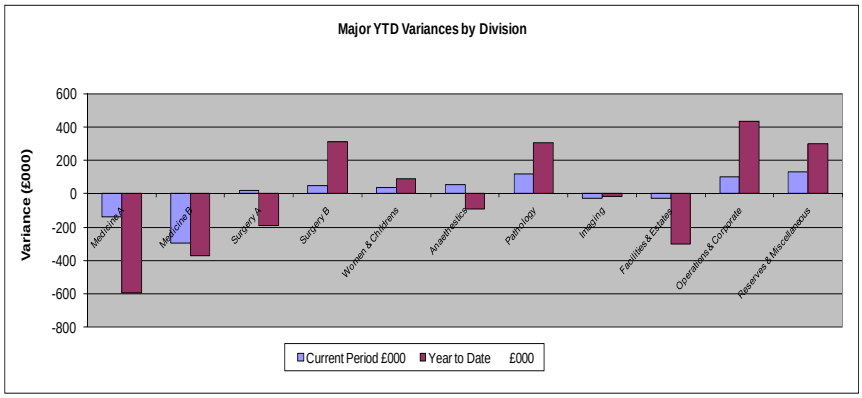


The tables adjacent and overleaf show a mixed position across divisions. The performance of Medicine A, Medicine B and Nursing – Facilities continues to worsen. Although Surgery A and Anaesthetics and Critical Care still have sizeable year to date deficits, their overall performance has again improved in month.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

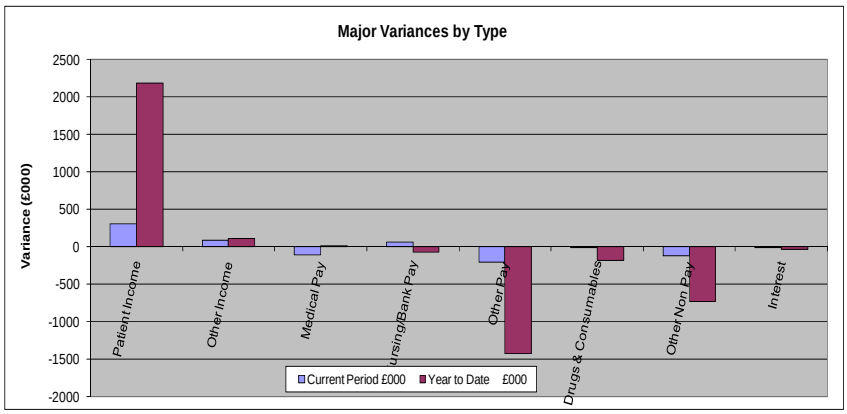
Financial Performance Report – September 2009

Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine A	-137	-595
Medicine B	-295	-370
Surgery A	20	-191
Surgery B	50	315
Women & Childrens	37	90
Anaethestics	56	-94
Pathology	120	307
Imaging	-24	-16
Facilities & Estates	-26	-303
Operations & Corporate	102	436
Reserves & Miscellaneous	132	299



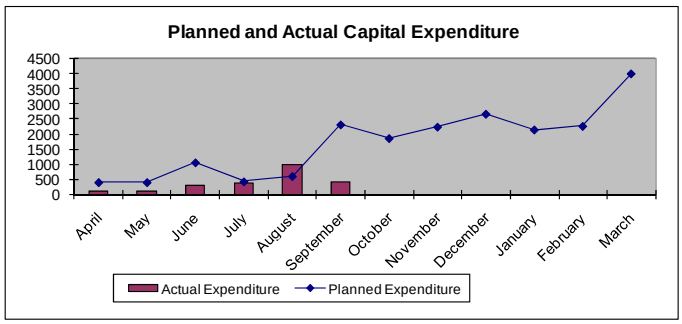
The tables below illustrate that overall income has performed better than plan for the year to date, benefiting in-month from a combination of patient related SLAs and other income. Although patient related SLAs continue to over perform, a limited degree of casemix adjustments have been effected. Overall pay expenditure is significantly above plan and expenditure on bank and agency remains high, although in the case of agency, spending fell when compared with August. In month, non pay expenditure continues to be in excess of plan, particularly in respect of medical equipment and consumables, reflecting the additional activity undertaken.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	310	2184
Other Income	90	104
Medical Pay	-109	11
Nursing/Bank Pay	67	-77
Other Pay	-207	-1427
Drugs & Consumables	6	-185
Other Non Pay	-123	-729
Interest	-6	-37



Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Expenditure of £433,000 was incurred in September mainly relating to statutory standards, ophthalmology clinics and mixed sex accommodation. This brings total capital expenditure for the year to date up to £2,307,000.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2009

Capital Expenditure Continued

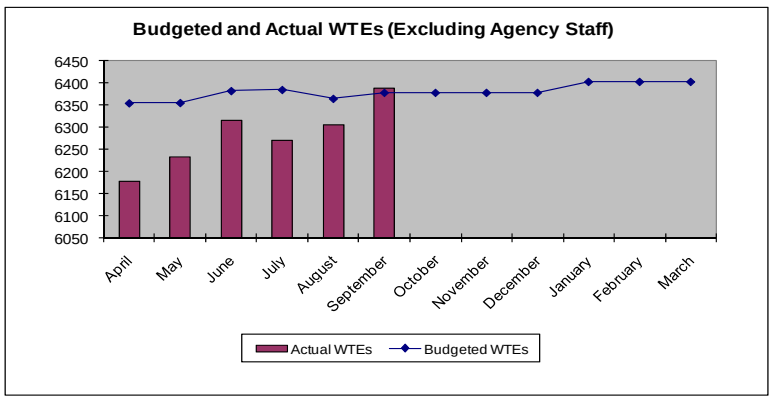
- The following changes are proposed to the capital programme:
  - •Addition of Pathology Vitamin D Analyser £250k
  - •Removal provisional sum of £50k for Pharmacy automation which will be reconsidered at a later date.

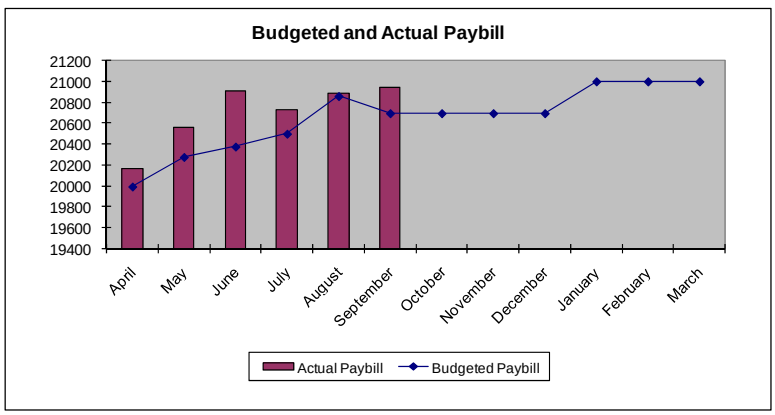
Paybill & Workforce

• Overall workforce numbers (wtes), excluding the effect of agency staff, are 9 above plan for September, which is a worsening on the position for August of approximately 70 wte's and an absolute increase in wte's worked of 84. Taking an estimate of the wte effect of agency staff, wte numbers are effectively 142 above plan.

•Paybill (including agency staff) is £249,000 above budgeted levels for the month and £1,493,000 for the year to date. This represents a continuing worsening of performance against planned levels and represents a key risk that must be managed in terms of delivering the yearend forecast surplus.

•In month expenditure on agency staff was £442,000, a reduction of £109,000 against expenditure in August. This compares with a year to date monthly average of £483,000.





Pay Variance by Pay Group

• The table below provides an analysis of all pay costs by major pay group 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 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 – September 2009

Analysis of Total Pay Costs by Staff Group						
	Year to Date to September					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	36,059	35,930		1,102	37,032	-973
Management	6,960	6,458		0	6,458	502
Administration & Estates	13,810	13,465		626	14,091	-281
Healthcare Assistants & Support Staff	6,061	6,021	963	700	7,684	-1,623
Nursing and Midwifery	43,143	40,054	2,153	344	42,551	592
Scientific, Therapeutic & Technical	16,641	16,233		123	16,356	285
Other Pay	19	14			14	5
Total Pay Costs	122,693	118,175	3,116	2,895	124,186	-1,493

Balance Sheet

• The opening balance sheet for the year at 1st April reflects the final audited accounts for 2008/2009.

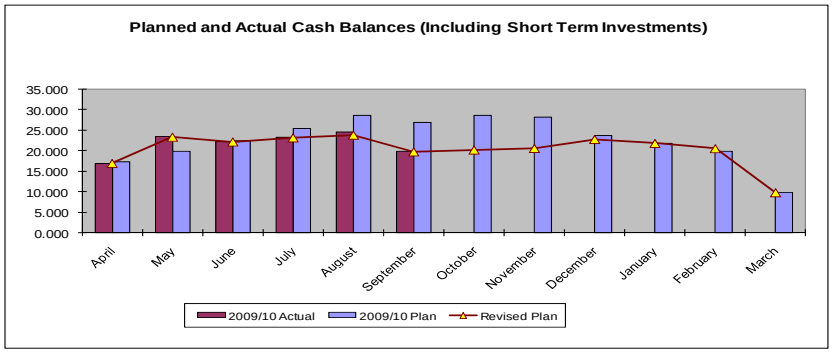
•Cash balances at 30th September are almost exactly in line with the revised plan with no significant variances in month. The Trust is still planning to hold the same year end cash balance as included in its original financial plan for the year.

Sandwell & West Birmingham Hospitals NHS Trust
BALANCE SHEET

		Opening Balance as at March 2009 £000	Balance as at September 2009 £000	Forecast at March 2010 £000
Fixed Assets	Intangible Assets	547	470	522
	Tangible Assets	255,007	248,691	256,327
	Investments	0	0	0
Current Assets	Stocks and Work in Progress	3,295	3,276	3,300
	Debtors and Accrued Income	20,242	19,092	18,500
	Investments	0	0	0
	Cash	8,752	19,793	9,751
Current Liabilities	Creditors and Accrued Expenditure Falling Due In Less Than 1 Year	(27,328)	(32,816)	(24,753)
	Loan Repayments Due in Less Than 1 Year	0	0	0
Long Term Liabilities	Creditors Falling Due in More Than 1 Year	0	0	0
Provisions for Liabilities and Charges		(7,633)	(4,312)	(5,500)
		252,882	254,194	258,147
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	161,047
	Revaluation Reserve	60,699	60,699	63,199
	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	18,378	19,690	20,647
		252,882	254,194	258,147

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2009



Cash Flow

• The table below shows cash receipts and payments for September 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 September 2009

ACTUAL/FORECAST	Sept-09 £000s	Oct-09 £000s	Nov-09 £000s	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
Receipts													
SLAs: Sandwell PCT	**13,013**	13,040	13,040	13,040	13,040	13,040	13,040	13,236	13,236	13,236	13,236	13,236	13,236
HoB PCT	**7,195**	7,198	7,198	7,198	7,198	7,198	7,198	7,306	7,306	7,306	7,306	7,306	7,306
South Birmingham PCT	**1,286**	1,264	1,264	1,264	1,264	1,264	1,264	1,282	1,282	1,282	1,282	1,282	1,282
BEN PCT	**1,733**	1,732	1,732	1,732	1,732	1,732	1,732	1,757	1,757	1,757	1,757	1,757	1,757
Pan Birmingham LSCG	**1,208**	1,213	1,213	1,213	1,213	1,213	1,213	1,231	1,231	1,231	1,231	1,231	1,231
Other PCTs	**2,306**	2,496	2,496	2,496	2,496	2,496	2,496	2,534	2,534	2,534	2,534	2,534	2,534
Over Performance Payments	**168**	0	0	750	0	0	0	1,000					
Education & Training	**1,295**	1,501	1,501	1,501	1,501	1,501	1,501	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	6	6	6	7	6	11	8	8	8	8	8
Other Receipts	**3,388**	2,412	2,412	2,412	2,412	2,412	2,412	2,090	2,090	2,090	2,090	2,090	2,090
Total Receipts	31,599	30,861	30,860	31,610	30,861	30,861	30,861	31,971	30,968	30,968	30,968	30,968	30,968
Payments													
Payroll	**12,229**	12,311	12,350	12,350	12,520	12,520	12,520	12,673	12,673	12,673	12,673	12,673	12,673
Tax, NI and Pensions	**8,182**	8,429	8,456	8,456	8,571	8,571	8,571	8,677	8,677	8,677	8,677	8,677	8,677
Non Pay - NHS	**3,055**	2,465	2,465	2,157	2,465	2,465	3,096	2,490	2,490	2,490	2,490	2,490	2,490
Non Pay - Trade	**7,334**	6,035	6,035	5,281	6,035	6,035	7,579	5,940	5,940	5,940	6,250	6,200	6,200
Non Pay - Capital	**375**	771	771	771	1,850	2,158	4,932	500	500	500	501	501	501
PDC Dividend	**4,629**	0	0	0	0	0	4,629	0	0	0	0	0	4,200
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	**361**	325	325	325	325	325	325	335	335	335	335	335	335
Other Payments	**79**	70	70	70	70	70	70	355	355	356	357	358	359
Total Payments	**36,244**	30,406	30,472	29,409	31,835	32,144	41,722	30,969	30,969	30,970	31,282	31,233	35,434
Cash Brought Forward	**24,438**	19,793	20,248	20,637	22,838	21,864	20,581	9,720	10,721	10,720	10,717	10,402	10,137
Net Receipts/(Payments)	**(4,645)**	455	389	2,201	(975)	(1,283)	(10,861)	1,001	(2)	(3)	(315)	(266)	(4,467)
Cash Carried Forward	**19,793**	20,248	20,637	22,838	21,864	20,581	9,720	10,721	10,720	10,717	10,402	10,137	5,670

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 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 AUGUST	Activity			Finance		
	Planned	Actual	Variance	Planned £000	Actual £000	Variance £000
Accident & Emergency	98,603	98,617	14	7,236	7,318	82
Admitted Patient Care - Elective	25,093	26,752	1,659	22,766	23,876	1,110
Admitted Patient Care - Non Elective	23,816	25,072	1,256	37,743	36,913	-830
Excess Bed Days	14,815	14,873	58	3,067	2,977	-90
Other	72	72	0	31,970	32,231	261
Out-Patients First Attendance	65,268	66,872	1,604	10,958	11,146	188
Out-Patients Follow Up	154,266	164,923	10,657	13,403	14,494	1,091
Out-Patients With Procedure	3,069	9,068	5,999	638	2,027	1,389
Unbundled Activity	6,145	23,301	17,156	4,594	4,565	-29
Total	**391,148**	**429,550**	**38,402**	**132,375**	**135,547**	**3,172**

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 for Major Commissioners

PERFORMANCE UP TO AUGUST	Finance		
	Planned £000	Actual £000	Variance £000
SANDWELL PCT	63,864	64,122	257
HEART OF BIRMINGHAM TEACHING	35,503	35,872	369
BIRMINGHAM EAST & NORTH PCT	8,531	8,680	150
SOUTH BIRMINGHAM PCT	6,235	6,922	687
PAN BIRMINGHAM LSCG	5,994	6,664	670
WALSALL PCT	2,648	2,598	-50
WEST MIDLANDS SCT	2,190	2,225	36
DUDLEY PCT	1,858	2,112	254
WORCESTERSHIRE PCT	1,107	1,283	176
SOLIHULL CARE TRUST	966	1,076	110
TOTAL	**128,897**	**131,554**	**2,658**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 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 broad indication of performance within each area as there may be different issues affecting different patient types within a service.

Year to Date SLA Performance: Major Variances From Plan

PERFORMANCE UP TO AUGUST	Finance		
	Planned £000	Actual £000	Variance £000
Cardiology	4,182	5,506	1,324
Gastroenterology	1,872	3,077	1,204
Urology	2,835	3,553	719
Respiratory Medicine	1,048	1,637	589
Ophthalmology	9,468	10,002	534
Elderly	8,081	8,612	531
Clinical Haematology	1,642	2,147	505
ENT	2,097	2,476	380
Direct Access	2,134	2,498	364
Other	9,610	9,932	322
Neurology	823	1,145	321
Rehabilitation	0	251	251
Gynaecology	3,595	3,828	233
Plastic Surgery	1,353	1,576	223
Vascular Surgery	972	1,187	215
Oral Surgery	407	619	212
Maternity	10,153	10,329	176
Gynaecological Oncology	956	1,119	163
Clinical Immunology	169	323	155
General Surgery	8,382	7,929	-452
Trauma & Orthopaedics	10,482	9,924	-558
A&E	8,670	8,071	-598
General Medicine	15,482	11,253	-4,229
TOTAL	**104,412**	**106,994**	**2,582**

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	8.5%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	99.2%	4
Return on Assets	Surplus before dividends over average assets employed	2.5%	2
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	6.4	1
Overall Rating			**2.2**

Risk Ratings

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

•The only significantly weak area remains liquidity which will only be substantially corrected with the introduction of a working capital facility.

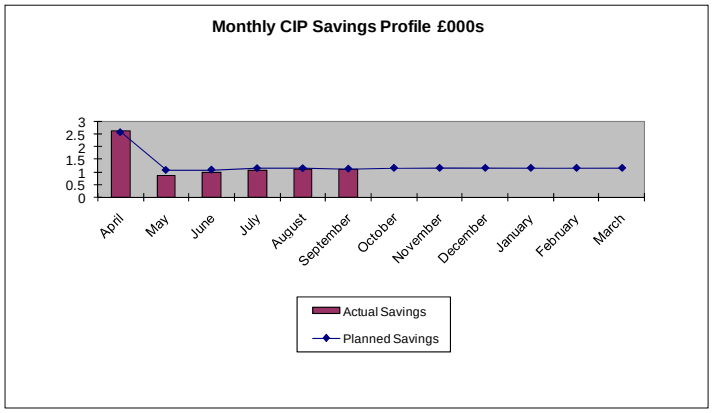
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2009

Cost improvement Programme

•The adjacent graph shows the monthly profile of the Trust's cost improvement programme and actuals achieved up to September.

•As at September, there is a shortfall against planned levels of £194k or 2.4% which is a further improvement on the shortfall reported for August.



External Focus and Forward Look

•Based on performance up to August, Sandwell and West Birmingham Hospitals continues to forecast fairly significant over performance against its Service Level Agreements with PCTs. Although there are still outstanding data challenge issues, this over performance will impact on the financial position of PCTs, particularly if they are experiencing over performance elsewhere in the acute sector. In addition, the Right Care, Right Here proposals are based upon a common understanding and agreement of expected activity levels and the extent to which actual activity, if sustained, is out of line with these assumptions. A review of Right Care, Right Here assumptions is currently underway and this, along with the impending round of LDP negotiations, will be a key factor in ensuring the financial stability of the whole local health economy.

• 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.

•NHS organisations are currently in the process of preparing Long Term Sustainability Models which are early assessments of the likely financial situation for the next few years. Although submission is actually from PCTs, the contents of the models need to be validated by whole health economies and will play a significant part in determining the financial position of the Trust. Latest assumptions by the StHA are reflected in the need to develop upside and downside scenarios. On the basis of the latest guidance, the expected uplift in funding for 2010/2011 is as follows:

- •PCT Funding Uplift 5.5%
- •Overall Tariff Uplift (inflation and cost pressures) 3.5%
- •Efficiency -3.5%
- •Net Tariff Uplift 0.0%
- •CQUIN 0.5%

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2009

External Focus and Forward Look Continued

•For 2011/2012, modelling scenarios are as follows:

	Base Case	Scenario 1	Scenario 2
	Flat Cash	Flat Cash	GDP Uplift
PCT funding Uplift	0.0%	0.0%	2.5%
Tariff Uplift	2.5%	2.5%	2.5%
Efficiency	-4.5%	-4.0%	-3.5%
Net Tariff Uplift	-2.0%	-1.5%	-1.0%

•Modelling of the Trust's medium term financial plan will, initially at least, need to be based on these scenarios.

Conclusions

•For the year to 30th September 2009, the Trust has generated an overall income and expenditure surplus of £1,312,000 which is £156,000 below plan. For the current month, the actual surplus of £257,000 was £28,000 above plan.

•Capital expenditure in September was significantly lower than planned levels and the year to date actual spend remains adrift from plan as some of the larger schemes are yet to come on stream.

•At 30th September, cash balances are in line with the revised cash plan.

• Medicine A, Medicine B and Nursing/(Facilities) have all generated significant in month deficits. These divisions, along with Anaesthetics and Critical Care and Surgery A have year to date deficits. This is balanced by better than planned performance in other divisions and, in particular, in corporate services. An in-depth review of the income position of the medicine divisions is being completed which may result in budget realignment given emerging information regarding the mix of short and long stay patients.

•Expenditure against pay budgets has worsened in month and this continues the trend of earlier months with only a temporary improvement in August. Numbers of whole time equivalents (wtes) in post has increased by 84 in month and the variance against budgeted wtes has decreased. Taking into account an estimated effect on wtes of agency staff, wte numbers are 142 or 2.2% greater than planned. It remains imperative that staff costs, and particularly the use of agency staff, are realigned to budgeted levels.

•Review and management of the performance of key divisions, in particular Medicine A and Medicine B, is ongoing. Controls on pay and staffing remain in place and will need to be strengthened and applied with increasing rigour if the current trend of increasing wte numbers is to be reversed, particularly in the light of the financial situation facing the whole of the NHS over the next few years.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2009

Recommendations

The Trust Board is asked to:

i. **NOTE the contents of the report;**

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

iii. **APPROVE the proposed changes to the capital programme.**

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – September 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 and Trust Management Board on 20 October 2009; Finance and Performance Management Committee on 22 October 2009.

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - SEPTEMBER 2009

EXECUTIVE SUMMARY

<table>
<tr><th>Note</th><th>Comments</th></tr>
<tr><td>a</td><td>Cancelled Operations during September further reduced to 0.5% across the Trust. Of the 30 cancellations recorded, 26 were attributable to the City site.</td></tr>
<tr><td>b</td><td>Overall Delayed Transfers of Care increased during September to 2.6% (2.1% during August). The majority (23 of 28)of delays on the census date were attributable to the City site.</td></tr>
<tr><td>c</td><td>Stroke Care - the proportion of patients spending at least 90% of their hospital stay on a Stroke Unit increased to 67.3% during August.</td></tr>
<tr><td>d</td><td>Accident & Emergency 4-hour waits - performance during the month of September was 98.6% and for the year to date 99.05%.</td></tr>
<tr><td>e</td><td>Cases of C Diff reduced to 10 across the Trust during September, with fairly even distribution between sites. 1 case of MRSA Bacteraemia was reported. The Trust continues to meet National and Local performance trajectories.</td></tr>
<tr><td>f</td><td>Infant Health & Inequalities - data for Quarter 2 is included within the report. Smoking data completeness remains at 96.9%, compared with 99.9% for 2008/09. Completeness of data remains a fundamental component of the Care Quality Commission's assessment of the Trust's performance.</td></tr>
<tr><td>g</td><td>Referral to Treatment Time targets for the month of September were all met. There were no diagnostic waits in excess of 6 weeks.</td></tr>
<tr><td rowspan="7">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 overall rate across the Trust increased to 27.6% during September. The rate for the first 6 months of the year is 23.1%, within the trajectory for the period.</td></tr>
<tr><td>Brain Imaging - During the month of September the proportion of patients admitted as an emergency following a stroke who received a brain scan within 24 hours of admission increased to 74.6%, increasing the year to date performance to 67.9%.</td></tr>
<tr><td>Hip Fracture - Performance during each of the most recent 4 months has exceeded the agreed trajectory, with performance for the 6 months to date 89.0%.</td></tr>
<tr><td>Smoking Cessation Referrals - A total of 501 referrals to PCT smoking cessation services have been made during the year to date. Of these however, relatively few (34) are differentiated as prior to listing for Elective Surgery, which is the specific definition of this target. The Trust is now able to capture smoking cessation referral data electronically which will assist with recording referrals, staff are being trained in its use. Additionally, a range of measures are being implemented to ensure the number of referrals prior to elective surgery increase.</td></tr>
<tr><td>Inpatient Patient Satisfaction Survey - The initial survey as reported previously has as intended informed the future composition of this indicator, with formal assessment against coverage of a further survey scheduled to be conducted later in the year.</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>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>1224</td><td>1134</td><td>90</td><td>7.9</td><td>6863</td><td>6372</td><td>491</td><td>7.7</td></tr>
<tr><td>Day case</td><td>4402</td><td>4303</td><td>99</td><td>2.3</td><td>25824</td><td>24188</td><td>1636</td><td>6.8</td></tr>
<tr><td>IPE plus DC</td><td>5926</td><td>5437</td><td>489</td><td>9.0</td><td>32687</td><td>30560</td><td>2127</td><td>7.0</td></tr>
<tr><td>IP Non-Elective</td><td>5330</td><td>5789</td><td>-459</td><td>-7.9</td><td>33609</td><td>33764</td><td>-155</td><td>-0.5</td></tr>
<tr><td>OP New</td><td>14517</td><td>14019</td><td>498</td><td>3.6</td><td>81089</td><td>79945</td><td>1144</td><td>1.4</td></tr>
<tr><td>OP Review</td><td>36396</td><td>32667</td><td>3729</td><td>11.4</td><td>205778</td><td>194576</td><td>11202</td><td>5.8</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>6745</td><td>6863</td><td>118</td><td>1.7</td></tr>
<tr><td>Day case</td><td>25093</td><td>25824</td><td>731</td><td>2.9</td></tr>
<tr><td>IPE plus DC</td><td>31838</td><td>32687</td><td>849</td><td>2.7</td></tr>
<tr><td>IP Non-Elective</td><td>33822</td><td>33609</td><td>-213</td><td>-0.6</td></tr>
<tr><td>OP New</td><td>75216</td><td>81089</td><td>5873</td><td>7.8</td></tr>
<tr><td>OP Review</td><td>185483</td><td>205778</td><td>20295</td><td>10.9</td></tr>
</table></td></tr>
<tr><td>k</td><td>Bank and Agency - Nurse Bank and Agency use reduced during September, with both shifts worked and costs incurred for the period to date within the profile set. Overall Medical Agency/ Medical Locum costs and Other Agency costs also fell, with the Overall Agency spend reducing to 2.11% (2.33% year to date).</td></tr>
<tr><td>l</td><td>Overall Sickness Absence reduced during August to 4.36% (4.67% in July), influenced by a reduction in short-term absence from 1.51% to 1.17% during the same period of comparison.</td></tr>
<tr><td>m</td><td>Almost 50% of staff have received a PDR during the first 6 months of the year. 1377 staff have received Conflict Resolution training during the year to date, well in excess of the target for the period.</td></tr>
</table>

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - SEPTEMBER 2009

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS			May	June	July	August			September			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	357 ▼	-5 ■	364 ■	→		177 ▲	→		257 ▲	1312	1468	2269		0%	0 - 1%	>1%	3399	6547	2535
RK	Cancer	2 weeks	%	92.9 ■	93.3 ■	93.0 ▼	→		93.7 ▲	→			93.4	=>93	=>93		No variation		Any variation	100	97.1	98.6
		31 Days	%	100 ■	99.4 ▼	100 ▲	→		99.4 ▼	→			99.7	=>96	=>96		No variation		Any variation	99.9	99.9	100
		62 Days	%	91.4 ▼	88.1 ▼	86.0 ▼	→		87.9 ▲	→			89.1	=>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	%	0.8 ■	1.1 ■	1.0 ■	0.6 ■	0.7 ■	0.6 ■	0.2 ▲	0.7 ■	0.5 ▲	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	%	3.2 ■	2.6 ■	2.5 ▲	2.0 ▲	2.1 ▲	2.1 ▲	1.5 ▲	3.6 ■	2.6 ▼	2.5	<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)	%	82 ■	93 ▲	79 ■	75 ■	100 ▲	83 ■				76.7	80	80		>80	75-80	<75	n/a	63.0	70.5
		Rapid Access Chest Pain	%	98.4 ▼	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	99.7	=>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	%	47.6 ▼	61.11 ▲	55.36 ▼	→		67.3 ■	→			55.9	67	70	c	+>70	65 - 70	<65	n/a	n/a	36.5
RK	A/E 4 Hour Waits		%	99.5 ▲	99.2 ▼	99.1 ▼	99.3 ▲	99.1 ■	99.2 ▲	99.4 ▲	98.1 ▼	98.6 ▼	99.05	=>98	=>98	d	=>98		<98	98.20	98.28	98.16
	GUM 48 Hours	Patients seen within 48 hours	%	81.8 ■	89.6 ▲	89.6 ■	→		91.2 ■	→		88.2 ■	88.5	=>95	=>95		No variation	0 - 10% variation	>10% variation	n/a	n/a	81.0
		Patients offered app't within 48 hrs	%	100 ■	99.1 ■	100 ■	→		100 ■	→		100 ■	99.8	100	100		No variation	0 - 10% variation	>10% variation	35.8	80.7	98.3
R0	Infection Control	C. Diff - EXTERNAL (DH) TARGET	No.	11 ▲	7 ▲	14 ▼	3 ▲	12 ■	15 ▼	4 ▼	6 ■	10 ▲	71	136	264	e	No variation		Any variation	n/a	355	163
		C. Diff - INTERNAL (LHE) TARGET	No.	11 ▲	7 ▲	14 ▼	3 ▲	12 ■	15 ▼	4 ▼	6 ■	10 ▲	71	113	220		No variation		Any variation	n/a	355	163
		MRSA - EXTERNAL (DH) TARGET	No.	1 ▲	2 ▼	1 ■	0 ■	0 ▲	0 ▲	0 ■	1 ▼	1 ▼	7	18	33		No variation		Any variation	61	43	15
		MRSA - INTERNAL (LHE) TARGET	No.	1 ▲	2 ▼	1 ■	0 ■	0 ▲	0 ▲	0 ■	1 ▼	1 ▼	7	12	23		No variation		Any variation	61	43	15
RK	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	94 ■	94 ■	95 ▲	→			→			94	90	90		>/=90	89.0-89.9	<89	90.0	89.0	87.0
RO	Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	→	96.9 ■	→	→			→		96.9 ■	96.9	=>99.0	=>99.0	f	>99	98 - 99	<98	99.9	99.5	99.9
		Breast Feeding Status Data Complete	%	→	99.1 ■	→	→			→		98.8 ■	99.0	=>99.0	=>99.0		>99	98 - 99	<98	98.3	99.8	97.8
		Maternal Smoking Rates	%	→	12.3 ■	→	→			→		10.5 ■	11.4	<12.0	<12.0		<12.0	12-14	>14.0	13.2	13.1	12.6
		Breast Feeding Initiation Rates	%	→	62.9 ■	→	→			→		62.0 ▼	62.4	>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	%	1 breach ■	0 ■	0 ■	→		0 ■	→		0 ■	0.001	0	0		<0.03		>0.03	4	0	5
RK	RTT Milestones	Admitted Care (RTT <18 weeks)	%	98.5 ▲	97.2 ▼	97.7 ▲	→		96.5 ▼	→		97.2 ▲	97.2	=>90.0	=>90.0	g	=>90.0		<90.0	52.0	90.6	98.6
		Admitted Care - Data Completeness	%	101.3 ■	101.7 ■	101.1 ■	→		102.0 ■	→		109.5 ■	109.5	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	100.4
		Non-Admitted Care (RTT <18 weeks)	%	98.7 ▲	98.6 ▼	97.9 ▼	→		98.0 ▲	→		98.0 ■	98.0	=>95.0	=>95.0		=>95.0		=<95.0	n/a	95.5	98.8
		Non-Admitted Care - Data Completeness	%	108.0 ■	101.0 ■	109.6 ■	→		105.0 ■	→		109.7 ■	109.7	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	98.1
		Audiology Direct Access Waits (<18 wks)	%	99.7 ▼	100 ▲	100 ■	→		100 ■	→		100 ■	100	=>95	=>95		=>95		<95	n/a	n/a	99.0
		Audiology Data Completeness	%	97.0 ■	91.0 ■	84.0 ■	→		91.0 ■	→		97.0 ■	97.0	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	96.0
		Diagnostic Waits greater than 6 weeks	No.	18 ▲	23 ▼	21 ▲	→		14 ▲	→		0 ■	0	0	0		0		>0	996	25	26
DO'D	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	96.8 Feb '09	89.1 March '09	82.0 April '09	→		85.5 May '09	→		80.5 Jun '09	87.1	Rate only	Rate only					101.1	100.2	99.0
		Peer (SHA) HSMR	HSMR	95.5	88.7	88.4	→		89.2	→		89.1	94.0	Rate only	Rate only					110.7	106.1	96.5
RK	CQUIN	OP Source of Referral Information	%	0.87 ▲	1.77 ▼	2.02 ▼	→		1.13 ▲	→		1.24 ▼	1.35	7.0	5.0	h	No variation		Any variation	n/a	n/a	10.0
DO'D		Caesarean Section Rate	%	22.7 ▼	23.9 ▼	20.5 ▲	21.2 ▼	22.4 ▲	21.8 ▼	26.6 ■	28.3 ■	27.6 ■	23.1	26.4	26.0		=<26.0		>26.0	n/a	27.7	27.0
		Brain Imaging for Em. Stroke Admissions	%	77.3 ■	70.3 ■	64.8 ▼	→		58 ▼	→		74.6 ■	67.9	72.0	72.0		=>72.0		<72.0	n/a	n/a	72.0
		Hip Fracture Op's <48 hours of admission	%	74.2 ■	92.9 ■	91.3 ▼	→		100 ▲	→		88.2 ▼	89.0	82.0	87.0		No Variation	0 - 2% Variation	>2% Variation	63.6	70.1	77.8
		Smoking Cesssation Referrals	No.			9 ■			15 ▲			10 ▼	34	500	1000		=>83	per month	<83	n/a	n/a	7
RO		IP Patient Satisfaction (Survey Coverage)	%														=>90		<90	n/a	n/a	n/a

Exec Lead	CLINICAL QUALITY			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	Readmission Rates	(Within 28 days of discharge)	%	12.3	10.9	11.2	13.3	10.4	11.7				11.5	No. Only	No. Only					10.1	n/a	11.6
		(Within 14 days of discharge)	%	9.1	8.1	8.1	9.6	7.6	8.5				8.4	No. Only	No. Only					n/a	n/a	7.3
R0	Infection Control	Savings Lives Compliance	%	99	99	99	→		99	→		99	99	>95	>95		< YTD target		> YTD target	n/a	n/a	99.0
		Phlebitis Rate	%	0.97	0.43	0.54	→		0.49	→			0.49	<5	<5		< YTD target		> YTD target	n/a	1.77	
		Phlebitis Compliance	%	80.7	84.9	86.1	→		83.7	→			83.7	>95	>95		>95%	75-95%	<75%	n/a	78	
		MRSA Screening (Elective)	No.	1692	2007	1782	→		1871	→		2242	11416	No. Only	No. Only		0 - 10%	10 - 15%	>15%	n/a	n/a	6495
		MRSA Screening (Non-Elective)	No.	527	678	595	→		332	→		557	3763	No. Only	No. Only		0 - 10%	10 - 15%	>15%	n/a	n/a	n/a
DO'D	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	3	1	0	1	0	1	0	1	1	7	24	48		=<2	3 - 4	>4	n/a	n/a	
		Admissions to Neonatal ICU	%	6.3	6.7	5.2	4.2	6.1	5.3	5.8	9.9	8.2	6.3	=<10	=<10		=<10	10.0-12.0	>12.0	n/a	9.6	
		Adjusted Perinatal Mortality Rate	/1000	7.5	17.1	8.6	8.5	10.2	9.4	4.7	0.0	2.0	2.0	<8.0	<8.0		<8	8.1 - 10.0	>10	n/a	n/a	
	FINANCE & FINANCIAL EFFICIENCY																					
RW	Gross Margin		£000s	2569	2206	2565	→		2382	→		2462	14546	14665	29805		0%	0 - 1%	>1%	26429	33250	26436
	CIP		£000s	949	949	1060	→		1105	→		1126	7901	8095	15075		0 - 2.5%	2.5 - 7.5%	>7.5%	19679	14027	11084
	In Year Monthly Run Rate		%	0.3	-102	1.11	→		4.12	→		12.23	-10.6	0	0		NO or a + variation	0 - 5% variation	>5% variation	329	45	1.4
RK	Income / WTE		£s	4991	4908	4998	→		4917	→		4892	4940	5127	5127		No variation	0 - 5% variation	>5% variation	5460	4924	5014
	Income / Open Bed		£s	32944	32662	32615	→		32904	→		32353	32411	31184	31184		No variation	0 - 5% variation	>5% variation	24774	29065	30498
	Income per Spell	Total Income	£s	2836	2719	2649	→		3082	→		2853	2808	2762	2762		No Variation	0 - 4% Variation	>4% Variation	2635	2740	2701
		Clinical Income	£s	2561	2448	2389	→		2760	→		2560	2528	2454	2454		No Variation	0 - 4% Variation	>4% Variation	2317	2449	2400
		Non-Clinical Income	£s	275	272	260	→		322	→		293	280	308	308	i	No Variation	0 - 4% Variation	>4% Variation	318	291	301
	Cost per Spell	Total Cost	£s	2803	2720	2618	→		3065	→		2829	2788	2742	2742		No Variation	0 - 4% Variation	>4% Variation	n/a	2643	2682
		Total Pay Cost	£s	1882	1834	1751	→		2077	→		1912	1873	1825	1825		No Variation	0 - 4% Variation	>4% Variation	1772	1737	1785
		Medical Pay Cost	£s	547	515	506	→		609	→		562	542	544	544		No Variation	0 - 4% Variation	>4% Variation	543	517	532
		Nursing Pay Cost (including Bank)	£s	666	648	605	→		711	→		658	651	639	639		No Variation	0 - 4% Variation	>4% Variation	609	615	625
		Non-Pay Cost	£s	921	886	867	→		988	→		917	915	917	917		No Variation	0 - 4% Variation	>4% Variation	n/a	906	897
		Mean Drug Cost / IP Spell	£s	110	107	114	→		122	→		121	115	123	123		No Variation	0 - 4% Variation	>4% Variation	n/a	95	120
		Mean Drug Cost / Occupied Bed Day	£s	44	44	42	→		48	→		51	47	48	48		No Variation	0 - 4% Variation	>4% Variation	n/a	35	47
	PATIENT EXPERIENCE																					
KD	Complaints	Number Received	No.	→	228	→	→			→			228	No. Only	No. Only					673	697	789
		Response within initial negotiated date	%	→	75.9	→	→			→			75.9	85	85		80%+	70 - 79%	<70%	77.4	81.2	81.1
	Thank You Letters		No.	→	411	→	→			→			411	No. Only	No. Only					6026	3491	2912
RK	Elective Access Contact Centre	Number of Calls Received	No.	11244	13516	12366	→		11117	→		12667	72895	No. Only	No. Only					n/a	n/a	190434
		Average Length of Queue	mins	0.39	0.50	1.03	→		1.00	→		1.54	1.54	0.5	0.5		No variation	0 - 10% variation	>10% variation	n/a	n/a	0.44
		Maximum Length of Queue	mins	13.4	22.5	17.5	→		12.5	→		7.4	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.	110735	121140	93372	→		77550	→		81809	601440	No. Only	No. Only					n/a	1826476	1559688
		Calls Answered	%	76.0	75.2	87.3	→		88.8	→		8804.0	81.7	No. Only	No. Only					n/a	81.0	82.3
		Answered within 15 seconds	%	44.2	43.0	48.8	→		46.7	→		44.6	44.6	No. Only	No. Only					n/a	n/a	39.1
		Answered within 30 seconds	%	56.9	55.9	64.5	→		63.0	→		60.9	60.9	No. Only	No. Only					n/a	n/a	55.5
		Average Ring Time	Secs	22.5	22.6	24.9	→		26.9	→		28.0	28.0	No. Only	No. Only					n/a	n/a	28.8
		Longest Ring Time	Secs	741	917	741	→		719	→		877	877	No. Only	No. Only					n/a	n/a	695
	STRATEGY																					
RK	Referrals	Total By Site	No.	15287	17146	17093	→		14632	→			80240	73899	178070		No Variation	0 - 2% Variation	>2% Variation	138580	151755	178070
		Total GP Referrals	No.	9993	11471	11157	→		9559	→			52762	49857	120138		No Variation	0 - 2% Variation	>2% Variation	98476	95857	120138
		Total Other Referrals	No.	5294	5675	5936	→		5073	→			27478	24042	57932		No Variation	0 - 2% Variation	>2% Variation	40104	55898	57932
		By PCT - Heart of B'ham	No.	4088	4547	4642	→		4074	→			21758	24092	49859		No Variation	0 - 2% Variation	>2% Variation	40394	41628	49859
		By PCT - Sandwell	No.	7733	8751	8565	→		7221	→			40478	36341	87779		No Variation	0 - 2% Variation	>2% Variation	72580	77592	87779
		By PCT - Other	No.	3466	3848	3886	→		3337	→			18004	17066	40453		No Variation	0 - 2% Variation	>2% Variation	25606	32535	40453
		Conversion (all referrals) to New OP Att'd	%	81.9	83.6	84.3	→		84.8	→			84.3	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.	1080	1204	1185	375	703	1078	395	829	1224	6863	6372	13077	j	No Variation	0 - 2% Variation	>2% Variation	13887	13395	13106
		Elective DC	No.	4062	4451	4715	1703	2136	3839	2032	2370	4402	25824	24188	49636		No Variation	0 - 2% Variation	>2% Variation	45831	46304	50873
		Total Elective	No.	5142	5655	5900	2078	2839	4917	2427	3199	5626	32687	30560	62713		No Variation	0 - 2% Variation	>2% Variation	59718	59699	63979
		Non-Elective - Short Stay	No.	1323	1406	1499	702	750	1452	681	746	1427	9404	6774	13745		No Variation	0 - 2% Variation	>2% Variation	12414	11575	12770
		Non-Elective - Other	No.	4453	4338	4433	1561	2124	3685	1648	2255	3903	24205	26990	54971		No Variation	0 - 2% Variation	>2% Variation	52662	55163	56226
		Total Non-Elective	No.	5776	5744	5932	2263	2847	5137	2329	3001	5330	33609	33764	68716		No Variation	0 - 2% Variation	>2% Variation	65076	66738	68996
	Outpatients	New	No.	12521	14333	14405	4132	8275	12407	4805	9712	14517	81089	79945	159666		No Variation	0 - 2% Variation	>2% Variation	127449	131941	152923
		Review	No.	33914	35633	35583	11531	19751	31282	13010	23386	36396	205778	194576	385680		No Variation	0 - 2% Variation	>2% Variation	370970	361113	374867
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	14984	17984	16319	6777	8638	15415	6843	8390	15233	99209	101577	197122		No Variation	0 - 2% Variation	>2% Variation	200561	195093	191141
	A/E Attendances	Type II (BMEC)	No.	3197	2923	2854	→	2955	2955	→	3079	3079	18048	15845	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	4.5	4.3	4.3	4.4	4.4				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.	305	257	322	134	158	292	144	137	281	281	No. Only	No. Only					n/a	345	312
		All Patients with LOS > 28 days	No.	161	145	154	73	84	157	66	76	142	142	No. Only	No. Only					190	174	152
		Min. Stay Rate (Electives (IP/DC) <2 days)	%	92.4	92.2	92.44	93.5	90.2	91.59	94.2	89.3	91.39	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)	%	82.6	86.1	86.0	87.6	85.5	86.3	87.5	82.7	84.3	84.3	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	63.2	76.5	79.4
		Day of Surgery (IP Non-Elective Surgery)	%	66.2	69.8	63.78	69.8	69.58	69.68	66.72	66.23	66.44	68.5	No. Only	No. Only					n/a	68.3	70.2
		With no Procedure (Elective Surgery)	%	9.2	10.2	10.1	10.5	10.5	10.5				10.0	No. Only	No. Only					10.6	n/a	10.6
		Per Bed (Elective)	No.	4.89	5.27	6.47	4.37	5.74	5.08	4.52	5.58	5.07	5.48	5.90	5.90		No Variation	0 - 5% Variation	>5% Variation	4.66	4.87	5.33
	Discharges	Pt's Social Care Delay	No.	14	10	16	5	6	11	4	13	17	17	<18	<18	b	No Variation	0 - 10% Variation	>10% Variation			
		Pt.'s NHS & NHS plus S.C. Delay	No.	12	8	3	1	4	5	1	10	11	11	<10	<10		No Variation	0 - 10% Variation	>10% Variation			
	Beds	Occupied Bed Days	No.	26257	25305	26501	11706	13889	25595	11426	14472	25898	160450	169464	342000		No Variation	0 - 5% Variation	>5% Variation	378060	348676	342793
		Occupancy Rate	%	83.57	85.71	85.2	83.4	85.2	84.3	84.2	87.8	86.1	85.2	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.	940	949	961	462	480	942	469	497	966	966	975	975		No Variation	0 - 2% Variation	>2% Variation	1039	1007	975
	Day Case Rates	All Procedures	%	79.0	76.3	78.5	80.3	73.2	76.2	82.2	71.6	76.1	77.4	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	76.0	76.9	79.0
		BMEC Procedures	%	79.5	80.2	80.74		79.09	79.09		77.93	77.93	78.7	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	71.5	77.2	79.7
	Non-Admitted Care	New : Review Rate	Ratio	2.71	2.49	2.47	2.79	2.39	2.52	2.67	2.42	2.50	2.54	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	2.91	2.74	2.45
		DNA Rate - New Referrals	%	16.3	15.3	14.6	15.6	15.2	15.3	13.2	13.5	13.4	13.4	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	10.8	10.9	12.0
		DNA Rate - Reviews	%	14.5	13.8	13.1	13.1	12.3	12.6	12.3	12.1	12.2	12.0	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	12.8	13.5	13.5
	Pathology	Cervical Cytology Turnaround	Weeks	4.3	4.3	3.3	→		2.4	→		1.8	1.8	<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	%	17	17	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	<10.0	<10.0		<10	10 - 12.5	>12.5	n/a	29.1	19.0
		(West Midlands average)	%	20	19	n/a	→		n/a	→		n/a	n/a	No. Only	No. Only					n/a	31.1	21.0
		In Excess of 60 minutes	No.	9	26	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0		0	1 - 5	>5	n/a	n/a	
THEATRE UTILISATION																						
RK	Sitrep Declared Late **Cancellations** by Specialty	General Surgery	No.	5	16	13	1	0	1	2	1	3	44	30	60	a	0-5% variation	5 - 15% variation	>15% variation	n/a	75	104
		Urology	No.	1	2	4	1	0	1	0	4	4	15	24	48		0-5% variation	5 - 15% variation	>15% variation	n/a	67	102
		Vascular Surgery	No.	0	1	0	0	0	0	0	0	0	1	2	3		0-5% variation	5 - 15% variation	>15% variation	n/a	1	7
		Trauma & Orthopaedics	No.	0	5	11	5	2	7	1	4	5	31	36	72		0-5% variation	5 - 15% variation	>15% variation	n/a	100	75
		ENT	No.	0	3	2	0	0	0	0	1	1	6	6	12		0-5% variation	5 - 15% variation	>15% variation	n/a	19	23
		Ophthalmology	No.	19	14	12	1	4	5	0	7	7	66	54	108		0-5% variation	5 - 15% variation	>15% variation	n/a	139	153
		Oral Surgery	No.	0	6	0	0	4	4	0	1	1	13	4	8		0-5% variation	5 - 15% variation	>15% variation	n/a	10	19
		Cardiology	No.	1	1	1	1	0	1	0	0	0	4	11	21		0-5% variation	5 - 15% variation	>15% variation	n/a	28	31
		Gynaecology	No.	1	6	4	3	7	10	1	2	3	27	27	54		0-5% variation	5 - 15% variation	>15% variation	n/a	69	71
		Plastic Surgery	No.	0	1	5	0	0	0	0	1	1	8	6	12		0-5% variation	5 - 15% variation	>15% variation	n/a	17	21
		Dermatology	No.	10	1	0	0	0	0	0	5	5	16	12	24		0-5% variation	5 - 15% variation	>15% variation	n/a	4	24
		TOTAL	No.	37	56	52	12	17	29	4	26	30	231	212	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.	6232 ▼	6315 ▼	6271 ▲	→		6304 ▼	→		6388 ■	6388	6375	6241		NO Variation	0 - 1% Variation	>1% Variation	6000	5875	6042
		Medical and Dental	No.	756 ▲	744 ▲	739 ▲	→		770 ▼	→		763 ▲	763	779	761		NO Variation	0 - 1% Variation	>1% Variation	822	736	755
		M'ment, Admin. & HCAs	No.	1972 ▲	2015 ▼	2016 ▼	→		2050 ■	→		2054 ▲	2054	2002	1952		NO Variation	0 - 1% Variation	>1% Variation	1806	1765	1852
		Nursing & Midwifery (excluding Bank)	No.	2346 ▼	2355 ▼	2344 ▲	→		2337 ▲	→		2360 ▼	2360	2580	2547		NO Variation	0 - 1% Variation	>1% Variation	2481	2255	2259
		Scientific and Technical	No.	942 ▼	935 ▲	949 ▼	→		959 ▼	→		958 ▲	958	1013	981		NO Variation	0 - 1% Variation	>1% Variation	891	869	913
		Bank Staff	No.	216	266	223	→		188	→		253	253	No. Only	No. Only					n/a	250	260
		Gross Salary Bill	£000s	20556 ■	20906 ▼	20724 ▲	→		20887 ▲	→		20944 ▼	124186	122693	243342		NO Variation	0 - 1% Variation	>1% Variation	220244	219667	238674
RK	Bank & Agency	Nurse Bank Fill Rate	%	87.7	82.8	86.4	→		87.2	→		86.5	86.3	No. Only	No. Only	k				n/a	87.6	81.8
		Nurse Bank Shifts covered	No.	5225 ▼	5136 ▲	5261 ▼	→		5420 ■	→		4885 ■	31143	30918	61836		0 - 2.5% Variation	2.5 - 5.0%	>5.0% Variation	67330	68707	69675
		Nurse Agency Shifts covered	No.	264 ▲	466 ■	495 ▲	→		262 ■	→		250 ▲	2036	2486	4972		0 - 5% Variation	5 - 10% Variation	>10% Variation	2879	5524	4765
		Nurse Bank AND Agency Shifts covered	No.	5489 ▲	5602 ▼	5756 ▼	→		5682 ▲	→		5135 ▲	33179	33404	66808		0 - 2.5% Variation	2.5 - 5.0%	>5.0% Variation	70209	74231	74440
		Nurse Bank Costs	£000s	536 ▼	529 ▲	530 ▼	→		510 ▲	→		522 ▼	3099	3211	6423		0 - 2.5% Variation	2.5 - 5.0%	>5.0% Variation	6883	6980	6844
		Nurse Agency Costs	£000s	24 ▲	24 ■	103 ■	→		89 ■	→		68 ■	374	496	992		0 - 5% Variation	5 - 10% Variation	>10% Variation	474	1078	832
KD		Medical Agency Costs	£000s	109 ■	277 ■	174 ▲	→		238 ▼	→		156 ▲	1073	596	1192		0 - 5% Variation	5 - 10% Variation	>10% Variation	693	1296	2026
RK		Other Agency Costs	£000s	198 ▲	331 ▼	240 ▲	→		224 ▲	→		218 ▲	1449	705	1410		0 - 5% Variation	5 - 10% Variation	>10% Variation	1661	2223	3759
KD		Medical Locum Costs	£000s	200 ▲	174 ■	293 ■	→		238 ▲	→		265 ▼	1426	1125	2250		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	2566	2445	2747
RK/KD		Agency Spend cf. Total Pay Spend	%	1.61 ■	3.02 ■	2.49 ▲	→		2.64 ▼	→		2.11 ■	2.33	<2.00	<2.00		<2	2 - 2.5	>2.5	1.50	2.15	2.77
CH	Sickness Absence	Long Term	%	2.58 ▼	2.60 ▼	3.16 ■	→		3.19 ▼	→			2.81	<3.00	<3.00	l	<3.0	3.0-3.35	>3.35	2.50	3.52	3.16
		Short Term	%	1.10 ▼	1.26 ■	1.51 ■	→		1.17 ■	→			1.23	<1.25	<1.25		<1.25	1.25-1.40	>1.40	2.17	1.26	1.22
		Total	%	3.68 ▼	3.86 ▼	4.67 ■	→		4.36 ▲	→			4.04	<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	91	79	→		72	→		90	477	No. Only	No. Only					n/a	1143	1124
		New Starters	wte	69	56	54	→		274	→		142	680	No. Only	No. Only					n/a	855	1066
		Leavers	wte	57	35	53	→		245	→		94	520	No. Only	No. Only					n/a	1004	999
		Inductions	No.	88	72	71	→		104	→		87	481	No. Only	No. Only					n/a	442	896
	Learning & Development	PDRs (includes Junior Med staff)	No.	330 ▲	450 ■	636 ▲	→		630 ▼	→		366 ■	2641	2670	5341	m	0-5% variation	5 - 15% variation	>15% variation	n/a	1963	4518
		Mandatory Training	No.	n/a	n/a	n/a	→		n/a	→		n/a	n/a				0-5% variation	5 - 15% variation	>15% variation	4313	2770	4044
		Conflict Resolution Training	No.	298 ▲	270 ▼	253 ▼	→		171 ▼	→		226 ▲	1377	1000	2000		0-5% variation	5 - 15% variation	>15% variation	1441	1712	1050

KEY TO PERFORMANCE ASSESSMENT SYMBOLS

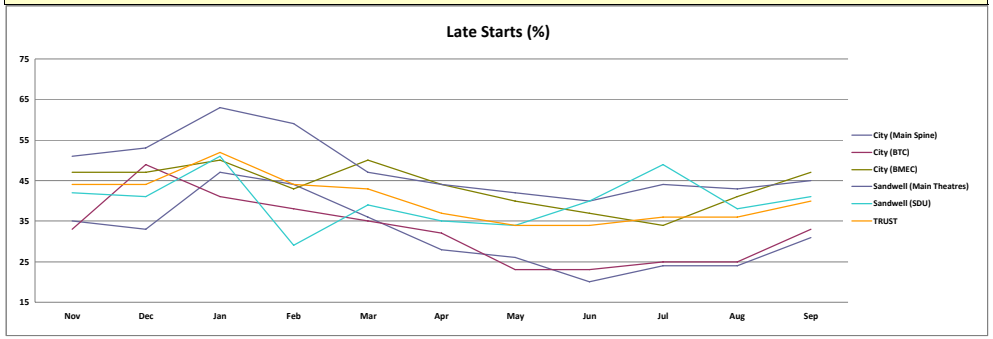
▲	Fully Met - Performance continues to improve
■	Fully Met - Performance Maintained
▼	Met, but performance has deteriorated
▲	Not quite met - performance has improved
■	Not quite met
▼	Not quite met - performance has deteriorated
▲	Not met - performance has improved
■	Not met - performance showing no 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

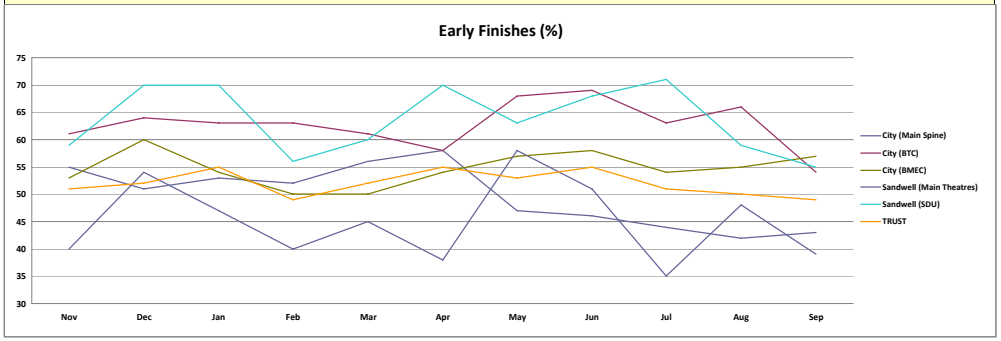
LATE STARTS (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	35	33	47	44	36	28	26	20	24	24	31						
City (BTC)	33	49	41	38	35	32	23	23	25	25	33						
City (BMEC)	47	47	50	43	50	44	40	37	34	41	47						
Sandwell (Main Theatres)	51	53	63	59	47	44	42	40	44	43	45						
Sandwell (SDU)	42	41	51	29	39	35	34	40	49	38	41						
TRUST	44	44	52	44	43	37	34	34	36	36	40						

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



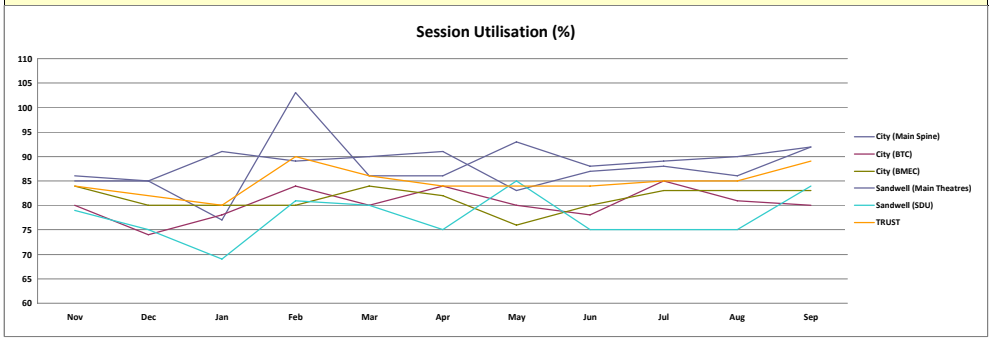
EARLY FINISHES (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	55	51	53	52	56	58	47	46	44	42	43						
City (BTC)	61	64	63	63	61	58	68	69	63	66	54						
City (BMEC)	53	60	54	50	50	54	57	58	54	55	57						
Sandwell (Main Theatres)	40	54	47	40	45	38	58	51	35	48	39						
Sandwell (SDU)	59	70	70	56	60	70	63	68	71	59	55						
TRUST	51	52	55	49	52	55	53	55	51	50	49						

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



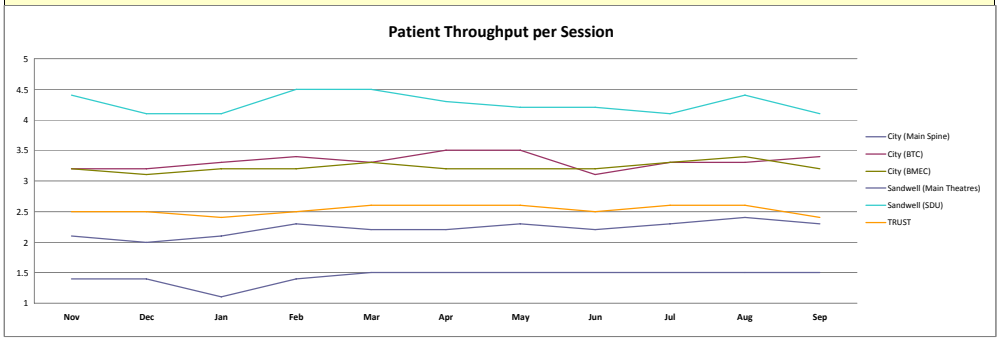
SESSION UTILISATION (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	86	85	77	103	86	86	93	88	89	90	92						
City (BTC)	80	74	78	84	80	84	80	78	85	81	80						
City (BMEC)	84	80	80	80	84	82	76	80	83	83	83						
Sandwell (Main Theatres)	85	85	91	89	90	91	83	87	88	86	92						
Sandwell (SDU)	79	75	69	81	80	75	85	75	75	75	84						
TRUST	84	82	80	90	86	84	84	84	85	85	89						

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						
City (BTC)	3.2	3.2	3.3	3.4	3.3	3.5	3.5	3.1	3.3	3.3	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						
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						
Sandwell (SDU)	4.4	4.1	4.1	4.5	4.5	4.3	4.2	4.2	4.1	4.4	4.1						
TRUST	2.5	2.5	2.4	2.5	2.6	2.6	2.6	2.5	2.6	2.6	2.4						

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:	29 October 2009

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. The area of underachievement identified in the report, which relates to August is:

- Stroke (Stay on Stroke Unit) – performance is reported as 67.3%. Performance thresholds are Achieve equal to or greater than 80%, Underachieve 51% - 79% and Fail equal to or less 50%.

Foundation Trust Compliance Report – the overall performance score for September remains 0.4 and the overall Governance Risk Rating remains GREEN.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Accessible and Responsive Care, High Quality Care and Good Use of Resources
Annual priorities	National targets and Infection Control
NHS LA standards	
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 22 October 2009.

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 Q1	Score	Weight x Score	July	Score	Weight x Score	August	Score	Weight x Score	September	Score	Weight x Score	Q2	Score	Weight x Score
A/E Waits less than 4-hours	1.00	98.00%	97.00%	99.39%	3	3.00	99.10%	3	3.00	99.20%	3	3.00	98.60%	3	3.00	98.90%	3	3.00
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	0	3	3.00
MRSA Bacteraemia	1.00	0	>1.0SD	5	3	3.00	1	3	3.00	0	3	3.00	1	3	3.00	2	3	3.00
Clostridium Difficile	1.00	0%	>1.0SD	32	3	3.00	14	3	3.00	15	3	3.00	10	3	3.00	39	3	3.00
18-weeks RTT (Admitted)	1.00	90.0%	85.0%	98.0	3	3.00	97.7	3	3.00	96.5	3	3.00	97.2	3	3.00	>90.0%	3	3.00
18-weeks RTT (Non-Admitted)	1.00	95.0%	90.0%	98.5	3	3.00	97.9	3	3.00	98.0	3	3.00	98.0	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%	3	1.50	>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%	90.0%	>95.0%	3	1.50	97.3	3	1.50	>95.0%	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%	90.0%	93.1%	3	3.00	93.6%	3	3.00	93.7%	3	3.00	>93.0%*	3	3.00	>93.0%*	3	3.00
Cancer - 31 day second or subsequent treatment (surgery and drug)	0.50	98.0%	94.0%	100%	3	1.50	100%	3	1.50	98.7%	3	1.50	>98.0%*	3	1.50	>98.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers	0.50	96.0%	94.0%	99.8%	3	1.50	100%	3	1.50	99.4%	3	1.50	>96.0%*	3	1.50	>96.0%*	3	1.50
Cancer - 62 day referral to treatment from screening	0.33	90.0%	80.0%	99.8%	3	0.99	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	90.0%	80.0%	66.70%	0	0.00	96.3%	3	0.99	100%	3	0.99	>90.0%*	3	0.99	>90.0%*	3	0.99
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%	90.6%	3	0.99	87.0%	3	0.99	87.9%	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	0.0%	3	3.00
2-week Rapid Access Chest Pain	1.00	98.0%	95.0%	99.50%	3	3.00	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%	99.60%	3	3.00	100.00%	3	3.00	100.00%	3	3.00	100.00%	3	3.00	100.00%	3	3.00
Delayed Transfers of Care	1.00	3.5%	5.0%	2.60%	3	3.00	2.50%	3	3.00	2.10%	3	3.00	2.60%	3	3.00	2.40%	3	3.00
Stroke (Stay on Stroke Unit)	1.00	80%	50.0%	53.50%	2	2.00	55.36%	2	2.00	67.30%	2	2.00	60 - 70%	2	2.00	60 - 70%	2	2.00
Outpatient Waits >13 weeks (% of First OP Attendances)	0.50	0.03%	0.5%	0.002%	3	1.50	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%	0.5%	0.000%	3	1.50	0.000%	3	1.50	0.000%	3	1.50	0.000%	3	1.50	0.000%	3	1.50
													*projected			*projected		
Sum	**16.00**					**45.98**			**46.47**			**46.97**			**46.97**			**46.97**
Average Score						**2.87**			**2.90**			**2.94**			**2.94**			**2.94**

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				SCORING			2009 / 2010							
Criteria	Metric	Weight (%)		3	2	1	July	Score	Weight x Score	August	Score	Weight x Score	September	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	-0.05%	3	0.6	-0.05%	3	0.6	-0.04%	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.	7.83%	3	0.15	7.79%	3	0.15	7.81%	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.	7.77%	3	0.15	7.74%	3	0.15	7.71%	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	0.61%	3	0.15	0.61%	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	7.78%	3	0.15	7.75%	3	0.15	7.72%	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	70.00%	2	0.05	74.00%	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	73.00%	2	0.05	67.00%	2	0.05	70.00%	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	1.23	3	0.15	1.21	3	0.15	1.28	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	17.75	3	0.15	18.88	3	0.15	18.71	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	38.83	2	0.1	41.43	2	0.1	34.85	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:	Annual Audit Letter
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	KPMG LLP
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

The annual audit letter summarises the key issues arising from the work that the Trust's external auditors, KPMG LLP have carried out during 2008-9.

The letter highlights both areas of good performance and provides recommendations designed to help the Trust improve performance in coming years.

The scope of the audit covers use of resources and a review of the financial statements and the Trusts Statement on Internal Control. The audit opinion highlights that the published accounts present a true and fair view of the Trust's financial affairs and that the processes and procedures adopted in producing the accounts were sound.

The letter was presented to the Audit Committee for review on 3 September 09 and after review by the Trust Board will be published on the Trust's website.

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 letter and key messages contained within

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	Financial reporting – The Trust produces annual accounts in accordance with relevant standards and timetables, supported by comprehensive working papers

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

Financial	**X**	
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	**X**	Satisfies the statutory responsibilities and powers of the appointed auditors as set out in the Audit Commission Act 1998
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Audit Committee on 3 September 2009

KPMG

SWBTB (10/09) 190 (a)

HEALTHCARE

Annual Audit Letter

2008/09

Sandwell and West Birmingham Hospitals NHS Trust

3 September 2009

AUDIT

AUDIT ▪ TAX ▪ ADVISORY

Concordat
Improving services
Reducing burden

Content

The contacts at KPMG in connection with this report are:

Mike McDonagh
Engagement Partner
KPMG LLP (UK)

Tel: 0121 335 2440
Fax: 0121 232 3578
michael.a.mcdonagh@kpmg.co.uk

Sarah Ann Moore
Manager
KPMG LLP (UK)

Tel: 0121 232 3694
Fax: 0121 232 3578
sarah-ann.moore@kpmg.co.uk

Ben Stone
In-charge Auditor
KPMG LLP (UK)

Tel: 0121 232 3694
Fax: 0121 232 3578
ben.stone@kpmg.co.uk

Executive Summary

Purpose

This Annual Audit Letter (the letter) summarises the key issues arising from our 2008/09 audit at Sandwell and West Birmingham Hospitals NHS Trust (the Trust). Although this letter is addressed to the directors of the Trust, it is also intended to communicate these issues to key external stakeholders, including members of the public. The letter will also be published on the Audit Commission website at www.audit-commission.gov.uk. It is the responsibility of the Trust to publish the letter on the Trust website at www.swbh.nhs.uk. In the letter we highlight areas of good performance and also provide recommendations to help you improve performance. Our recommendations are summarised in Appendix 1. We have reported all the issues in this letter to you throughout the year and a list of all reports that we have issued is provided in Appendix 2.

Scope of our audit

The statutory responsibilities and powers of appointed auditors are set out in the Audit Commission Act 1998. Our main responsibility is to carry out an audit that meets the requirements of the Audit Commission's *Code of Audit Practice* (the *Code*) which requires us to review and report on your:

- *use of resources* - that is whether you have made proper arrangements for securing economy, efficiency and effectiveness ('value for money') in your use of resources. Our work in this area is summarised in section 2;
- *accounts* – that is the Financial Statements and the Statement on Internal Control. This work is summarised in section 3.

Key Messages

The key areas which we draw to your attention to are:

- The Trust achieved its targeted financial position in 2008/09 delivering an in year surplus of £2.5m.
- The Trust's indicative Auditor's Local Evaluation (ALE) scores have shown stability in the overall scores with improvement in several areas since the previous year. Whilst the assessment still needs to go through final national quality assurance, the Trust's indicative overall score is a level 3 for 2008/09 *(2007/08: level 3*). This means that the Trust is assessed as "consistently above minimum performance, performing well".
- The Trust has been proactive in preparing for the NHS accounts conversion to International Financial Reporting Standards (IFRS) in 2009/10. From our work on the Trust's arrangements for converting its 1 April 2008 balance sheet to IFRS, we assessed that "*adequate arrangements appear to be in place for the balance sheet area to provide not materially misstated amounts for the balance sheet restatement.*"
- We issued unqualified audit opinions on the Trust's financial statements and on its value for money conclusion in 2008/09.

Future Challenges

- The Trust is forecasting a surplus of £2.3m for 2009/10 but to achieve this it will need to deliver a Cost Improvement Plan of £15.1m. The Trust has detailed plans in place to achieve the required savings and has proven its ability to achieve challenging CIPs in the past. However, public expenditure forecasts indicate significant pressure on future NHS funding and the Trust will have to manage the impact of funding pressures with its commissioners and continue to deliver real efficiency and productivity improvements to maintain its financial stability, whilst balancing this with continuing to deliver high quality care to patients.
- The Trust is in the process of applying for Foundation Trust status and is working hard on amendments to its Integrated Business Plan (IBP) and Long Term Financial Model (LTFM), as well as continuing to look at other areas such as Board development, to ensure that the Trust's application is successful. The Trust must look to ensure that it has the capacity to meet the application timetable whilst managing the challenging financial position and continuing to meet its service targets going forward.
- The Trust is progressing with the "Right care, Right Here" (formerly "Towards 2010") programme, the centrepiece of which will be a new hospital replacing the Trust's existing City and Sandwell General Hospitals. The programme may result in additional accounting issues for discussion and resolution in the coming period, particularly in relation to the acquisition of assets and commencement of construction works. The Trust should ensure that the Board continues to be fully informed of any issues as the project progresses.
- NHS financial results for 2009/10 will be reported using IFRS. The Trust is required to re-state its 2008/09 financial statements into IFRS and then produce its 2009/10 accounts in IFRS during the early summer of 2010. The Trust needs to continue to address the challenges of IFRS conversion whilst embedding the principles of IFRS to ensure that it is ready to undertake its financial reporting on an IFRS basis in future.

Executive Summary (continued)

- Through *Saving carbon, improving health* the NHS is aiming to reduce carbon emissions by 10% by 2015. All NHS bodies are going to be monitored and measured on their performance in reducing emissions. The Treasury is developing guidance for 2010/11 which will require all NHS bodies to report publicly on sustainability performance in annual reports. This information will be subject to audit and public scrutiny. NHS organisations need to act now to prepare for sustainability reporting and to realise the huge opportunities that addressing sustainability brings, including cost reduction.

We will liaise with the Trust regarding these and any other issues as they emerge. We will work with you to continue to achieve a smooth accounts and audit process.

Fees

Our audit fee for 2008/09 was £198,000 excluding VAT. This excludes the audit of charitable funds. These fees were in line with those highlighted within our audit plan.

We have undertaken non-audit work during the year in respect of Board Development. This work commenced in 2007/08 following a competitive procurement exercise by the Trust. The agreed fee for this work was £46,000 of which £40,000 was billed in 2008/09.

Use of resources

The main elements of our use of resources work are:

- *Auditor's Local Evaluation (ALE)* - we assess how well you manage and use financial resources by providing scored judgements on arrangements in five areas (Financial Reporting, Financial Management, Financial Standing, Internal Control, and Value For Money). We also follow up prior year recommendations to support this conclusion.
- *Value for money conclusion* – we issue a conclusion on whether we are satisfied that you have put in place proper arrangements for securing economy, efficiency and effectiveness in your use of resources. This is based on the ALE assessment and on the local reviews carried out.

The findings from this work are summarised below.

<table>
<tr><th>Element of work</th><th>Key findings</th></tr>
<tr><td>Auditors Local Evaluation</td><td>Our assessment of Sandwell and West Birmingham Hospitals NHS Trust against the five specified areas resulted in the following scores on a scale of one (inadequate) to four (performing strongly):

<table>
<tr><th>Area</th><th>Score</th></tr>
<tr><td>Financial reporting</td><td>3</td></tr>
<tr><td>Financial management</td><td>3</td></tr>
<tr><td>Financial standing</td><td>4</td></tr>
<tr><td>Internal control</td><td>3</td></tr>
<tr><td>Value for money</td><td>3</td></tr>
</table>

These scores are indicative at present. They were submitted for national quality assurance on 3 July 2009 and the final scores will be released by the Care Quality Commission in September 2009.

The 2008/09 ALE assessment has seen the Trust build upon its 2007/08 ALE scores. For Financial Management, Internal Control, Financial Reporting and Value for Money KLOEs you maintained a level three, however improvement was noted on the prior year in several individual KLOE areas which helped to consolidate your position. In addition, fulfilment of the Trust's three year financial recovery plan resulted in a level four being awarded for Financial Standing, an improvement from level three in 2007/08.

These scores would suggest an overall ALE score of level three meaning that the Trust is assessed as "consistently above minimum performance, performing well".</td></tr>
<tr><td>Value for money conclusion</td><td>We issued an unqualified value for money conclusion for 2008/09. This means that we are satisfied that you put in place proper arrangements for securing economy, efficiency and effectiveness in your use of resources.</td></tr>
</table>

Based upon our work we concluded that the Trust had made proper arrangements to secure economy, efficiency and effectiveness in its use of resources during 2008/09. We issued our VFM conclusion on 11 June 2009.

The details of our findings and recommendations in relation to ALE will be reported to the Audit Committee in our 2008/09 ALE report which will be issued in September 2009.

The Audit Commission is a signatory to the concordat between bodies inspecting, regulating and auditing healthcare. We provide an annual update of progress against all recommendations arising from our use of resources and accounts work to the Audit Committee in Appendix 1.

Audit opinion

We issued an unqualified opinion on your accounts on 11 June 2009. This means that we believe the accounts give a true and fair view of the financial affairs of the Trust and of the income and expenditure recorded during the year. We have also confirmed that you have complied with the Department of Health requirements in the preparation of your Statement on Internal Control.

Before we give our opinion on the accounts, we are required to report to your Board any significant matters identified. We did this in our report to the Board meeting on the 11 June and the key issues are summarised here.

Accounts production and adjustments to the accounts

- We received a complete set of draft accounts ahead of the Department of Health deadline supported by very good quality working papers.
- We identified a small number of audit differences. There were three significant adjustments that were identified and were not adjusted by management. These were in relation to a Clinical Negligence Scheme for Trusts (CNST) provision, "adjustments to balances" acting as NHS provision for irrecoverable debt and a provision for redundancy. Had these items been adjusted, the effect on the Trust's Income and Expenditure account would have been a £2,861,000 increase in the Trust's surplus. We also identified a number of more minor numerical and presentational errors to the draft accounts which were corrected by management.
- We raised 11 recommendations for performance improvement in our Interim Audit and Auditors Local Evaluation Report (May 2009) and Audit Memorandum (June 2009). A summary of these recommendations, along with the Trust's response, is provided at Appendix 1. No "priority one" (high priority) recommendations were identified during the period.

Financial Standing

NHS bodies are given financial targets every year. One of these, the breakeven duty, is statutory, which means you **must** achieve it. The others are administrative, which means you **should** achieve them. Your performance against the targets is outlined below:

Target name	What it means	Your performance
In-year breakeven	Keeping expenditure payable for the year within the amount of income received for the year	✓ You reported a surplus of £2.5m.
Cumulative breakeven	As above, over a three year period.	✓ You reported a break even over a three year period.
External Financing Limit	Keeping the requirement for cash financing within a limit set by the Strategic Health Authority	✓ You remained within the EFL by £1.138m.
Capital Resource Limit	Keeping net capital expenditure within a limit set by the Strategic Health Authority	✓ You remained within the CRL by £1.413m.

International Financial Reporting Standards (IFRS)

You have undertaken work on the balance sheet to understand and quantify the impact of IFRS. The Trust has been proactive in discussing any material issues identified as part of this process with us. Our interim report included a summary of our review on the Trust's processes to restate its IFRS opening balance sheet at 1 April 2008. Our assessment was that, overall, "*adequate arrangements appear to be in place for the balance sheet area to provide not materially misstated amounts for the balance sheet restatement*".

We made three recommendations as a result of this work which are detailed in Appendix 1.

Challenges for 2009/10 and beyond

• In 2009/10 NHS Trusts must plan for a minimum 3.0% cost improvement. The Trust is currently planning a Cost Improvement Plan (CIP) of 4.5% (which equates to savings of £15m) and is forecasting a surplus of £2.3m for the year ending 31 March 2010. Key risks to this forecast include:

- achievement of the CIP;
- management of the introduction of the new payment by results tariff, HRG4;
- additional costs incurred by the Trust associated with the "Right Care, Right Here" programme; and
- any impact on the Trust of developments within primary care through provider separation.

The Trust has detailed plans in place to achieve the required savings and has proven its ability to achieve challenging CIPs in the past. However, public expenditure forecasts indicate significant pressure on future NHS funding and the Trust will have to manage the impact of funding pressures with its commissioners and continue to deliver real efficiency and productivity improvements to maintain its financial stability, whilst balancing this with continuing to deliver high quality care to patients.

• The Trust in the process of applying for Foundation Trust status and is working hard on amendments to its Integrated Business Plan (IBP) and Long Term Financial Model (LTFM), as well as continuing to look at other areas such as Board development, to ensure that the Trust's application is successful. The Trust must look to ensure that it has the capacity to meet the application timetable whilst managing the challenging financial position and continuing to meet its service targets going forward.

• NHS financial results for 2009/10 will be reported using IFRS. The Trust is required to re-state its 2008/09 financial statements into IFRS and then produce its 2009/10 accounts in IFRS during the early summer of 2010. The Trust needs to continue to address the challenges of IFRS conversion whilst embedding the principles of IFRS to ensure that it is ready to undertake its financial reporting on an IFRS basis in future.

• The Trust is progressing with the "Right care, Right Here" (formerly "Towards 2010") programme , the centrepiece of which will be a new hospital replacing the Trust's existing City and Sandwell General Hospitals. The programme may result in additional accounting issues for discussion and resolution in the coming period, particularly in relation to the acquisition of assets and commencement of construction works. The Trust should ensure that the Board continues to be fully informed of any issues as the project progresses.

• Through *Saving carbon, improving health* the NHS is aiming to reduce carbon emissions by 10% by 2015. All NHS bodies are going to be monitored and measured on their performance in reducing emissions. For those Trusts in the Carbon Reduction Commitment scheme there will be implications for cash flow, energy bills, and investment decisions - these could be significant. There are huge opportunities in addressing sustainability with clear cost reduction opportunities from saving energy which will become more and more significant over time.

• The Treasury is developing guidance for 2010-2011 which will require all NHS bodies to report publicly on sustainability performance in annual reports. All reported information will be subject to audit and public scrutiny. Sustainability reporting will be difficult to implement and organisations will need to act now to implement new information gathering processes

We will liaise with the Trust regarding these and any other issues as they emerge. We will work with you to continue to achieve a smooth accounts and audit process.

Appendix 1: Key recommendations

This appendix summarises the recommendations that we have identified during 2008/09, along with your response to them. No "priority one" (high priority) recommendations were made during the year.

Recommendation	Management Response / Timescale for implementation
The following recommendations have been agreed	
Arrangements review on the IFRS opening balance sheet at 1 April 2008	
IFRS: Project Plan The Trust's IFRS project plan and impact assessment should be developed and strengthened by: inclusion of all IFRS, SIC and IFRICs (including those standards with no anticipated impact for the Trust) to demonstrate completeness of the Trust's understanding; the impact assessment and plan should be risk assessed (RAG rated); the plan should cover the second half of the balance sheet restatement and the ongoing convergence processes including systems and process elements e.g. holiday pay accruals, changes to the FAR, review of business case process/ procurement procedures; identification of any training needs (for both finance and non-finance staff) and outlining arrangements for monitoring progress against the plan.	Ongoing. Updates and further details were approved by Audit Committee on 26 March 2009 and process changes are largely embedded within the Finance Department. However, final changes to procedures are being confirmed as a result of lessons learned in the production of restated IFRS accounts for 2008/2009.
IFRS: Accounting Policies The Trust has drafted IFRS accounting policies which identify the need to disclose estimation techniques and accounting judgements relevant to restated balance sheet areas. The Trust needs to complete these details and present the draft IFRS accounting policies to the Audit Committee for consideration and approval.	Implemented. Draft policies were presented to Audit Committee on 26 March 2009 with a finalised version to be presented on 3 September.
IFRS: Working Papers The Trust has working papers in place to justify/ explain the UK GAAP to IFRS balance sheet restatement movements. However working papers need to be developed to clearly evidence consideration of all relevant IFRS, SIC and IFRICs including those standards which the Trust does not has not identified restatement issues in relation to.	Implemented. Consideration of all IFRS related standards was presented to Audit Committee on 26March 2009.
Interim controls and Auditor's Local Evaluation (ALE) work	
ALE: Improving the ALE process The Trust should continue to improve its methodology for the completion of external assessments (such as ALE), and provide a comprehensive and cross-referenced evidence base supporting the self assessment. This should be built into the Trust's current process and involve the tracking of identified ALE risk areas at Director level. This will allow the Trust to identify any weaknesses and develop timely action plans helping the Trust to achieve improved ratings in future years. We recognise that ALE is not applicable to FTs and that the Trust is in the process of its FT application. However, the need to co-ordinate swift corporate responses to information requests remains a feature of the Monitor performance regime and the Trust should continue the improvements it has made to its corporate processes for dealing with external information requests.	Ongoing. The ALE process is subject to year on year improvements in accountability and co-ordination of evidence. This is an ongoing process lead by the Director of Finance and Performance Management. Consideration of ALE requirements occurs throughout the year, e.g. Board papers ask that consideration is given to ALE implications. The bulk of preparations will occur during the autumn culminating in the yearend submission. The Audit Committee have an opportunity to assess progress at their meeting in December 2009.

Appendix 1: Key recommendations (continued)

Recommendation	Management Response / Timescale for implementation
Interim controls and Auditor's Local Evaluation (ALE) work (continued)	
Controls: Physical Verification of Assets There is a risk that without a complete annual asset verification exercise redundant or misappropriated assets and inaccuracies or omissions on the fixed asset management system will not be identified in a timely manner, leading to inaccurate reporting of fixed assets. The Capital Accountant should issue on an annual basis lists of assets held by location and require a return from the relevant budget holders to confirm existence and location of assets. The Capital Accountant should ensure that all returns are completed and the process should be performance managed (e.g. through KPIs) to monitor the percentage of the asset base verified by budget holders. The Trust should also consider using members of the Estates team/ internal audit to physically verify a sample of returns once completed to ensure their accuracy. This will provide assurance over the accuracy of the fixed asset register and can be used as part of the Trust's working papers to support the financial statement audit.	Ongoing. For building and building related assets, the Trust is undertaking a complete MEAV review using external consultants. This will be undertaken in conjunction with Estates staff and will form the basis for the updating of building related information and a platform on which to build future review processes. For equipment, and primarily medical equipment, the Capital Accountant is working closely with Medical Engineering staff both to improve the links between operational and financial records and as part of enabling physical verification of assets. Medical Engineering staff hold primary records for medical equipment (for example maintenance schedules) and are best placed to offer professional advice both in the verification of assets and in the identification of potential impairment or other changes in value. This will continue to be developed as the year progresses with a progress report to Audit Committee this financial year.
Controls: Pharmacy Stock Variances The Trust should ensure that any discrepancies identified between the stock system (JAS) and the physical quantity held are investigated thoroughly at the time of the stock count and before any adjustments to the JAS system are made. The Trust should consider the use of CCTV in pharmacy areas.	Ongoing. Investigation of discrepancies will be undertaken and, where appropriate, reported to Audit Committee. There are established SOPs (Standard Operating Procedure) for dealing with stock variations and these have been sent by the Head of Pharmacy to the DoF. The SOP is current and valid until Feb 2011. If necessary, Internal Audit resources will be used as part of this process when it is considered necessary. The Trust will consider the cost:benefit position of CCTV by December 2009 giving due regard to the risk of loss versus the capital outlay and ongoing revenue costs of monitoring and servicing such a system.
Final accounts work	
Revaluation of assets The Trust must ensure that it is in discussion with the District Valuer to establish the timings for the revaluation of the Trust assets on an MEA value basis. It is recommended that the Trust enter into this dialogue with the District Valuer as soon as possible in order that it can be established what the likely change in asset valuation will be and the potential impairment to be put through the Trust income and expenditure account.	Ongoing. The Trust is not obliged to use the District Valuer. At present a competitive procurement exercise is underway with responses from firms expected 21 August 2009 (approximately 7 or 8 responses expected). When a firm is appointed, the Trust plans to act swiftly in order to establish changes in valuation and any potential impact on the income and expenditure account.

Appendix 1: Key recommendations (continued)

Recommendation	Management Response / Timescale for implementation
Final accounts work (continued)	
NHS debtor recoverability As part of its year end processes the Trust should identify credit notes that are required to be issued to NHS organisations and agree accruals for them as part of the agreement of balances exercise. In addition, the Trust should identify to the Audit Committee those items included within the £755,000 "adjustments to balances" in the 2008/09 accounts and report back to the Committee regarding what values are eventually credited or recovered in 2009/10.	Implemented. A paper has been prepared for the Audit Committee to be discussed at its meeting on 3 September 2009.
Capitalisation of salaries The Trust should allocate the salaries of its Capital Projects team across projects based on the time spent by staff working on each project. This should ideally be evidenced by a staff time record.	Implemented. The Deputy Director of Finance has met with the Head of Capital Planning and a basis for monitoring resource allocation to schemes in is place.
Better Payment Practice Code The Trust should review its performance against the BPPC and establish the reason for the failure to meet the target. This should include a review of the creditors system to consider if the performance is due to a processing or systems issue or if, in fact, the required invoice signatories are not forwarding invoices for processing within the prescribed timescale. We understand that this issue has been raised at the Finance and Performance Committee and the Trust has commenced a response to this.	Ongoing. The finance committee received detailed flowcharts of the processes impacting on payment performance. Some of the solutions to improve performance were discussed and one project (rationalisation of mobile phone accounts) is underway. Further work is needed in the other significant volume area, this being Pharmacy. Patech (the Oracle system maintenance provider) has an established interface written for the pharmacy JACS system. However, it has recently come to light that for this to work the JACS system needs an upgrade. Implementing this solution should have a material effect on payment speed and hence payment performance times. The Director of Finance will liaise with the Chief Operating Officer to determine a timescale for completion.
Reconciliation of fixed asset register The fixed asset register should be fully updated and reconciled to the general ledger by the Capital Accountant on at least a quarterly basis so that any discrepancies are discovered and corrected in a timely manner.	Ongoing. Reconciliation processes are in place. Work is underway to establish a summary presentation of the reconciliation (current output produces all movements in assets) that will compliment the more detailed working papers. This will be presented to auditors during the interim audit in February 2009.

Appendix 2: Reports issued

Report	Date issued
Audit Plan	April 2008
Interim Audit and Auditors Local Evaluation Report	May 2009
Audit Memorandum	June 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Assurance for Preparedness on Pandemic Influenza (H1N1)
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Matthew Dodd, Deputy Chief Operating officer Andrew Dunn, Emergency Planning Officer
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

A statement of SWBHT preparedness for a further wave of H1N1 was submitted to the September 2009 Trust Board meeting.

Some actions were identified as not completed and this report provides an update on these.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. NOTE the Trust's preparedness for H1N1
2. NOTE the updated progress actions identified as the next steps in preparation for H1N1
3. APPROVE the Trust's state of readiness for a further wave of H1N1

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	Business Continuity & Contingency Planning
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial	**X**	Costs of additional equipment and staff Loss of elective income streams
Business and market share	**X**	Escalation plans have the potential to involve cessation of some routine activity
Clinical	**X**	Clinical practice for H1N1 patients Clinical priorities for treatment/cessation of activity
Workforce	**X**	Staff vaccination and sickness & absence
Environmental	**X**	Conversion of adult clinical areas into critical care/paediatric facilities
Legal & Policy	**X**	Ensuring indemnity for staff offering mutual aid
Equality and Diversity	**X**	Arrangements for deciding on clinical priorities
Patient Experience	**X**	Treatment expectations during an influenza pandemic
Communications & Media	**X**	Arrangements for internal and external communications identified
Risks		• Clinical attack and complication rates higher than national planning assumptions • Staff absence higher than national planning assumptions

PREVIOUS CONSIDERATION:

Trust Board on 24 September 2009

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD ASSURANCE ON PREPAREDNESS FOR PANDEMIC INFLUENZA (H1N1)

UPDATE OCTOBER 2009

1.0 INTRODUCTION

A statement of SWBHT preparedness for a further wave of H1N1 was submitted to the September 2009 Trust Board meeting.

Some actions were identified as not completed and this report provides an update on these.

2.0 PROGRESS

2.1 Mutual Aid and Indemnity Agreement

It was agreed at the last Board meeting that the Trust will indemnify staff to work in other health and social care organisations should the need arise. Mutual aid with Sandwell PCT, Sandwell Mental Health & Social Care Trust and social care will be managed via the Sandwell Influenza Steering Group. It has been agreed that each organisation will identify induction requirements for any staff redeployed to support them.

2.2 Discharge Processes

The ability of social care to be able to discharge all patients in a timely manner throughput the winter period still requires confirmation. A meeting is being arranged with the SWBHT Chief Operating Officer, Sandwell Director of Adult Services & Health and SPCT Director of Commissioning to agree plans to deal with a winter peak.

2.3 Enhanced Capacity in Surge Demand

The Trust has established a mechanism to provide guidance on ethical issues during a second wave of H1N1. This process involves senior clinicians and managers as well as the use of further specialist technical advice as appropriate.

2.4 Social Care Capacity

Social services have been working with their staff around business continuity and management of sickness.

2.4 Ambulance Capacity

The Trust plans for ensuring rapid turnaround of ambulances in the A&E Departments have been agreed and shared with local PCTs and other agencies

2.5 Medical Staff Plans

Fit testing for medical staff has continued during this period. A programme of ongoing training has been developed for medical and nursing staff so that fit testing is able to be expanded as the number of in-patients with H1N1 increases.

2.6 Maximise available staff levels

Specialist nurses have now been contacted to identify where they could be redeployed in the event of severe staff shortages. Training packages on use of oxygen and care for respiratory patients have been drawn up to support staff being asked to work in different areas. The Sandwell & West Birmingham NHS Retirement Fellowship has also contacted the Trust offering support from some of its members.

2.7 Seasonal and Swine Flu Vaccinations

Trust staff have been offered the seasonal flu vaccine throughout October. This has been via walk in clinics as well as having nurses from within each division offering it in the workplace. The Trust programme for administering the H1N1 vaccine is due to start at the beginning of November.

3.0 CONCLUSION AND RECOMMENDATIONS

Planning for a further wave of H1N1 has continued throughout October. There remains a need to ensure that staff remain prepared and that plans are reviewed in the light of further information on the spread and severity of H1N1.

The Trust Board is recommended to:

1. NOTE the Trust's preparedness for H1N1

2. APPROVE the Trust's state of readiness for a further wave of H1N1

Matthew Dodd
20th October 2009

Winter and Flu Resilience plans checklist

Organisation name: Sandwell & West Birmingham Hospitals NHS Trust Board meeting date: 29th October 2009

Q	Action	Relevant to organisation (Y/N)	Included in resilience plan (Y/N)	Organisation overall assessment of readiness against criteria GREEN - assured and ready now AMBER - in progress complete as planned RED - in progress not expected to complete as planned	Comments
	Health economy wide issues				
1	**Leadership** - organisations in the Health Economy demonstrate joined up multi-agency approach to planning. Flu Resilience plans for each organisation in the Health Economy have been shared and agreed. Agreements in place on any local cross borough border issues to ensure patient care is seamless.	Y	Y		
2	**Local leaders** - every organisation has senior leadership arrangements in place to manage Flu and Winter resilience which is clearly documented. There is a reliable system in place for keeping the CEO, Board and Flu Lead Director appraised of progress, receiving exception reports and for escalating their involvement as required.	Y	Y		
3	**SITREP reporting** - every organisation has in place robust procedures to comply with all SITREP reporting processes.	Y	Y		
4	**Resilience plans tested** - assurance that both Winter and Flu resilience plans have been tested or exercised particularly known stress points in the plan.	Y	Y		
5	**Infection control** - plans take into account both Swine Flu and also major increase in activity in 'surge' conditions.	Y	Y		
6	**Escalation processes** – there is a clear well communicated multi-agency plan for health economy response to 'surge' demand that is owned and shared with all key health and social care partners in the health economy. The trigger levels to move to each escalation level are well defined and understood by all agencies.	Y	Y		
	Patients				
7	**Antiviral Collection Points - f**acilities in place so that anyone with suspected swine flu gets issued with antivirals within 48 hours including those patients without a GP and vulnerable groups - include PCTs full roll out plan of ACPs.	N	N		Sandwell PCT has assessed this as GREEN
8	**Vaccination programme** for each PCT's patients is in place and is flexible enough to respond to vaccine supply issues and priority group issues.	N	N		Sandwell PCT has assessed this as GREEN
	Winter resilience plans				
9	**Discharge processes** – multi-agency co-ordination to minimise the number of delayed transfers of care.	Y	Y		Further meeting with social services and SPCT being arranged
10	**A&E performance** - specific plans to cope with 2 known dips in A&E performance early December and early January.	Y	Y		
11	**Business continuity** - evidence that organisation has a robust plan to respond to issues such as bad weather (snow).	Y	Y		
	Flu Pandemic second wave resilience				
12	**Enhanced capacity in 'surge' demand**- details of capacity that can be made available in each organisation for each key service including staffing and equipment resources. Details of the trigger levels to release this capacity into the organisation.	Y	Y		
13	**Capacity modelling** - each health economy has taken account of worst case scenario set out by DH in July 2009 and has plans in place to respond to the peak weeks of the pandemic.	Y	Y		
14	**Essential services** - plan identifies clinical and non-clinical essential services that must continue to be provided or that can be scaled back in a pandemic, as well as identifying critical and non-critical functions	Y	Y		
15	**Logistics** - plans identify and regularly review key vital supplies, without which the trust could not function, and include local plans as to how these supplies can be maintained (e.g. utilities, food, linen, medical supplies).	Y	Y		
16	**Communication** - plan for effective communication to staff, patients and the wider community before, during and after the pandemic.	Y	Y		
17	**Recovery from pandemic** -plan includes detail on recovery from a pandemic.	Y	Y		

Winter and Flu Resilience plans checklist

Organisation name: Sandwell & West Birmingham Hospitals NHS Trust

Board meeting date: 29th October 2009

Q	Action	Relevant to organisation (Y/N)	Included in resilience plan (Y/N)	Organisation overall assessment of readiness against criteria GREEN - assured and ready now AMBER - in progress complete as planned RED - in progress not expected to complete as planned	Comments
	Specific organisational capacity issues				
18	**Acute hospital capacity**– senior clinical decision making for initial assessment of emergency admissions / inpatient capacity / A&E - UCC interface / Maternity Services Capacity – clear policies exist which prioritise women who need hospital care and limit unnecessary admission.	Y	Y		
19	**Critical care capacity**– organisation has been through critical care checklist provided by DH (available early August) and have specific plans to increase capacity by 100% to respond to Flu and clear and agreed prioritisation plans.	Y	Y		
20	**Primary care capacity** - including normal GP capacity and out of hours services. Plans in place to ensure that those most likely to access healthcare services have care plans to reduce the likelihood that they will be admitted.	N	N		Sandwell PCT has assessed this as AMBER
21	**Intermediate care capacity** – implementing simplified access criteria, enhancing admission avoidance and palliative care services.	N	N		
22	**Social care capacity** – streamlining placement process, understanding total potential nursing and residential home capacity in each Borough with ability to utilise capacity. Plans in place to ensure social care workforce resilience	Y	Y		
23	**Mental Health capacity**- robust acute psychiatric liaison services to minimise A&E breaches and timely assessment of inpatients.	Y	Y		
24	**Ambulance capacity** - plans from each hospital to deliver the required 'hand over' waiting time targets.	Y	Y		
25	**Diagnostic and therapy capacity** – enhanced levels of services working 7 days per week in both primary and secondary care.	Y	Y		
	Staffing				
26	**Seasonal and Swine Flu vaccination plans** for organisation's staff, that prioritises staff to be vaccinated according to service needs.	Y	Y		
27	**Medical staff plans** - demonstrate that have recruited sufficient staff to cover EWTD rotas in all critical services and that number of medical staff available take account of the busiest times of day. If the decision is taken nationally for a temporary derogation of WTD compliance to be instated, the terms and conditions of job offers to all medical staff are amended to reflect this.				
28	**Maximise available staffing levels** in all roles during an influenza pandemic, including arrangements for temporary postponement of all training, appropriate re-deployment of staff, re-employment of newly retired staff or staff who have left recently, flexible working arrangements (part-time to full-time, working at home, etc) and refresher course for staff who have a clinical background, but who no longer practice.	Y	Y		
29	**Response to likely absence levels** due to sickness, carer responsibilities and the impact of the anticipated closure of schools, that are not reliant on temporary staffing solutions. Cover arrangements are in place for all key members of staff who may be taken ill, such as CEO, the Board, senior clinicians, and Flu Resilience team. Review of all policies that may affect staff attendance to ensure that they clarify how staff should report sickness during the pandemic.	Y	Y		
30	**Engagement with the Trade Unions** to ensure their contribution and support for staff arrangements over the period of the pandemic	Y	Y		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Patient Experience Progress report
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Sheila Peacock, Assistant Director of Nursing - Patient Experience
DATE OF MEETING:	29 October 2009

SUMMARY OF KEY POINTS:

The Patient Experience action plan was developed as a result of Patient surveys, PALS data, complaints trends and meetings with the PPI forums. It focuses on the key areas of public concern listed below and outlines timescales, lead officers and outcome measures for each section:

- Privacy and Dignity
- Nutrition/Meal Service
- Hygiene Needs
- Communication and Information
- Appointments Processes

The action plan is monitored and driven by the Patient Experience Group which meets bi-monthly and is chaired by the Chief Nurse.

The report enclosed demonstrates the progress achieved against the Patient Experience action plan over the last four months.

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 update.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	o No 4 Respond to our patients o No 5 Improve quality and standards of care o No 7 Promote education, training and research o HCC core standards o Essence of Care standards o Privacy and Dignity National Standards
Annual priorities	
NHS LA standards	2.5.2 – Raising concerns
Core Standards	C13a - staff treat patients, their relatives and carers with dignity and respect
Auditors' Local Evaluation	

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

Financial	**X**	None known currently although may be some as the action plan is implemented.
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity	**X**	Close links with the Single Equality Scheme (SES)
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Routine quarterly update

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

PATIENT EXPERIENCE TRUST BOARD OCTOBER 2009

Purpose of this report

This report is designed to:

- Set out the progress that has been made from the Patient Experience Action Plan

The Patient Experience action plan was developed as a result of Patient surveys, PALS data, complaints trends and meetings with the PPI forums. It focuses on the key areas of public concern listed below and outlines timescales, lead officers and outcome measures for each section:-

- Privacy and Dignity
- Nutrition/Meal Service
- Hygiene Needs
- Communication and Information
- Appointments Processes

The action plan is monitored and driven by the Patient Experience Group which meets bi-monthly and is chaired by the Chief Nurse. The following sections outline the achievements to date:-

1. Privacy and Dignity

One of the key outcomes of the Privacy and Dignity domain of the Patient Experience Action Plan is to provide the patient with an environment that is aesthetically pleasing and safe.

1.1 The Chief Operating Officer has established a DSSA project team to oversee and monitor progress towards single sex accommodation. A separate report will be submitted to the Trust Board outlining progress achieved against the DSSA action plan.

1.2 A dignity in care nurse has been appointed who is co-ordinating the work outlined in the NSF for Older People and is promoting the Department of Health dignity challenges. Matrons and Ward Managers have been nominated as Dignity Champions to drive the action plan forward.

1.3 In December the Nursing Division are launching the Privacy, Dignity and Respect campaign which will raise awareness to the importance of P&D. Stands, training, information leaflets on a variety of themes will take place on all 3 sites from 1 – 31st December.

1.4 Key actions have been identified that will be driven by senior nursing staff across the organisation throughout December. These are common themes in complaints and it is thought will have significant impact on the patient experience if they can be embedded in every day practices:

1) Patients will always be covered through appropriate use of night attire, own clothes or bed clothes.
2) Patients will, wherever possible, be taken to the bathroom/toilet rather than washed or offered commodes at the bedside.
3) Gloves will only be worn when handling bodily fluids or when it is indicated in infectious patients.
4) Continence pads should only be used where it is in the norm for patients at home or where patients have requested it.
5) Patients should be transferred between wards/departments with dignity and respect.
6) Patients are always assisted with meals where needed and this is done with care and respect for their dignity.
7) Protected meal times are respected.

8) Difficult conversations with patients will be conducted in private or, where this is not possible, with curtains drawn.
9) Patients are always referred to by their name and never by pet names, bed number or diagnosis.
10) The visitor policy will be adhered to.

1.5 The Patient Experience team will provide information on key issues relating to Privacy, Dignity and Respect for Hot Topics, Heartbeat and the Patient Experience website in November.

1.6 The Nursing Division is working with Facilities to find alternative options to improve nightwear for patients. New products will be piloted as soon as they are available.

1.7 A new Privacy, Dignity and Respect policy is currently under widespread consultation.

2. Nutrition

2.1 The MUST report submitted to the Board in May 2009 has been widely shared and an action plan developed to improve the compliance of assessing patients on admission. The Dietetic team are providing ward based training across the organisation and the audit will be repeated in October to measure improvements in preparation for the ward reviews.

2.2 In July the Catering Monitoring team completed a patient satisfaction survey on menu choice. These results showed that despite 24 menu choices individuals felt there was insufficient choice. Further work needs to be undertaken by the Catering team to determine if this has any bearing on cultural options.

2.3 The 'Red Tray' and 'Blue Beaker' campaign to assist vulnerable patients with feeding and drinking has been audited. The results are currently being collated.

2.4 An observation of meal times audit will be carried out in November.

3. Hygiene

3.1 The 2008 Essence of Care audits in relation to hygiene revealed 43% compliance to the standards. Local action plans were created and specialist nursing teams provided ward based raising awareness training with the positive outcome of compliance increasing to 77% in 2009.

3.2 Access to toiletries has been identified as an issue for some patient's hygiene. The Facilities team have sourced and made available a hygiene pack. A charitable bid is currently being developed to support the funding of this product across the organisation.

3.3 The Continence team continue to undertake quarterly continence pad audits. Analysis has revealed some ward areas continue to use pads excessively and inappropriately. Clinical teams are providing local based training to these areas and a follow up continence management review. This work has identified that one reason for inappropriate use of pads are because some patients do not have underwear and staff are therefore resorting to adult nappy pads as an alternative to underwear. Research into paper pants is being undertaken to resolve this.

3.4 A key action of the dignity campaign is to promote taking patients to the bathrooms for toileting and washing rather than at the bedside. Protective gloves are only to be used when dealing with body fluids or infectious patients. The widespread inappropriate use of gloves is to be discouraged.

3.5 Corporate training programmes for nurses and health care assistants have hygiene elements as an essential part of the modules. The Virtual Case creator e learning tool has had hygiene policies, guidelines and practice integrated into its care delivery programs. All teams are populating hygiene information onto the trust intranet websites for easy access.

4. Communication and Information

Several initiatives are underway to try to improve communication between staff, patients, visitors and clinical teams.

4.1 Wards have updated their ward vision/mission statements and ward profiles. This provides clear information about the team and type of clinical care patients will receive during their stay on the ward. All the ward material will be uploaded onto the Trust internet site to improve access of information for everyone.

4.2 To improve the clinical team ward handover the Patient Experience team have produce the "Captains Log" and "Clinical Communication" book based on the feedback from the LIA handover group. A three month trial is in progress on the optimal wards with the intention to extend the scheme across all wards in the Autumn.

4.3 The Head of Communication is currently reviewing the content and quality of Patient Information leaflets across the organisation. A new patient information policy is under consultation and will be presented to the Governance Board.

4.4 Following discussions at the Patient Satisfaction Working Group the in-patient survey is being translated into the top five languages to assist in obtaining feedback from non-English patients. A pictorial version has been developed and launched to assist vulnerable adults with learning disability or mental impairment.

4.5 Following a way finder audit undertaken by the Independent Living Group touch screen kiosk terminals are to be installed at key entrances throughout the hospital sites. These will include location maps for 72 destinations. Language options will be available for non-English visitors. The Facilities team have updated the Trust location maps and signage.

4.6 The Patient Experience Facilitator will be producing "meet and greet" standards to be piloted on all wards and implemented throughout the Trust. This work is in conjunction with the Customer Care LIA promises which were launched in October.

5. Appointments

5.1 The Trust continues to receive an increasing number of PALS concerns and complaints regarding appointments. This is predominantly due to reconfiguration, short notice cancellation and multiple confusing letters. The Deputy Director of IM&T is working with divisions to resolves the issues that have been raised however this is proving problematic due to the number of staff involved in booking patient appointments. Further work is being undertaken to streamline the appointments system.

6. Conclusion

In order to measure tangible improvements of the Patients' Experience, measure boards are being introduced on each ward that will monitor key performance indicators. This will compliment the information gathered during the ward reviews where all elements of the action plan are monitored by the Chief Nurse.

The Patient Experience team have created a Patient Experience forum of Trust Foundation Members who will assist in auditing and participating in user feedback initiatives.

One of the key challenges for the next quarter is to change the culture of the organisation in relation to maintaining a high standard of Privacy and Dignity across care settings.

The current Patient Experience action plan is currently being revised in light of the DSSA report, the dignity challenges\ actions and results of various nutrition reports. It will be made available to Trust Board as soon as it is complete.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance and Performance Management Committee – v0.2

Venue Executive Meeting Room, City Hospital **Date** 17 September 2009; 1430h – 1630h

Members Present		In Attendance	Apologies
Mr R Trotman	[Chair]	Mr J Adler	Prof D Alderson
Mrs S Davis		Mr R White	
Miss I Bartram		Mr R Kirby	**Secretariat**
Mrs G Hunjan		Mr A Stevenson	Mr S Grainger-Payne
Dr S Sahota		Mr T Wharram	
Miss P Akhtar		Mr M Harding	

Guests

Mr P Thomas-Hands	[Item 4 only]	Mrs S Tyler	[Item 4 only]	Mr M Beveridge	[Item 5 only]
Dr R Rasanayagam	[Item 5 only]	Mrs C Bromley	[Item 5 only]	Mr N Cruickshank	[Item 5 only]
Mrs L Barnett	[Item 6.3 only]				

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson. Mr Adrian Stevenson was welcomed as interim Director of Business Development and Planning.	
2 Minutes of the previous meeting – 20 August 2009	**SWBFC (8/09) 079**
The minutes of the previous meeting were agreed to be an accurate reflection of discussions held on 20 August 09.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBFC (8/09) 079 (a)**
Mr Kirby reported that the review of medical staffing in Surgery A had been completed and therefore action SWBFCACT.068 should be closed. The verbal updates were noted to be picked up under other items on the meeting agenda.	
4 Presentation by Medicine B division	**SWBFC (9/09) 188**
Mr Philip Thomas-Hands and Mrs Sharon Tyler joined the meeting to present an overview of the financial position and activities in connection with Medicine B division.	

Mr Thomas-Hands reported that the division was currently underperforming on excess bed days, although it was noted that length of stay in summer is historically low. Accident and Emergency attendances are lower than expected, although there is currently a discussion underway around how the urgent care centre attendances are counted. The value of the dispute over this matter is c. £110k. The division's CIP is £1.547m and achievement of this is to be very challenging. However, all schemes are on track to be delivered at present. The division has overperformed on both inpatient and outpatient contracts, although this has been offset by the underperformance in Accident and Emergency. In terms of pay expenditure, spend on nursing is on budget, although spend on agency staff is higher than planned. This expenditure covers medical, nursing and administration staff, of which medical staff and administration staff are the main areas of concern. Agency expenditure in Accident and Emergency is high due to the need to cover the weekend rota, although a middle grade medic is being recruited to assist with this situation. It was noted that rotas in Accident and Emergency will always need limited coverage by locum staff. The new clinical director for the area is currently undertaking a review, including the medical staffing arrangements. It has been suggested that immediate investment should be considered in the form of two or three additional middle grades to bolster the rota. There is a difficulty in recruiting into these positions at present however. The current arrangements for administration staffing are being reconsidered and potentially, the positions due to be covered for maternity leave and long term sick leave may not be covered to bring the establishment back in line with plan. The division was reported to have a small non-pay deficit of £11k, relating to cardiology devices, where the income for fitting these will be reported in the Month 6 position. The division's winter plan was discussed and is based on a substantive nursing workforce. Lyndon 4 and Newton 4 have beds now assigned specifically for stroke patients. Mr Thomas-Hands was thanked for his informative presentation and wished well for his future career when he leaves the Trust.	
5 Theatre utilisation update	**Presentation**
Mr Mike Beveridge, Mrs Corrine Bromley, Dr Romesh Rasanayagam and Mr Neil Cruikshank joined the meeting to present an update on progress and plans for improving theatre utilisation. Mr Beveridge reported that the Trust has 28 operating theatres, excluding those in maternity. The Committee noted that late starts are now 4-5-% better than previously reported and last minute cancellations have also improved. In terms of the late starts, ophthalmology was reported to account for a significant amount of the cases, as consultants in this area tend to be shared between a number of Trusts. The reasons for delay are not always correctly coded, however the top reasons reported are due to surgeon unavailability, patient management issues, anaesthetic issues and patient unavailability. In respect of early finishes, ophthalmology again accounts for a significant number of instances. Recent audit work suggests that there is a possible issue with	

cancellation of patients at the end of lists due to lack of time to complete the procedure. Dr Sahota asked why ophthalmology was the poorest performer in terms of late starts and early finishes. Mr Kirby advised that there was a need to review the management of theatre lists, review the consultants' time management and examine the late starts and early finishes for any patterns or relationships. Dr Rasanayagam highlighted that cross-site job plans are problematic. Mrs Davis suggested that sessions should be amalgamated onto the same day where possible and asked what impact an overrunning clinic presents. Mr Beveridge responded that this can present resource issues and advised that patients cancelled at the end of theatre lists are generally rescheduled to the next day. Actions undertaken to manage the issues were reported to include a Listening into Action event, which has resulted in processes to escalate theatre issues more quickly. Monthly monitoring reports have also been introduced. Mr Trotman asked whether the surgeons and anaesthetists had been fully involved with the Listening into Action work. He was advised that the experience had been positive and there had been good engagement. Mrs Bromley highlighted that the WHO surgical checklist is being rolled out. Patient flows in the Birmingham Treatment Centre were also under review. An audit of cancellations and DNAs has been introduced in the Birmingham and Midlands Eye Centre (BMEC). The productive operating theatres initiative is due to be launched within the Trust and on a national level shortly. Preoperative assessment has been implemented and standards setting for each speciality has been introduced. Mr Beveridge advised that the reconfiguration work has created more all day lists which are proving more efficient. Work is underway to harmonise the work of the anaesthetists in the same way. Measures used to determine efficiency include percentage of sessions available that are used; productive time per session; and case per list. Mr Trotman noted the significant work undertaken and underway and asked for a further update in January 2010. He thanked the team for the informative and encouraging presentation.	
ACTION: **Mr Kirby to present updated progress on addressing theatre utilisation issues at the Finance and Committee meeting planned for January 2010**	
6 Trust Board performance management reports	
6.1 2009/10 month 5 financial position and forecast	**SWBFC (9/09) 181** **SWBFC (9/09) 181 (a)** **SWBFC (9/09) 181 (b)**
Mr Wharram reported that an in-month surplus of £177k against a target surplus of £170k was achieved in-month. In-month FTEs were noted to be 61 below plan, with the cash balance being £0.5m above plan at present. The overall performance was slightly better than plan, although the year to date position has not changed significantly. A number of data challenges have been received from the commissioners which are being worked through at present. The biggest area of overperformance against contact relates to outpatients with	

procedures. The proportion of long stay cases in relation to short stay has declined, which has affected the income position. The estimate for the number of WTEs accounted for by agency staff was noted to be included within the report and amounts to 158. This calculation has been necessary for the national accounts. A number of proposed changes to the capital programme were noted and will be presented to the Trust Board for approval. Two of the schemes will be developed further into proposals for consideration by the Trust Board: CT scanner replacement at Sandwell Hospital and refurbishment of MAU at City Hospital. Mr Wharram noted that performance between divisions remains varied, with Medicine A and Surgery A having substantial deficits. Some divisions are however making a surplus. Mrs Hunjan highlighted a number of inaccuracies required in the report, which Mr Wharram agreed to amend before presentation to the Trust Board.	
6.2 Progress with divisional recovery plans	**Verbal**
Mr Kirby reported that there was confidence that all divisions will be in an acceptable financial position by the year end, although there is an element of risk to achieving this in Surgery A and Medicine A. The action plans for these two divisions do however indicate there that their accrued debt can be recovered, dependent on the income position in the second half of the year. Divisions that are currently carrying a surplus are expected to retain this, particularly Surgery B and Pathology.	
6.3 HR dashboard	**SWBFC (9/09) 187** **SWBFC (9/09) 187 (a)**
Mrs Lesley Barnett joined the meeting to present the HR dashboard that had been developed in response to a request to monitor some of the workforce metrics more closely. The dashboard also satisfied a number of assurance criteria required by the Care Quality Commission and the NHS Litigation Authority. It was noted that the pre-employment check information is not readily available at present and some of the diversity data may be missing as some staff are reluctant to provide this information. NHS Jobs has assisted to some degree in populating this information. Mr Trotman noted that as there is no longer a requirement to register disability, there is likely to be a disparity in the information for this measure, with more people being in the organisation who are disabled than registered as such. The mandatory training detail was reported to cover all elements, with the exception of medical devices training. Mrs Barnett proposed that the report be prepared on a quarterly basis. Mr Harding agreed with this proposal, highlighting that this would align to the reporting timetable for divisional reviews. Mr Adler suggested that more narrative should be included in the report to explain what the data shows, particularly in terms of key trends, and what action is being taken to address any issues where identified. Mrs Davis recommended that a graphical analysis of measures such as changing headcount and diversity would be useful. Mrs Hunjan added that a split between	

grades across a number of the indicators should also be considered. Mr Trotman thanked Mrs Barnett for her useful report.	
ACTION: Mrs Barnett to amend future versions of the HR dashboard to reflect the input of the Finance and Performance Management Committee	
6.4 Performance monitoring report	**SWBFC (9/09) 182** **SWBFC (9/09) 182 (a)**
Mr Harding provided an overview of performance against key indicators and targets between April – August 2009. Performance against the stroke care target has not improved as expected, therefore the revised pathways are being investigated. Managers involved in improving the stroke pathway are ensuring that there are protected beds for stroke patients and admissions bypass MAU. All referral to treatment targets were met, apart from that for Trauma and Orthopaedics for admitted care. Performance against the CQUIN targets was reviewed. Validation is being undertaken on the brain imaging information, as the reported performance does not accord with the clinical view. In terms of the hip fracture target, 100% patients were treated within the requisite time. Performance against the cessation referrals target appear to be good, however a verification exercise is underway to determine the proportion applicable to patients prior to elective surgery. It was noted that switchboard response data is now included in the report. Mr Kirby highlighted that the voice recognition system (IVOR) used internally had now been extended to external callers phoning into the Trust. The number of calls that the operators were receiving has reduced due to this introduction.	
6.5 Foundation Trust compliance report	**SWBFC (9/09) 185** **SWBFC (9/09) 185 (a)**
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 remains green.	
6.6 NHS performance framework	**SWBFC (9/09) 186** **SWBFC (9/09) 186 (a)**
Mr Harding presented the Trust's performance against the indicators comprising the NHS performance framework. The Committee was pleased to note that the score for August was 2.94, classifying the Trust as a 'performing' organisation.	
7 Cost improvement programme (2009/10)	
7.1 CIP delivery report	**SWBFC (9/09) 183** **SWBFC (9/09) 183 (a) -** **SWBFC (9/09) 183 (d)**
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. The impact of the CIP on the 2010/11 position was also included in the report.	

At present, the plan contains just above £1m of revised non-recurrent schemes and is expected to carry a £500k shortfall moving forward in 2010/11. In response to a question at the previous meeting, Mr Wharram confirmed that the VAT scheme contained an element of both recurrent and non-recurrent measures. Mrs Davis urged for the expected shortfall to be built into plans for 2010/11 and that any elements of next year's plan should be started immediately if possible.	
7.2 Strategic CIP update	**Verbal**
Mr Adler advised that an internal response to the tightening financial position of the NHS had been developed and was termed the Quality and Efficiency Programme (QuEP). The QuEP focuses on a number of workstrands, including benchmarking a number of key metrics across the Trust. A systematic review of posts will also be undertaken, evaluating each for the added value contribution it makes. The programme will include an element of service redesign which is inextricably linked with the principles of the 'Right Care, Right Here' programme. Engagement of the clinical directorates is to be critical to the plans. A capacity review is to be undertaken, which links into the work of the 'Right Care, Right Here' programme, where it is envisaged that capacity will be reduced to restrain demand from Primary Care. Further work will be undertaken on revising current procurement and shared services processes. It was noted that at a national level, the profile of shared services is currently very high as part of the drive for national efficiency. Certain areas of high expenditure are to be targeted as part of the QuEP, including bank and agency staff costs. Clinical coding and counting efficiency will also be considered as part of plans to maximise income. Market share improvement plans will also be introduced and greater efficiency from out of hours rotas and some parts of the estates will be considered. With regard to the latter, work is underway to determine what benefits would be provided by closing parts of the estate in terms of the savings in capital charges. The value of the QuEP was reported to be c. £20m annually and starts in 2010/11, ahead of the tightening position. In terms of manpower, a target reduction to 6000 staff by the start of 2010/11is to be set. Manpower targets have not been set for future years. In terms of communication and engagement, the Listening into Action approach is to be used and a communications plan has been developed. Miss Bartram suggested that the Joint Consultation and Negotiating Council (JCNC) would be amenable to the plans. She also proposed that a statement around defending market share should be included, along with the plans to improve market share. Dr Sahota recommended that consideration be given to outsourcing some activities, such as appointment booking. Mr Adler agreed to include this within the thinking around the programme. Mrs Davis suggested that the work needed to be aligned to the local health economy plans and therefore the 'Right Care, Right Here' partners should be involved in the programme. A section of the plan should also discuss the linkages to the local health economy. Mr Adler advised that a HR framework has been developed in case there is a need for redeployment.	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

The QuEP is to be monitored through the Financial Management Board, however Mr Adler agreed to provide a regular update to a future meeting of the Committee.	
8 Minutes for noting	
8.1 Minutes of the Strategic Investment Review Group	**SWBSI (9/09) 001**
The Committee noted the minutes of the SIRG meeting held on 11 August 09.	
8.2 Actions and decisions from the Strategic Investment Review Group	**SWBFC (9/09) 184**
The Committee noted the actions and decisions arising from the meeting of SIRG meeting held on 8 September 09.	
8.3 Minutes of the Financial Management Board	**SWBFM (8/09) 080**
The Committee noted the minutes of the FMB meeting held on 18 August 09.	
9 Any other business	**Verbal**
There was none.	
10 Details of next meeting	**Verbal**
The next meeting is to be held on 22 October 2009 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** 17 September 2009; 1030h – 1230h

Members Present		**Apologies**
Miss I Bartram	[Chair]	Professor D Alderson
Mr R Trotman		Mr J Adler
Mr D O'Donoghue		Mrs R Gibson
Mr R White		
Miss R Overfield		
Ms K Dhami		

In Attendance		**Secretariat**
Mr A Stevenson		Mr S Grainger-Payne
Mr S Parker	[Items 1 – 4 only]	
Mr D Masaun	[Items 6 – 9 only]	
Miss D Dunn	[Item 10 only]	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Professor Derek Alderson, Mr John Adler and Mrs Ruth Gibson.	
2 Minutes of the previous meeting	**SWBGR (7/09) 044**
The Governance and Risk Management Committee approved the minutes of the meeting held on 23 July 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 (7/09) 044 (a)**
The updated actions list was noted by the Committee. It was agreed that action SWBGRACT.032 concerning the analysis of unsafe staffing level incidents should be reopened, with a view to the analysis being presented at the next meeting.	
4 Clinical audit forward plan – monitoring report 2009/10	**SWBGR (9/09) 046** **SWBGR (9/09) 046 (a)**

Mr Parker presented an update on progress with the clinical audit forward plan for 2009/10. Evidence of an effective clinical audit forward plan is key to the achievement of Core Standard C5d and to satisfy the national priority indicator to participate in clinical audit. There are no significant delays in the audit plan and no audits have been completed yet, given the early stage in the year. The national audit data collection is on track. In terms of the hip fracture audit, on which an update was requested at a previous meeting, Mr Parker reported that a hip fracture database has now been established and data collection has started. Key items of data are being sourced which will provide a picture of the quality of service throughout the pathway. Mr White asked how simple it was to demonstrate compliance with clinicians participating in audits. He was advised that there has not been an issue with participation to date and the requirement is now built into consultants contracts. Miss Dhami stressed that a degree of practicality needed to be exercised regarding the extent of participation, however this would be monitored through clinical directorates in future. Mr Trotman suggested that inclusion of the end dates for audits in the report might be helpful and for ongoing audits, the frequency of reporting should be presented.	
ACTION: **Mr Parker to include the end dates for audits in the clinical audit progress report and for ongoing audits, present the frequency of reporting**	
5 Mortality update	**SWBGR (9/09) 053** **SWBGR (9/09) 053 (a)**
Mr Parker reported that a Mortality Steering Committee has been established, which has met three times to date. The workplan for the group has been approved. The mortality data collection forms are being piloted at present and are being used in conjunction with Dr Foster alerts. This information is to feed into the Quality Management Framework reports and aim to ensure that every death is being reviewed on a systematic basis. When death certificates are sent to the record of deaths office, they are scanned and sent along with the completed mortality proformas to the clinical director to review for any issues of care. Resources in terms of IT and manpower, will be needed to support this process in due course, therefore a business case will be developed for this requirement. Mr Trotman asked for details of the members of the Mortality Steering Committee and of the Chair. He was advised that there is representation from most divisions and the Medical Director acts as Chair of the group. Mr Trotman asked by when the Board could be assured that every death was being reviewed. He was assured that this process would be in place by January 2010. Miss Dhami added that a regular report will be presented to the Trust Board, which will outline the deaths in the Trust and flag any instances of deviation from the expected rate. Mr Parker reported that a validation exercise will be undertaken to ensure that the information harmonises with that obtained from Dr Foster. It was agreed that a modified version of the mortality report should be presented to	

the Trust Board, highlighting the decline in the Trust's Standardised Mortality Rate (SMR) and the progress with improving the process to ensure all deaths are reviewed routinely.	
6 Annual Health and Safety report	**SWBGR (9/09) 050** **SWBGR (9/09) 050 (a)**
Mr Dally Masaun presented the annual report into Health and Safety. Mr Masaun reported that there had not been any enforcement action by the Health and Safety Executive within the last year. Training in Health and Safety is to be delivered in line with NHS Litigation Authority requirements. The Trust has received 113 alerts from the Central Alerting System (CAS), of which 75 were not applicable to the Trust and implementing the actions to respond to four is still ongoing. Following the recent introduction of the Health and Safety file, all divisions are due to receive a copy shortly. This will be used as the main tool for risk assessments. Incidents reported have increased by 20%, many of which relate to falls as a consequence of reinforcement of the falls policy. Policies and procedures around sickness and stress have been revitalised. In terms of stress management, a separate working party is to be set up, which includes key members of staff and a questionnaire will be issued to establish the impact of stress across the Trust. Work is underway with Communications to include Health and Safety matters within 'Hot Topics' briefings. Mr Trotman noted that an occupational health nurse had been employed to assist specifically with the management of sickness absence. He asked what benefit this post was providing. Mr Masaun advised that there had been a drop in long term and short term sickness absence since the introduction of the sickness absence management team. The Committee was asked to note that near miss health and safety incidents are now included in the annual report. There are a significant number of green incidents and low levels of red incidents, reflecting a good reporting culture and a low level of serious cases. Work has been undertaken on the prevention of needlestick injuries. It was agreed that prevention should be a matter for personal responsibility, however good practice should be reinforced. There has been a decline in instances of needlestick injury by 18%. RIDDOR incidents increased by 75%, although this is anticipated to be due to better reporting, rather than a larger number of incidents. Fire incidents have decreased and there is now improved training in place to ensure that fire hazards are more readily identified. Mr Trotman asked how the procedure in the event of a fire was communicated. He was advised that this was as part of relevant mandatory training modules and as part of regular fire drills. There has been a 72% increase in slips, trips and falls, a number of which resulted in a RIDDOR incident. The estates team is undertaking work around the entrances, exists and pathways to ensure that any hazards are minimised. An increase in violence and aggression incidents by 4% was reported. A number of these relate to patients who were undergoing detoxification.	

Miss Bartram thanked Mr Masaun for the useful report. She suggested however, that future versions should provide more extensive narrative around the graphs presented in the report.	
ACTION: **Dally Masaun to expand the narrative against the graphs in future versions of the Health and Safety report**	
7 Annual risk report	**SWBGR (9/09) 051** **SWBGR (9/09) 051 (a)**
Mr Masaun presented the annual risk report, highlighting that the patient safety development plan is on track. Key risk-related policies have been reviewed. There has been a 19% overall increase in incidents, however there has been a decline in the number of red incidents due to the change in the threshold of post partum haemorrhages needing to be reported as such. Aspects of care incidents have increased, anticipated to be related to the improved reporting of pressure sores incidents. Medical equipment incidents have declined due to improved performance of BBraun. Mr Trotman observed that the high levels of incidents relating to Medicine A, Medicine B and Women and Child Health divisions is due to the high throughput of patients in these areas. He asked however for a year on year comparison to be included in future reports. The use of the Safeguard database to log incidents has improved and regular risk reports are issued to the National Patient Safety Agency (NPSA).	
ACTION: **Dally Masaun to ensure that a year on year comparison of incidents relating to Medicine A, Medicine B and Women and Child Health divisions is included in future reports**	
8 National Patient Safety Agency (NPSA)	**SWBGR (9/09) 049** **SWBGR (9/09) 049 (a)**
Miss Dhami presented the position statement showing progress with addressing NPSA alerts. Work is on track for most actions, however the outstanding work required was also noted, including training and policy development. It was agreed that NPSA alerts should remain as a standard agenda item.	
9 Integrated risk, complaints and claims report – Quarter 1	**SWBGR (9/09) 048** **SWBGR (9/09) 048 (a)**
Miss Debbie Dunn reported that there has been a change in the complaints procedure to provide greater flexibility on timescales for responding to complex complaints, whereby the timeframe for the response is negotiated with the complainant. This change makes a year on year comparison difficult. There has been an increase in the overall number of complaints, although this may be due in part to the recent publicity around the new complaints process. It was noted that there has been an increase in the number of similar complaints which relate to a single issue. In terms of grading, the number of red and amber complaints are consistent with the level expected in Trusts of a similar size. Complaints around clinical treatment remain the highest category. Issues with cancellations and rescheduling appointments have also generated a high number of complaints. Miss Overfield and Mr O'Donoghue confirmed that the use of 'Choose and Book' is proving to be problematic at present and the issue has been	

raised during the recent round of GP visits. The number of new claims has been consistent with previous quarters. There are currently 243 clinical negligence claims and 89 personal injury claims ongoing. A large amount of claims have reached the disclosure of records stage, many of which are not expected to proceed any further. Falls, slips and trips and needlestick injuries are reported as the highest category of incidents for staff. The number of clinical incidents reported, rose during the quarter, while the number of red incidents declined to 1% of the total incidents. Incidents relating to medication errors rose slightly, although there was a fall in the number of incidents relating to medical equipment. Miss Dhami was asked to check the reasons for the increase in the incidents relating to admission, discharge and transfers and determine whether there is any connection with reconfiguration activities. Mr Trotman noted that there had been a drop in 'thank you' letters. Miss Dunn advised that there was not likely to have been a drop in these letters, although reporting that these letters have been received is likely to have deteriorated.	
ACTION: **Kam Dhami to check the reasons for the increase in the incidents relating to admission, discharge and transfers and determine whether there is any connection with reconfiguration activities**	
10 Annual complaints report	**SWBGR (9/09) 047** **SWBGR (9/09) 047 (a)**
Miss Dunn reported that the Trust had been an early adopter of the new complaints process and had trialled fast track complaints responses. The numbers of contacts was reported, in addition to all those resulting in a formal complaint. Complaints between NHS bodies were also recorded. There are a number of complaints that have not been accepted due to the time elapsed since the issue. Of the contacts made, 791 formal complaints were raised, a notable increase on the same number during 2007/08. Of all complaints, 1% are graded as red. There have been more complaints relating to property loss and personal records. The top areas generating complaints are high throughput areas including Accident and Emergency, Ophthalmology and Trauma and Orthopaedics. The Committee reviewed a list of changes made as a consequence of complaints. A comparison with other local Trusts was reviewed, showing that the Trust performs favourably in terms of response times.	
11 Update on preparation for NHS Litigation Authority assessment	**Verbal**
Miss Dhami reported that an interim visit by the NHS LA had occurred on 2-3 September 2009. Assessment against the Level 1 maternity standards is planned for March 2010 and preparatory work is underway in areas such as training needs, however the overall position is optimistic. Assessment against Level 2 is provisionally December 2010, however there will need to be evidence covering the full 12 months period	

available, therefore consideration will be needed as to the feasibility of the assessment against the proposed timetable. In terms of the general standards, assessment against Level 2 is planned for December 2009. There are still some concerns around some areas including mandatory training, patient information, consent and patient transfer. Mock assessments involving the operational leads are planned shortly to determine the readiness for the assessment.	
12 Minutes from the Governance Board	**SWBGB (7/09) 117** **SWBGB (7/09) 117**
The Governance and Risk Management Committee received and noted the minutes from the Governance Board meetings held on 3 July 2009. The Committee also reviewed the actions log presented at the meeting held on 4 September 2009.	
13 Minutes from the Clinical Quality Review Group	**SWBGR (9/09) 052**
The Governance and Risk Management Committee received and noted the minutes from the Clinical Quality Review Group meeting held in July 2009.	
14 Any other business	**Verbal**
There was none.	
15 Details of the next meeting	**Verbal**
The date of the next meeting is 17 November 2009 at 1030h in the Executive Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit Committee – Version 0.2

Venue Executive Meeting Room, City Hospital **Date** 3 September 2009; 1030h – 1230h

Members		**In Attendance**	**Secretariat**	
Dr S Sahota	[Chair]	Mr R White	Miss R Fuller	[Minutes]
Ms I Bartram		Mr P Smith		
Ms P Akhtar	[Part]	Mr P Westwood		
		Mr P Capener		
		Ms R Chaudary		
		Ms S-A Moore		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mr John Adler, Prof. Derek Alderson, Mr. Paul Dudfield, Mr. Mike McDonagh, Mr. Paul Westwood and Mr. Tony Wharram.	
2 Minutes of the previous meetings	**SWBAC (5/09) 046** **SWBAC (6/09) 047**
The minutes of meetings 7th May 2009 and 11th June 2009 were accepted as a true and accurate reflection of discussions.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meetings	**SWBAC (6/09) 046(a)**
In connection with action SWBAC (6/09) 046 (a), Mr. White informed the Committee that he would speak to Tony Wharram and would email a response as soon as possible.	
3.1 Audit Commission triennial review findings	**SWBAC (9/09) 055** **SWBAC (9/09) 055(a)**
Mr. Capener, attending in place of Mr Paul Dudfield, introduced himself to the Committee and informed them his role as Chief Internal Auditor would be to strengthen the team. Mr. Capener referred to a report produced by the Audit Commission which has been used to review Internal Audit's work against the audit standards.	

Results are positive since the Committee last met. The conclusions and the ten mandatory audit standards were reviewed. The Trust fully meets these with minor exceptions. Mr. White noted that on page 3, the list of clients, Sandwell & West Birmingham NHS Trust was not included. Mr. Capener explained that the list in question pertained to District Audit clients (i.e. those under the auspices of the Audit Commission where KPMG is not). Mr. Capener and team were thanked for their report.	
3.2 Process for reviewing limited assurance reports	**Verbal**
On behalf of the Audit Committee Chair, who was not present, Dr Sahota asked Mr. White to speak to this item on her behalf. The Chair has asked that prior to all Limited Assurance Reports being sent to the Audit Committee, that these are separately sent to her immediately upon final sign-off so that she may determine whether she wishes to call the responsible Director to a future Audit Committee to speak to any issues of concern. This could involve the Director inviting the relevant auditor.	
ACTION: Mr. Capener to provide copies of Limited Assurance audit reports to Mrs. Hunjan prior to submission to the Audit Committee	
3.3 Position paper – external audit accounts recommendations	**SWBAC (9/09) 051** **SWBAC (9/09) 051(a)** **SWBAC (9/09) 051(b)**
Mr. White presented an update against previous audit recommendations, although it was noted that this information was also included in a separate report on the agenda by KPMG. The Committee was informed of the action taken or planned to address the recommendations. One area in particular concerned the year end process for agreeing debtor/creditor balances. Mr White showed that many of the provisions/accruals had indeed been utilised as anticipated, post balance sheet. However, it was accepted that practice could be improved by ensuring disputed balances are resolved prior to year end, so that debtor/creditor balances are more in line. Dr. Sahota enquired about a provision made for Coventry PCT, Mr. White explained that this goes back a number of years as the Trust hosted all pathology trainees in the West Midlands. It now only hosts radiology and Ophthalmology trainees and recharges neighbouring Trusts. The PCT adopted the same support obligations from the previous Health Authority but is disputing this. The cost of arbitration in this case is likely not to be justifiable. A settlement will be sought but the debt may need to be written off. In terms of the Sandwell PCT debtor position, Mr. White reported that he had met with Director of Finance for Sandwell and found a way forward for this area. It concerned the recognition, or otherwise, of costs for multiple eye treatments.	

4 External Audit matters	
4.1 External audit progress report including update on ALE assessment	**SWBAC (9/09) 059**
Mrs Moore reported on progress with external audit activity to date in 2009/10. An unqualified position was issued on the 2008/09 accounts. The ALE is now complete but final scores are not to be available until 16 September. The work on IFRS will commence in the next quarter. A debrief on the 2008/09 audit with KPMG is due to take place imminently. Audited charitable funds accounts will need to be submitted to the Charity Commission at the end of January 2010, therefore work will commence next week. In terms of the ALE exercise, the Audit Commission contacted KPMG asking if they had examples of good practice and KPMG had intended with the Trust's agreement, to submit the engagement work undertaken (reference: the annual report).	
4.2 Agreement of Annual Audit Letter	**SWBAC (9/09) 060**
Mrs. Moore informed the Committee the annual audit letter and ISA 260 has already been shared. The letter has also been shared more widely across the Trust and a request has been made for it to be put on the Trust's intranet. Page 4 showed the breakdown of the Trust's draft overall ALE score of 3. The future challenges faced include the foundation trust application and Right Care Right Here programme. The IFRS statement is in the final stage of re-stating. Key recommendations in appendix 1 were reviewed. All recommendations made in the year were outlined, along with the management responses obtained. All recommendations have been discussed at previous meetings, so further discussion was not necessary. Mr. White clarified, in relation to the entry on page 9, that the suggested CCTV in pharmacy would be for the pay machine for prescriptions on the main corridor, as the current camera has been moved to look at the ATM. The department itself is very secure with card access and a key pad entry system. On page 10, the Patech interface for paying for the high volume of pharmacy bills needs to be upgraded and a new time line sought. It is envisaged that this will bring improvements to the payment of bills within the 30 day payment schedules. Miss Bartram commented that Pharmacy was a department regularly discussed by the Audit Committee and asked whether there were any operational/efficiency issues that the Committee should be considering. Mr. White explained that for a period of time, chemotherapy drugs and consequent write-offs were high due to asceptic-suite flooding, however the work done by the Head of Pharmacy for stock rotation is very good and	

write offs have been reduced by 50%. Currently the Head of Pharmacy is suggesting obtaining robots in pharmacy to undertake some of the repetitive jobs. The department in Mr. White's opinion, was moving in the right direction.	
5. Restated IFRS accounts	**Sent separately**
The restated 2008/09 accounts were circulated separately from the main agenda. Mr. White informed the Committee that from 1st April 2009 the accounting policy had moved to IFRS. Page 2 summarised what effect this would have; the BTC would need to be included in the accounts and treated as if the Trust owned the asset. Impairments and valuations will also change. The capitalisation of finance leases is also a matter being dealt with. Mr. White has asked Tony Wharram to speak to KPMG to discuss the technical implications of unwinding discounts as there may be a very high charge associated in unwinding discounts, which would have a budgetary effect, therefore requiring a reserve to be made in future. Dr. Sahota asked what effect the new hospital and land costs would have on the accounts. Mr. White confirmed that normal accounting approaches would be adopted insofar as the land would appear as an asset of the Trust (due to its purchase) and the hospital is likely to be deemed 'on balance sheet' due to the substance of any PFI agreement. Mr. White informed the Committee that the draft IFRS restated accounts did not require formal approval, but rather needed to be signed off by Mr. White and the Chief Executive before onward submissions to auditors.	
ACTION: Mr. White to submit rebased accounts to auditors	
6. IFRS accounting policies	**SWBAC (9/09) 049** **SWBAC (9/09) 049(a)** **SWBAC (9/09) 049(b)**
Mr. White informed the Committee that the model policies had been published by the Department of Health and the Trust will adopt them. The model is similar to what the Trust currently uses with the exception to Section 7.1 capitalisation and Section 7.2 Valuation.	
7 Internal Audit matters	
7.1 Internal Audit progress report and recommendations tracking	**SWBAC (9/09) 057** **SWBAC (9/09) 057(a)**
Mr. Capener informed the Committee that a new style progress report had been developed. The first quarter shows progress to date against audit days, reviews completed and those audits in progress. Feedback is also	

given on follow up. Mr. Capener also reported that the 2008/09 internal audit plan was given a significant level of assurance and the FT application was given full assurance with a caveat being the completion of the long term financial model. Section 4, reviewing progress on EWTD, was noted to require an exit meeting to be arranged. The agreed actions in connection with recommendation tracking were noted. The table showed the level of reviews and that 12 actions were outstanding as at 30th June 2009. Appendix 2.1 was noted to be a detailed analysis of progress with addressing actions, yet presented no conclusions; it shows age level of risk for high and medium actions and identified owners of those. Mr. Capener asked the Committee for views on resolving those outstanding actions presented in Appendix 2.2, as a number of managers are cited regularly for their slow response. Mr. White advised that the Executive Director would be the best way of escalating this issue. Mr. White also asked for an update on the 10 outstanding actions as the implementation dates were some time ago. Mr. Capener agreed to provide this information. Mr. Capener informed the Committee that each recommendation requires sign off by the responsible director. Dr. Sahota asked what security measures were in place for external agency members of staff working for the Trust and using personal computers. Mr. White confirmed to the Committee that security was featured as part of the terms of employment. Internally it was noted that Claire Mazurkiewicz was the Trust's Information Governance lead and in the last few months these issues have been addressed by ensuring all Trust laptops are encrypted, encrypted memory sticks issued to staff and data is read via smart cards.	
ACTION: Mr. Capener to provide Mr. White with a list of outstanding actions and the responsible manager	
7.2 NHS Internal Audit Standards	**SWBAC (9/09) 056** **SWBAC (9/09) 056(a)**
Mr. Capener presented this report for information to the Committee in response to the triennial review, however these standards may be superseded in the next 3 – 6 months.	
7.3 Counter fraud progress report	**SWBAC (9/09) 058** **SWBAC (9/09) 058 (a)**
Mr. Westwood highlighted the key issues in relation to counter fraud activity. Page 2 presented the work plan and the approach given to presentations to directorate managers. A schedule timetabling of events over the next	

few months was presented. It was noted however, the article for Heartbeat would not be published until November. Dr. Sahota asked if the Trust checks passports. Mr. Westwood stated the responsibility for checking an employee's right to work lay with HR and the employing manager. Mr. Westwood presented the detail of current investigations with an update for each. Currently in 2009, 6 referrals have been made and 5 have been carried over from the previous year. There has been nothing significant to report but each referral is actively pursued. Mr. White suggested it would be helpful to know if the publicity for counter fraud increased or decreased the number of referrals. Mr. Westwood stated that due to the mechanisms in place to report fraud, either internally or by the national fraud hotline, this would be difficult to measure. Dr. Sahota noted on the workplan, that 43 days were built in for awareness but only 5 actual days have been used. Mr. Westwood stated this would change during the year.	
8 Governance Matters	
8.1 Review of losses and special payments	**SWBAC (9/09) 053** **SWBAC (9/09) 053(a)** **SWBAC (9/09) 053(b)**
Mr. Smith presented the standard report which covered the period 1st April to 31st July 2009. 149 cases have been reported to a value of £104k. Of note was the pharmacy drug write off figure in July at £8.9k, which is a decrease in losses noted between April to June. Dr. Sahota asked whether a CCTV machine set up in pharmacy would reduce losses further. Mr. White explained that these costs related to expired stock and breakages, however further detail could be provided if required. Mr. Smith agreed to provide this for a future meeting.	
ACTION: Mr. Smith to present a breakdown of pharmacy losses at the next meeting	
8.2 Review of Debtors report	**SWBAC (9/09) 050** **SWBAC (9/09) 050(a)** **SWBAC (9/09) 050(b)**
Mr. White reported no significant movement since previous report. Sandwell PCT is currently the Trust's largest debtor. A letter has been sent to all hospitals notifying of the intent to terminate the administration of rotational trainees. Mr White has met with the Deanery requesting additional funding to continue but as yet, no response has been received. If the Trust does terminate trainees, radiology would be simple but ophthalmology would be	

more difficult. Mr. White continued to inform the Committee that last year the litigation premiums were based on head count and the Trust is having to pay any difference in cost.	
8.3 Assurance framework	**SWBAC (9/09) 054** **SWBAC (9/09) 054(a)**
Mr. White provided this report for information, advising that the report had been seen by the Trust Board at its earlier meeting. One key item concerning the risk around failure to achieve the OBC was highlighted, as this was graded red at the time that the report was written. Since then however, the OBC had been approved and this will be reflected in the next version of the report.	
8.4 Interim Standing Orders and Standing Financial Instructions	**SWBAC (9/09) 052** **SWBAC (9/09) 052(a)** **SWBAC (9/09) 052(b)** **SWBAC (9/09) 052(c)**
Mr. White explained that he had prepared this report as it was good practice to review the Trust's Standing Orders and Standing Financial Instructions and it was also part of the ALE process. The language of the document has been changed to reflect current names/titles of officers in the document and terms such as non officer member, will be replaced. Amendments have been made to tendering values and the number of quotations needing to be sought. This has been revised as it was noted that it proved difficult to obtain six tenders in some work areas so this has been reduced to four and in other areas the numbers have been reduced to three. This will not however, affect the number companies who are invited to tender. Dr Sahota asked if there was any mechanism in place to ensure that the same organisation was not always winning contracts. Mr. White stated that the Supplies department track the gross expenditure and there are European tendering thresholds of contractors and rules for extending current contracts. A good example of this would be recent appointment of Trust legal advisors. The Chair's singular authorisation of tenders has been removed and anything above £500,000 would be sent to the Trust Board. In terms of the revised single tender and quotation forms, a tick box for the provision for reasons as to why a tender is sought is to be added. This will ensure that reasons given are in line with the SFIs. Mr. White requested that the revised SFI/SOs be placed on the Trust's intranet. Mr. Westwood suggested adding a clause regarding fraud and Miss Bartram	

suggested that a declaration of interest was needed in connection to the tendering process. It was felt this was covered via the main SFIs. The Committee approved the new documentation subject to amendments above.	
ACTION: Mr White to ensure that a disclaimer is to be placed on single tender forms reminding staff of prosecution if a fraudulent breach of the SFI is made. **AGREEMENT: The Committee agreed for the SFI/SOs be placed on the Trust's intranet, subject to Trust Board approval**	
9 Minutes from Trust Board committees	
9.1 Finance and Performance Management Committee	**SWBFC (4/09) 040** **SWBFC (5/09) 049** **SWBFC (6/09) 061** **SWBFC (7/09) 071**
The Committee noted the minutes from the Finance and Performance Management Committee meetings held on 23rd April 2009, 21st May 2009, 18th June 2009 and 23rd July 2009.	
9.2 Charitable Funds Committee	**SWBCF (5/09) 010**
The Committee noted the minutes from the Charitable Funds Committee meeting held on 7 May 2009.	
9.3 Governance and Risk Management Committee	**SWBGR (5/09) 032** **SWBGR (7/09) 044**
The Committee noted the minutes from the Governance and Risk Management Committee meetings held on 21 May and 23 July 2009.	
10 Any other business	**Verbal**
Mr. Capener informed the Audit Committee that a demonstration of the internal tracking system is planned, although it was agreed that this should be rescheduled to coincide with the availability of the Non Executive directors.	
ACTION: Mr. Capener to rearrange demonstration of the internal audit tracking system.	
11 Details of next meeting	**Verbal**
The next meeting is planned for 3 December 2009 in the Executive Meeting Room, City Hospital at 1030h.	

Signed: ……	
Name: ……	
Date: ……	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Charitable Funds Committee – Version 0.1

Venue CEO Office, City Hospital **Date** 3 September 2009 at 1430h

Present

Dr S Sahota	[Chair]	Mr R Beacon, COO of South Staffordshire & Shropshire Trust
Mrs S Davis		Mrs J Kinghorn
Miss I Bartram		Mrs L Pascall
Mr J Adler		
Mr R White		
Mr D O'Donoghue		
Miss R Overfield		
Mr P Smith		
Miss R Fuller	[Secretariat]	

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Mrs Gianjeet Hunjan, Professor Derek Alderson, Miss Parveen Akhtar and Mr Richard Kirby.	
2 Minutes of the last meeting	**SWBCF (5/09) 010**
The minutes of the last meeting were accepted as a true and accurate reflection of discussions held on 7th May 2009.	
AGREEMENT: The minutes of the meeting held on 7 May 09 were approved.	
3 Matters arising from the previous meeting	
Mr. White presented a report on rationalisation of the charitable funds. He informed the Committee that in the past small funds with little or no activity over a given period were identified for transferring to a new merged fund. This exercise commenced in 2006 and took approximately 12 months to complete. It was proposed that this would be done again, with the exception of some very small fund balances in ward funds and other funds with no known fund manager due to the current manager leaving the Trust. It is now proposed that Mr. Smith revisit these dormant funds, with a rationalisation programme of: 1 dormant funds with no transactions since April 2008 be transferred 2 review current spending plans. These are requested once a year.	

Smaller fund balances or a threshold of approximately £100 would be transferred to the merged fund. 3 merge funds with the same fund manager 4 merge funds with similar names and objectives The purpose of this was to encourage spending and is in line with best practice. The Charity Commission states that funds should not be held, unless for a specific purpose and trustees could be held in breach of the Commissioning rules. Merging similar funds as proposed could alleviate this risk. Mr. White explained the merged fund would be larger and existing fundholders could bid for money. Miss Overfield was concerned that some funds with £100 or less that are still actively used, should not be transferred to the merged fund. Mr. Smith assured the Committee that only funds that have had not seen activity within a period of 12 months would be transferred. A debate ensured on the monetary threshold. Dr. Sahota observed that on the quarterly finance report, many funds were under £100, so after the initial year the threshold should be increased to £500. Mr. O'Donoghue stated it would be useful to categorise the restriction of the funds. Mr. White confirmed that previously when a fund was created objectives were sent to the Charity Commission for registration, however funds are now created under an umbrella approach so the Trust did not have to report what each fund would be used for. More details pertaining to use of funds is on the Charity Commissions website. However there are some specific restrictions in matters such as legacies.	
AGREEMENT: The proposal to rationalise charitable funds was agreed, with a first year threshold of £100, increasing in the second year to £500	
4 Investment update – Barclays Wealth	
4.1 Notes from the meeting with Barclays Wealth held on 27 August 2009	**Hard copy paper**
4.2 Investment review and valuation from Barclays Wealth for the three month period 1 April 09 to 30 June 09	**SWBCF (9/09) 012**
Notes from the meeting with Barclays Wealth held on 27th August 2009, and Investment Review and valuation from Barclays Wealth for the three month period 1st April 2009 to 30th June 2009 were reviewed. Mr. White outlined the key points of the meeting between himself, the Barclays Wealth representative and Dr. Sahota. Barclays Wealth had highlighted that the current portfolio was risky and there were discussions as how to reduce the equity and get safer position by 2010. It was decided to use the £1/4m held by Barclays and transfer to income bonds. Also interest	

raised would be reinvested in overseas markets. Mr. White informed the Committee the value of the portfolio had increased from £3,785m at 30th June 2009 to £4,162k at 25th August 2009. Therefore the Trust Fund was almost in a position to refund all accounts in the unlikely situation that liquidation was required. Mr. White informed the Committee that compared to other charities, gains were very low as the objective was a £175k yearly return, by using measures such as interest baring bonds, the capital growth of the Fund is lower.	
5 Quarterly finance report	**SWBCF (9/09) 013** **SWBCF (9/09) 013 (a)** **SWBCF (9/09) 013 (b)** **SWBCF (9/09) 013 (c)**
Mr Smith presented the quarterly Charitable Funds finance report, advising that the reporting period had been extended to 31st July 2009 because of the timing of the meeting. However the investment report is still for the period to 30th June 2009. The amount of cash held by NatWest was noted to be £652k. Mr. White asked the Committee for approval to reinvest half of this sum into Barclays corporate and government bonds with a return of between 2% - 3%. At 30th June 2009 investment balance was £5.3m. Dr. Sahota noted that some funds have no fund manager and enquired who would be responsible. Mr. Smith informed the Committee he would write to the divisional general manager in those instances. Mr. O'Donoghue asked if investments from pharmaceutical and appliance companies were scrutinised as these companies may require a reciprocal arrangement, such as purchasing or renting their own equipment or services. Mr. White agreed that he would look into this issue but confirmed that the charitable funds were governed by the same set of standing orders and standing financial instructions as the rest of the Trust and the Audit Committee tracked tenders raised by departments. Mr. Smith also informed the Committee that any money generated from research was banked separately in the Trust's exchequer accounts and did not form any part of the charitable fund accounts. Mr. Adler asked how fund managers were appointed. Mr. Smith that explained a manager would request for an account to be created and to include two named fund signatories. This was then signed off by the finance department. Mr. Adler stated the older funds would need to be looked at noting in particular the Imaging monies, where the fund managers are not longer in an appropriate position to act as such. Miss Overfield suggested that fund managers should be a line manager.	

Miss Overfield confirmed she would look at the wards and check that all funds are administered by the ward manager and have a second signatory by a matron. Mrs. Davis noted trustees only received quarterly report and the full picture of smaller funds was not shown. Mr. White reported for any individual fund a full record of accounts could be produced. Dr. Sahota asked if a yearly report could be produced for funds around £100k. Mr. White would discuss this with Mr. Smith and inform the Committee at its next meeting. Mr. Adler stated the Committee would only need to know what the money was used for.	
ACTION: Miss Overfield to check signatories for all ward trust funds and inform Mr. Smith of any changes **ACTION: Messrs White & Smith to discuss reporting process for income and expenditure fund balances under £100k**	
6 Application for the use of charitable funds	
6.1 Volunteer uniforms	**SWBCF (9/09) 015** **SWBCF (9/09) 015 (a)**
Miss Overfield reported that the request for the volunteers uniforms should be £6k not £6 as in the report. The uniforms are required so staff and patients can easily recognise the volunteers in the Trust. This request would be a one-off request and any future costs would be borne by the division. The request was agreed.	
AGREEMENT: The Trustees agreed to the funding support of £6k for volunteers uniforms.	
7 Ratification of previous spending decisions	
7.1 Support for the Trust Ball	**SWBCF (9/09) 014**
Mr. White asked for ratification of a decision to support the Trust Christmas Ball with a subsidy of £10k. This would give staff a 50% discount and tickets would be £25.00 each. This request was agreed.	
AGREEMENT: The Trustees ratified the decision to provide funding of £10k for support for the Trust ball	
8 Any other business	**Verbal**
There was none.	
9 Details of next meeting	**Verbal**
The next meeting of the Charitable Funds Committee is planned for 3 December 2009 at 1430h in the Executive Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……