Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Board Meeting

A **public** meeting of the Trust Board will be held on **Thursday, 6th March 2008** at 2.30 pm in the Anne Gibson Board Room at City Hospital

A G E N D A

1.	**APOLOGIES FOR ABSENCE**	
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*	
3.	**CHAIR'S REMARKS/COMMUNICATIONS**	
4.	**MINUTES OF PREVIOUS MEETING** *To approve the minutes of the meeting held 7th February 2008 as a correct record*	**Enclosure 1**
5.	**MATTERS ARISING FROM MINUTES OF THE PREVIOUS MEETING**	
6.	**QUESTIONS FROM MEMBERS OF THE PUBLIC**	
7.	**CLINICAL SERVICE PRESENTATION** ▸ Critical Care	
	PERFORMANCE MANAGEMENT	
8.	Monthly Performance Monitoring Report	**Enclosure 2a**
9.	Monthly Finance Report	**Enclosure 2b**
	GOVERNANCE MANAGEMENT	
10.	Patients' Experience: (10.1) Quarterly Complaints Report (10.2) Quarterly PALS Report (10.3) Understanding the Patient Experience	 **Enclosure 3a** **Enclosure 3b** **Enclosure 3c**
11.	Quarterly Risk Report	**Enclosure 3d**

12.	Trust Risk Register Update	**Enclosure 3e**
	DEVELOPMENT	
13.	Trust Communications Strategy	**Enclosure 4a**
14.	Application for Foundation Trust Status: Progress Report	**Enclosure 4b**
15.	Connecting for Health Programme Report – Verbal update	
16.	Towards 2010 Programme (16.1) Progress Report (16.2) SHA External Review	 **Enclosure 4c** **Enclosure 4d**
17.	Interim Configuration Project: Progress Report	**Enclosure 4e**
18.	**BOARD SUB-COMMITTEES: MINUTES FOR NOTING** (18.1) Audit: 21st February (18.2) Finance and Performance Management: 31st January	 **Enclosure 5a** **Enclosure 5b**
19.	**ANY OTHER BUSINESS**	
20.	**DATE AND TIME OF NEXT MEETING** The next public meeting of the Trust Board will be held on **Thursday, 3rd April 2008 at 2.30pm**, in the Churchvale/Hollyoak Room, Medical Education Centre at Sandwell General Hospital	
21.	**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).*	

Sandwell & West Birmingham Hospitals NHS
NHS Trust

Enclosure 1

Minutes of the Public Trust Board meeting held on Thursday 7th February 2008 at 2.30pm in the Churchvale/Hollyoak Room, Medical Education Centre, Sandwell Hospital.

Present:	Mrs. Sue Davis (Chair)	Cllr Bill Thomas
	Mr. John Adler	Ms. Isobel Bartram
	Dr. Hugh Bradby	Mr. Richard Kirby
	Mr. Roger Trotman	Dr. Sarinder Sahota
	Mrs. Gianjeet Hunjan	Mr. Robert White
	Prof. J. Michie	Mrs. R. Stevens
In Attendance:	Miss Kam Dhami	Mr Graham Seager
	Ms. Judith Whalley	Mrs. Jessamy Kinghorn
	Dr Beryl Oppenheim for item 10.4	Ms Lesley Barnett on behalf of Mr. C Holden
	Mr. Matthew Dodd on behalf of Mr. T. Atack	Mrs. A. Winwood
	Mrs D Gospel	
Apologies:	Mr Tim Atack	Mr. Colin Holden

		ACTION
(08)28	**DECLARATION OF INTERESTS** Cllr Thomas declared an interest in any matters relating to Sandwell Council.	
(08)29	**CHAIR'S REMARKS/COMMUNICATIONS** Mrs Davis started the meeting by welcoming Cllr Thomas back from his recent illness. She added that Cllr Thomas would have a great deal of information to share with us on his recent stay in the Trust in terms of the patient experience. She went on to discuss an issue raised previously re the transitional period for the PPI forum and the new LINKS. Sandwell Council have now informed us that they are interviewing for a new host and they are not anticipating that the new host will be up and running until the end of April. They had asked the Trust to put a plan of action in place during the intervening period. Mrs Davis asked the Board to support the implementation of the interim arrangements. **The board agreed to this.**	**JK**

		ACTION
	Mrs Davis advised the board that this was the last meeting that Dr Hugh Bradby would be attending as Medical Director and she wished to express the Board's appreciation for his work with the Trust and its predecessors. She went on to say that in the last 20 months of being with the Trust she had gained enormous respect for Hugh as a clinician and a Board member. From their tours of the Trust together it was clear that Hugh was held in great affection by both patients and staff. He was a very wise, compassionate clinician who was dedicated to his patients. A presentation was made to Dr Bradby. Dr Bradby thanked the Chair for her kind words. He added that he had enjoyed his time as Medical Director in the trust and added it had been challenging and rewarding. He wished the Board all the best and success in the future.	
(08)30	**MINUTES OF PREVIOUS MEETING** The minutes of the meeting held on the 6th December 2007 were approved as a correct record once the following item had been amended to read:- "08(09) – Mr Trotman drew attention to the fact that the value of fixed assets in the balance sheet exceeded by some margin capital expenditure and the depreciation provision to date. Mr White explained that some items of capital expenditure approved in 06/07 would not have been fully commissioned until 07/08 hence the apparent difference."	
(08)31	**MATTERS ARISING FROM MINUTES OF THE PREVIOUS MEETING** There were no matters arising.	
(08)32	**QUESTIONS FROM THE MEMBERS OF THE PUBLIC** No public were present at the meeting.	
	PERFORMANCE MANAGEMENT	
(08)33	**MONTHLY PERFORMANCE MONITORING REPORT** Mr. White tabled the executive summary. The A&E target has improved in January and continued into February and year to date performance had increased to 98.01%. Mrs Davis stated that C. diff was still showing as red, Mr White responded that this is due to the October/November figures; Mr Adler noted that our comparative C. diff rates were very low. Mr White continued that activity was relatively low in December, as was bank usage. Sickness absence had shown a small improvement in December. Ambulance turnaround data was included for the first time – January data indicated improvement	

		ACTION
	(reduction) on both sites. **The Trust Board noted the contents of the report**	
(08)34	**MONTHLY FINANCE REPORT** Mr White presented the report. Overall performance as at 31st December showed the Trust continuing to be ahead of plan with a surplus in month of £613,000 compared with a plan of £167,000. The year to date surplus was ahead of target. CIP performance also improved in month. Mr Trotman noted that some pages had been missed in photocopying. This would be corrected. **The Trust Board noted the contents of the report**	**AW**
(08)35	**CORPORATE OBJECTIVES 2008/09** **Q3 Progress report** Mr Kirby presented the report. Most of the material was covered in more detail in the reports from Mr White and subject specific reports. He went on to highlight key areas. CIP performance had improved from amber to green, the new hospital timetable was red last time and was now amber as a new project plan had been identified. There were three areas remaining as amber – GUM access, theatre utilisation and reducing MRSA and HCAI. The ESR deliverable had been adjusted as the project had been refocused on priority areas. Mrs Davis asked if the HCAI should be a red, Mr Kirby said a discussion had taken place around this but how we set the objective this means it remains amber. **The Trust Board noted the contents of the report.**	
(08)36	**Assurance Framework Update** Ms Dhami presented the report. There had been progress across a number of areas and there would be further focus on the remaining amber areas. Mr Adler asked Mrs Barnett whether there was an overall project plan for the electronic staff record. Mrs Barnett responded that a project team had been re-established and was developing a new project plan focussing on key development areas. Mrs Barnett agreed to present an update at the end of March to the Executive Team. **GOVERNANCE MANAGEMENT** **INFECTION CONTROL AND CLEANLINESS**	**CH/LB**
(08)37	**Infection Control Assurance Framework** Mrs Stevens presented the report and drew attention to the assurance; the format had been updated to make it easier to track actions. There were several additions to the framework, either	

		ACTION
	where new national guidance had been issued or where we had identified further local\ priorities. Mrs Davis noted that the Trust was struggling to enforce restrictions on visitor numbers. Mrs Stevens replied that the visitor policy is due to be relaunched and new door signage was to be put in place so that we will be clear about our messages. We are also considering rostering senior nurses out of hours to give better support to ward staff. We are also commencing a fortnightly hand hygiene audit and each week everyone will be audited to see what our compliance is with hand washing. There are new hand washing posters on all wards; we are also looking at mobile hand washing facilities for areas where water supply is a problem. All things have been considered and hopefully with these measures we should see an improvement. Cllr Thomas noted from his experience that visitors often failed to adhere to restrictions or often failed to comply with hand washing rules. They could also be aggressive when challenged. Mr Seager asked whether access controls had been shown to make a difference; Mrs Stevens said that they could do but that they were often released during visiting hours. She added that it was important to provide better waiting facilities for visitors and this was being addressed. Mrs Hunjan asked when the hand hygiene audits would commence; Mrs Stevens replied that this would be next week. Mr Adler added that the front page of Heartbeat will identify the new infection control rules and this is to ensure everyone is clear of what is expected of them. The next phase is a system of advisory notes; it is very much like getting a parking ticket, if you are found not to do something right this is issued and if repeated disciplinary action will be taken. We have also devised a process for infection related red incidents where there will be a requirement to see if there was individual accountability for any bacteraemia; this will be fed into the normal line management process. These measures were designed to lead to a fundamental change in culture. Mrs Gospel commented that she had recently visited a hospital where visitors were allowed in in pairs by staff in a disciplined way which had been very effective. Mr Adler asked Mrs Stevens if we have issued guidance to nurses on what to do if visitors are not following protocol, she advised yes this is in place. Ms Whalley said the advisory notices were discussed at the JCNC and asked who is going to know if there are repeat offenders. Mrs Stevens advised a copy of the advisory note will be forwarded to a central point and a database to be developed and monitored and reports will be forwarded to JCNC on a regular basis, she added we may not pick up every breach but we can get the majority and take appropriate action. **The Trust Board noted the contents of the report.**	
(08)38	**Cleanliness Report** Mrs Stevens circulated a replacement report. There is improvement in the majority of areas, identified in the cleanliness	

		ACTION
	audits. We expect these figures to increase further for the last quarter due to the additional resources being deployed. . Weekly walkabouts take place across the trust and distinct improvements have been noted here as well. Mrs Davis asked that once an area has had a deep clean would this be readily evident. Mrs Stevens reported that this would be most obvious in hidden areas such as storage areas. The deep cleans are giving a good base for nurses to start from.	
(08)39	**Matrons' Report** Mrs Stevens presented the report. Mrs Davis asked how this is being compiled. Mrs Stevens responded that a proforma had been circulated to Matrons and key concerns had also been discussed at the Senior Nurses Forum. The key issue this month was whether the increased level of resources going into cleaning and related matters would be sustained into the new financial year. This was being addressed through the LDP process.	
(08)40	**Quarterly Infection Control Report** Dr Oppenheim presented the report and highlighted key issues. There have been changes in the organisation structure, there is now a single operational committee with divisional representation, a new committee which is a health economy wide group is due to meet to tease out issues around primary and secondary care, this will feed through the Infection Control Executive Committee. For C Diff there are two big initiatives: Firstly, rapid testing has been introduced and secondly new antibiotic prescribing guidelines have been issued. We have preliminary evidence that the changes are helping. With regard to MRSA the key issue is to identify patients with MRSA and target them for eradication therapy. The new rules are important in identifying to individuals the obligations; the simplest guidelines are available and will be circulated across the trust. Ms Bartram asked for an overview of where we were. Dr Oppenheim advised that in the case of MRSA the numbers were very small but we need aim for a zero tolerance approach. Mr Adler asked Dr Oppenheim to give an update on the pilot for rapid MRSA testing. She reported that this was being prepared and would give a result within 75 minutes. It was suitable for near patient testing and was likely to be introduced initially in the emergency assessment units. The Chair thanked Dr Oppenheim for the continuing hard work on these important issues. **The Trust Board noted the contents of the report**	
(08)41	**<u>RACE EQUALITY SCHEME – ANNUAL REVIEW</u>** Mrs Stevens presented the report; she explained that it covered all of the equality strands. It had been decided to summarise where	

		ACTION
	we are against all the schemes; this would be used as the basis for he single equality scheme which would come to the Board in April. There were deficiencies in the way that the existing schemas had been implemented and these needed to be comprehensively addressed. An Internal Audit review had been commissioned and the report from this would be shared with Board members. Ms Whalley pointed out that item 5 states a new steering group has been developed, she asked to be made aware of who is involved in this? Mrs Stevens agreed to send the Terms of Reference to her, but went on to say the group had not yet met. Ms Bartram asked about ageism, Mrs Stevens stated we are waiting for further guidance with regard to this. Mrs Hunjan asked about membership of the group, she asked if there is exec/non exec membership, this is to be discussed, Mrs Stevens stated she would be the chair of the group but further discussion is required. Mr Adler added that in July 2007 the Commission for Race Equality wrote to us following a complaint from Dr K Taylor. We responded to these concerns in August 2007. The Trust has received a further request for information and follow up this week. A response will be prepared and shared with the Board.	**RS/SD** **RS**
(08)42	**<u>SAFEGUARDING CHILDREN POLICY</u>** Ms Dhami introduced the item and noted that this paper followed on from the Safeguarding update which had been received at the last meeting. Mrs Hunjan asked if all staff know how to access information off the intranet; this was the case and a specific bulletin on Safeguarding had been attached to all payslips to ensure awareness. Dr Bradby added the intranet is turned on all the time on the wards for ease of access. The important thing with this policy is not the detail but who to go to for support and advice. **The policy was approved by the Board**.	
(08)43	**<u>REVISED TERMS OF REFERENCE: CHARITABLE FUNDS SUB COMMITTEE</u>** Mr Trotman presented the revised Terms of Reference, they were reviewed in September and minor changes have been made. They had been approved by the committee. **The Terms of Reference were approved by the Board.**	
(08)44	**<u>SINGLE TENDER ACTION WAIVERS</u>** Mr White presented the report. As there were a number of these in the system it was felt appropriate to present them in one report. <u>External audit Engagement KPMG £218,000 excluding VAT</u> KPMG have been appointed as the Trust's external auditors. The fee has been discussed with the auditor via the audit committee.	

		ACTION
	The Board were asked to approve the single tender arrangement. Patient food trolleys – Burlodge £108,700 (inc VAT) This needed to be amended to 3 trolleys not 4, with an appropriate reduction in cost. The project comprises 18 multigen trolleys and 3 minigen trolleys; the specification is consistent with the implementation model for the ward services patient feeding. The benefit of these trolleys is that they refrigerate and reheat. These will be purchased out of the money we have been allocated from SHA. The Board were asked to approve the single tender arrangement. Towards 2010 programme, ATM consultancy £83,002 This work is funded by the SHA and 2010 programme and falls into the Trust's consideration of procurement as it is hosting the funds from the SHA. The Board were asked to approve the single tender arrangement. Replacement of x-ray tube, cardiology theatre, City Hospital £84,028 inc VAT The theatre is equipped with a Phillips Integris x-ray screening system. The equipment failed during a procedure in January. Due to the need to replace this part urgently, Chair's approval was obtained to proceed with the repair. The Board were asked to ratify the Chair's action in approving the single tender arrangement. **The Board approved and ratified all tenders.** **DEVELOPMENT**	
(08)45	**APPLICATION FOR FOUNDATION TRUST STATUS: PROGRESS REPORT** Mr. Kirby presented this paper noting progress on the Foundation Trust application. He highlighted the key areas. Public consultation is now under way and was launched on 1st February. The timetable has a special trust board on 22nd April which will give the opportunity to see if the document is in a good state to submit or if we need to do more work. Up to then our timetable remains on track but then we need to be clear with the SHA what the next steps are as we are not clear on this. The Project Board terms of reference also required formal ratification. **The Trust Board noted and received the paper and agreed the Terms of Reference.**	
(08)46	**CONNECTING FOR HEALTH PROGRAMME REPORT** Mr Dodd presented the report. Sue Wilson and the team have been doing a lot of work and getting the teams to work with the new system. The report was detailed and there was nothing further to report.	
(08)47	**TOWARDS 2010 PROGRAMME: PROGRESS REPORT**	

		ACTION
	Mr Seager presented the acute hospital aspects of the report. We are in a position where we have a good understanding of the building, this will form the basis of a planning application which will be presented in April. Affordability is linked in with the Foundation Trust application and long term financial model; this requires further development. With regards to the land on the Grove Lane site, discussions were continuing regarding the regeneration of the wider site. The work is challenging but is still going forward. Mrs Davis added we have hit a difficult area this week and a discussion has been held with Cllr Thomas; an urgent meeting is required with key people to see if there is a mechanism to assist us. Pre planning consultation events have taken place with local businesses on the site along with meetings held with MPs and ward members, plus a further three community meetings and all were very positive. Cllr Thomas commented that he would assist as much as he could. Mr. Kirby added we will bring the full external review and plan to the next board. Ms Bartram asked about the separate agenda reports and if they can be available, Mr Kirby agreed to email to those interested. **The Trust Board noted and received the paper.**	**RK**
(08)48	**<u>INTERIM RECONFIGURATION PROJECT: PROGRESS REPORT</u>** Mr. Kirby presented this paper. The paediatric changes were now embedded and further information on activity trends would be available shortly. Work is continuing on the neonatal impact on maternity. The timetable for surgery was outlined on pages 4 and 5, this was approved at the last project board and the Trust Board were asked to endorse this. A detailed plan will be presented to the June board. Work on equality impact assessments continues. **The Board noted and approved the contents of the report.**	
(08)49	**<u>BOARD SUB-COMMITTEES: MINUTES FOR NOTING</u>** Mrs Davis asked Ms Dhami why we had not been seeing the most recent minutes for the meetings. The reason for this is probably due to them not being ready as they have recently met. Mrs Davis asked for this to be addressed. • CHARITABLE FUNDS: 14TH NOVEMBER 2007 • GOVERNANCE AND RISK MANAGEMENT: 26TH NOVEMBER 2007 • AUDIT: 29TH NOVEMBER 2007 • FINANCE AND PEFORMANCE MANAGEMENT: 20TH DEEMBER 2007 **The Board noted all of the minutes received.**	**KD**

		ACTION
(08)50	**ANY OTHER BUSINESS** Schedule of meetings – Mrs Davis reported that public health colleagues from PCTs have agreed to present their reports, we need to clarify when they will be here. Ms Dhami stated we are aiming for next month. Mr Trotman remarked on how much had been achieved in recent months and that he would like to compliment staff. Mr Adler said this comment was much appreciated. Foundation Trust -Mrs Gospel congratulated Mrs Kinghorn for the launch last week, she added she had received a lot of positive feedback from the public. ***The meeting closed at 4.25pm*** …….. …… **Signed** **Print**	**KD**

ENCLOSURE 2b

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD

6th March 2008

SUBJECT: Financial Position

REPORT BY: Director of Finance & Performance Management

AUTHOR: Robert White

PURPOSE OF THE REPORT:

To update the Board on the financial position at 31st January 2008.

IMPLICATIONS:

Financial:	Need to meet financial targets.
Personnel:	
Healthcare/ National Policy:	
Other:	

RECOMMENDATION(S):

The Board is recommended to note the contents of the report and endorse any actions taken to manage the financial position.

29th February 2008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT OF THE DIRECTOR OF FINANCE AND PERFORMANCE MANAGEMENT TO THE TRUST BOARD

Thursday 6th March 2008

FINANCE AND PERFORMANCE REPORT FOR PERIOD ENDING 31ST JANUARY 2008

1. Introduction

This report provides details of financial performance for month 10 (January 2008) and cumulative information covering the period 1st April 2007 to 31st January 2008. An Executive Summary is appended to this report.

Overall performance at 31st January shows the Trust continuing to be ahead of plan with a surplus in month of £448,000 compared with a plan of £174,000. The year to date surplus of £6,065,000 is £1,892,000 ahead of target (measured against original £4,500,000 surplus target) and leaves the Trust on course to deliver the revised forecast surplus of £6,500,000.

In terms of patient activity and income, there is fully coded data available up to 31st December. The financial impact of over and under performance using this data has been incorporated into both the Trust and individual divisions' performance.

The report provides more detailed information within five appendices, namely:

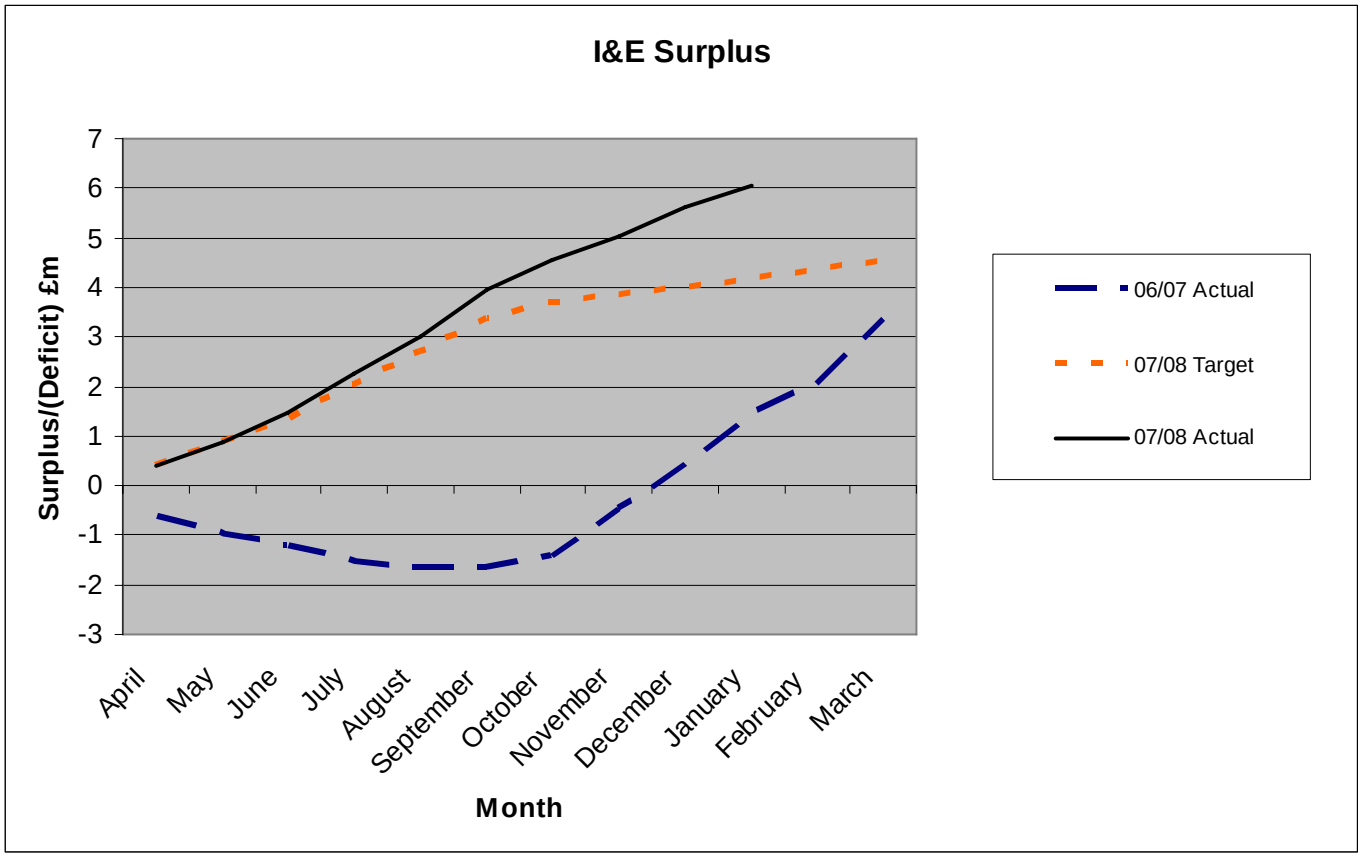
i.	the income and expenditure account	(Appendix A)
ii.	divisional budget positions	(Appendix B)
iii.	the balance sheet	(Appendix C)
iv.	capital expenditure	(Appendix D)
v.	the cash flow statement	(Appendix E)

The Trust is repaying one half of its loan liability due in 2008/09 during 2007/08. To effect this early repayment it must generate additional I&E surpluses. The movement from the original surplus target of £4.5m to a revised forecast of £6.5m has enabled an additional £2m repayment in the current financial year. This directly informs a revised planned surplus (subject to Board approval) of £2.5m in 2008/09. The improved position in 2007/08 must be regarded as a revised control total rather than additional headroom or budgetary flexibility.

2. Income & Expenditure

The financial trend line in Table 1a records the cumulative financial performance at the end of each month. The trend line from 2006/07 is also presented.

Table 1a: Cumulative Income and Expenditure Surplus 2006/07 and 2007/08



The Trust's Income and Expenditure performance for the year to date is shown in numeric format in Table 1b below.

Table 1b: Planned and Actual Surpluses 2007/2008

**plan and actual figures represent cumulative surpluses/(deficits)*

£000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	393	862	1346	2002	2685	3346	3678	3832	3999	4173	4349	4500
Act	408	886	1476	2239	3027	3937	4554	5004	5616	6065		
Var	15	24	130	237	342	591	876	1172	1617	1892		

**plan and actual figures represent In-Month surpluses/(deficits)*

£000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	393	469	484	656	684	660	332	154	167	174	176	151
Act	408	478	590	763	787	909	616	447	613	448		
Var	15	9	106	107	105	249	284	293	446	274		

2.1 Divisional Income and Expenditure Performance

Table 1c below shows the in month and year to date overall performance of divisions. Further details are shown in Appendix B to this report.

Table 1c: Summary Divisional Performance

Division	**In Month Variance £000**	**Year to Date Variance £000**
Anaesthetics & Critical Care	39	(91)
Imaging	83	298
Medicine A	(26)	102
Medicine B	(16)	93
Pathology	39	14
Surgery S	(8)	111
Surgery C	85	(130)
Surgery B	42	(110)
Womens & Childrens	86	225
Nursing - Facilities	(4)	45
Estates	7	13
Operations	37	256
Net Operational Position	**364**	**826**
Corporate and Reserves	(122)	769
Total	**242**	**1,595**

Note: Deficits are shown in brackets.

The overall position of the Trust up to 31st January shows a surplus of £153,000 against income budgets, a surplus of £1,605,000 on pay budgets and an over spend of £163,000 for non pay. This, together with better than planned earnings from interest generates an overall positive variance of £1,892,000 (YTD plan versus YTD actual).

Within the current income performance, there is a shortfall of approximately £128,000, including the effect of CIP income targets, on patient related income. This represents a small in month deterioration in performance although it should be noted that this is largely based on December performance which includes a significant amount of down time.

Non patient related income streams continue to be above budgeted levels with the major variances being in relation to education and training which is £216,000 above plan, transport services £143,000 above plan and catering which is £297,000 below plan.

Overall, both medical divisions have remained fairly stable in month. Both, particularly Medicine A, have improved their income position although they have also experienced in month cost pressures. In Medicine A, this is primarily related to high levels of bank and agency use keeping open capacity and dealing with winter pressures. Pressures in Medicine B are more related to patient based non pay including drugs and consumables.

Overall, all three surgical divisions have generated an acceptable bottom line position with Surgery C and Surgery B both making progress towards their break even targets while the performance of Surgery S has remained broadly stable in month. Both Surgery C and Surgery B have significantly exceeded their in month income targets although both have overspent against pay and non pay budgets. For both divisions, this is primarily driven by high bank and agency costs along with additional drugs and patient related consumable costs. The shortfall in income for Surgery S has largely been offset by lower medical pay costs.

The performance of the Women and Childrens Division has improved further in month. Although there is a shortfall against SLA income targets, this has been more than offset by growing under spending on pay budgets particularly in respect of nursing and midwifery costs where a number of posts remain vacant.

The performance of Anaesthetics and Critical Care has improved again in month with further progress being made towards its break even target particularly driven by under spending on nursing budgets. Although significant use of bank and agency staff continues, in month this is lower than the savings generated from vacancies. The performance of the Imaging Division continues to improve with savings primarily being driven by high levels of vacancies among medical and scientific staff. Performance on Pathology has improved and the division has now returned to a bottom line surplus position.

Corporate services continue to generate underspends against budget, primarily the result of vacancies being held in Finance, IM&T and Governance Divisions.

Miscellaneous and reserves contain items of expenditure which cannot accurately be attributed to specific divisions or which cover areas crossing the whole Trust. In particular, provisions for uncertain costs are held outside operational divisions.

Significant adjustments have been made to income and corresponding expenditure budgets in month to reflect the movement in additional funding streams, specifically as follows:

i. an additional £1.6m from HoB and Sandwell PCTs and £0.7m from the Strategic Health Authority in respect of patient experience, infection control and environmental improvements;
ii. an additional £1.0m from Sandwell PCT in respect of Connecting for Health (CfH); and
iii. a reduction of £0.5m from HoB in respect of the renal development.

Appendix A contains a forecast outturn position which is consistent with the expected £6.5m surplus now being reported to the Strategic Health Authority.

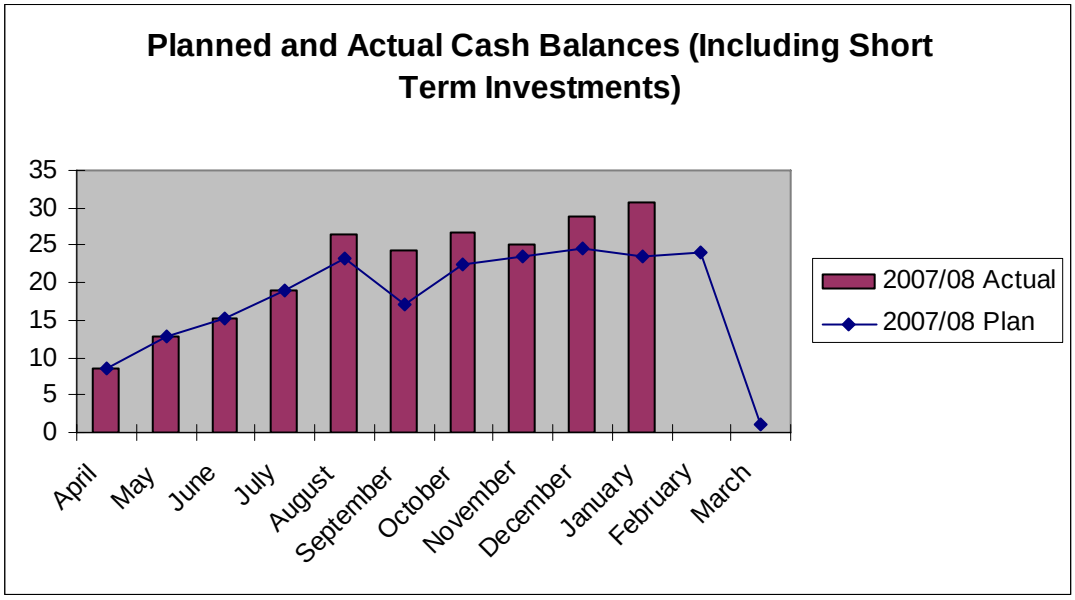
3. Cash and EFL

Details of the Trust's planned and actual cash position for the year is attached at Appendix E. Graphical representation of this performance is shown below at Table 2. At 31st March 2007, the Trust had a cash balance of £987,000 which was the required position to meet the EFL. Broadly, the Trust expects to build up cash balances during the year which will be used to repay loans and PDC (public dividend capital) as well as PDC dividends and loan interest in September and March.

At 31st January, the Trust's cash balance, including short term investments, was £30,765,000 which is higher than the planned position, in part the result of receipt of cash relating to environmental improvement funding, but still leaves the Trust on course to deliver its EFL for the year. The budgeted cash flow position shown at Appendix E has been updated to reflect the decision to pay an additional £2m toward the outstanding working capital loan.

The graph below shows the planned cash balances for the year and the actual balances up to January.

Table 2: Planned and Actual Cash Balances



4. Performance Against CBI Prompt Payment Target

All NHS organisations are required to pay commercial invoices within 30 days of receipt of a valid invoice or delivery of the goods. Performance to date is broadly in line with the improvements seen during 2006/2007 but is below target. Further improvements are largely dependent on changes in systems and processes which are planned to be implemented later in 2007/2008 and into 2008/2009.

Table 3a below shows performance against this target on a monthly basis.

Table 3a: Performance Against Prompt Payment Target

	05/06	06/07	Latest 3 Months			Year to Date
			November	December	January	
No of Invoices Paid in Period	95040	86667	6924	5041	10475	73260
No Paid Within Target	51457	59731	4986	3348	7333	49909
% Paid Within Target	54%	69%	72%	66%	70%	68%
Value of Invoices Paid (£000)	71,057	71,353	5,862	4,559	9,080	65,545
Value Paid Within Target (£000)	40,062	51,449	4,176	3,031	5,085	41,162
% Paid With Target	56%	72%	71%	66%	56%	63%

5. Capital Programme

The Trust currently has a capital programme of £14,647,000 which is matched by capital resources generated through depreciation charges. This is confirmed through the Trust's Capital Resource Limit.

Capital expenditure for the year to date is £7,125,000 which represents an increase in month of £515,000. This is net of the transfer of some IT expenditure previously regarded as capital being charged to revenue. The majority of year to date expenditure is accounted for by Sandwell neonatal and paediatric reconfiguration, IT equipment, statutory standards and medical equipment.

6. Debtors, Creditors and Other Working Balances

Overall, there has been a further small improvement in the debtors and accrued income position during January with a decrease of around £0.4m The overdue debtor position has also improved to some degree. Most overdue balances now rest with Foundation and NHS Trusts rather than PCTs and cash flow from PCTs, particularly Sandwell and HoB, has improved substantially in year.

Cash at bank and in short term investments has risen in month to £30,765,000 which is above planned levels. In month, the Trust has received approximately £1.8m in respect of environmental improvement funding as well as a number of other smaller additional receipts.

Interest receivable continues to be ahead of plan and is consistent with the higher than planned cash balances.

7. Workforce and Paybill

Table 4a below shows planned and actual whole time equivalents at 31st January 2008. Changes in both workforce numbers and paybill are shown graphically in Tables 4c and 4d below.

When compared with budgets, the Trust had vacancies in January of approximately 132 wte's (whole time equivalents). Most of the variation in wte numbers is the result of changes in bank working with wte numbers for permanent staff groups remaining broadly stable.

For the year to date, the Trust has spent £3,193,000 on agency staff. Employing agency staff is generally, although not always, more expensive than equivalent employed staff simply as a result of the added agency commission. Working on an average annual cost of £35,000, this equates to 109 wte's, at an annual cost of £45,000 this equates to around 85 wte's.

Table 4a: Planned and Actual WTE's by Staff Group at 31st January

Pay Group WTEs	Current Period			Year to Date Average		
	Budget	Actual	Variance	Budget	Actual	Variance
Medical	748.22	729.28	18.94	746.51	733.29	13.22
Management	257.70	226.59	31.11	260.13	233.17	26.96
Administration & Estates	1,058.82	997.89	60.93	1,053.33	995.36	57.97
Healthcare Assistants & Other Support	503.19	532.17	-28.98	527.27	533.34	-6.07
Nursing & Midwifery	2,504.58	2,211.34	293.24	2,497.14	2,260.20	236.94
Scientific, Therapeutic & Technical	898.98	856.07	42.91	906.38	869.48	36.90
Bank Staff	1.00	286.81	-285.81	4.13	250.68	-246.55
Agency Staff	0.00	0.00	0.00	0.00	0.00	0.00
Other Pay	0.00	0.00	0.00	0.00	0.00	0.00
Total	5,972.49	5,840.15	132.34	5,994.89	5,875.52	119.37

Table 4b: Planned and Actual Paybill by Staff Group at 31st January

Paybill by Pay Group	Current Period			Year to Date Average		
	Budget	Actual	Variance	Budget	Actual	Variance
Medical	5,648	5,449	199	5,505	5,381	124
Management	1,142	1,046	96	1,055	974	81
Administration & Estates	1,962	1,902	60	1,934	1,840	94
Healthcare Assistants & Other Support	872	886	-14	857	823	34
Nursing & Midwifery	6,625	5,986	639	6,350	5,816	534
Scientific, Therapeutic & Technical	2,475	2,290	185	2,427	2,313	114
Bank Staff	62	673	-611	29	571	-542
Agency Staff	105	474	-369	47	319	-272
Other Pay	-2	-36	34	-2	4	-6
Total	18,889	18,670	219	18,202	18,041	161

Table 4c: Planned and Actual WTE's by Period

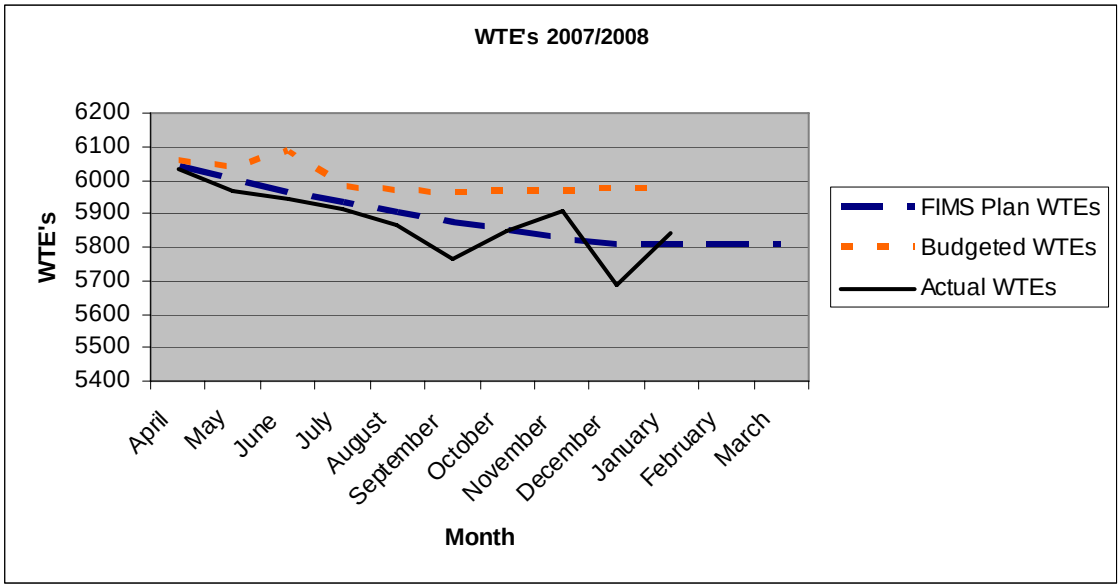
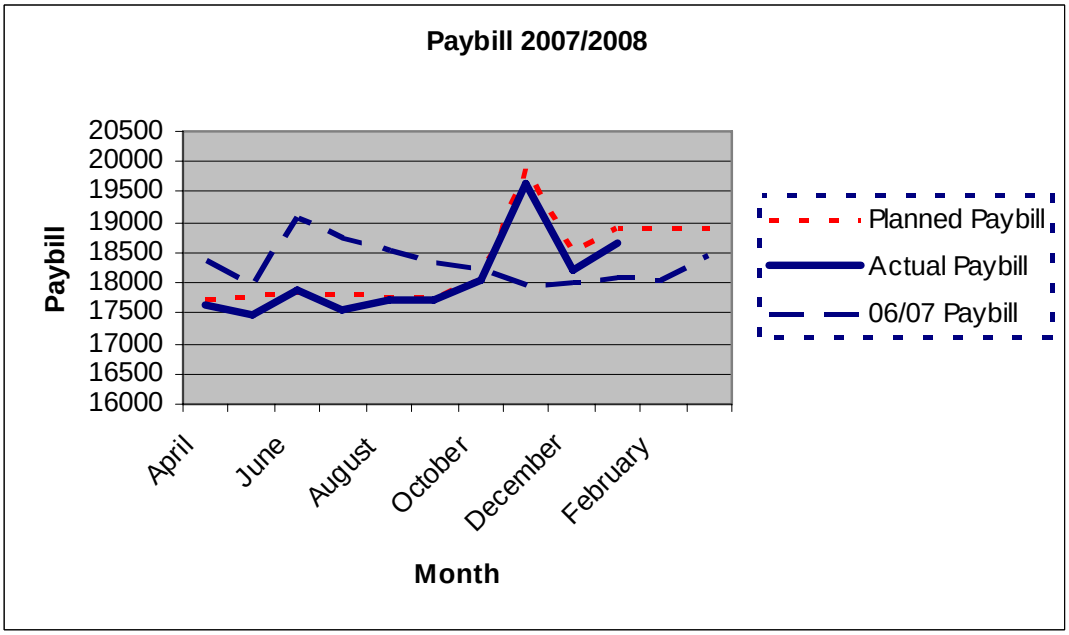


Table 4d: Planned and Actual Paybill by Period



8. Cost Improvement Programme

At 31st January, the cost improvement programme showed a slightly larger surplus against plan of £95,395 with an actual achieved of £11,788,713 against the plan of £11,693,318. This leaves the programme on track to deliver the planned savings for the full year.

9. Conclusion

At 31st January, the Trust has achieved a year to date income and expenditure surplus of £6,065,000 which is £1,892,000 ahead of the planned position with a revised yearend forecast surplus of approximately £6,500,000.

Overall income remains slightly above target although with a slight in month worsening in patient related income. Overall expenditure has improved in month with an improvement in both pay and non pay.

Net financial performance continues to be satisfactory and ahead of plan. The performance of most divisions has improved or remained fairly steady in month. For the year to date position, Surgery C, Surgery B and Anaesthetics and Critical Care remain in a deficit position although all improved in month. As in previous months, the overall Trust position continues to be assisted by strong performance in corporate divisions and reserves.

Cash balances are ahead of plan but the Trust remains broadly on track to deliver against its External Financing Limit. Although capital expenditure remains relatively low, the last few months have seen increased levels of spend and it is expected that this will accelerate towards the year end.

10. Recommendations

The Trust Board is asked to:

9.1 NOTE the contents of the report; and
9.2 Endorse any actions taken to manage financial performance.

Robert White
Director of Finance and Performance Management

Appendix A

Sandwell & West Birmingham Hospitals NHS Trust
SUMMARY INCOME & EXPENDITURE

MONTH: January 2008	2007/08 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 Actual £000's
INCOME								
Patient Related SLAs	302,285	27,274	27,191	(83)	251,766	251,458	(308)	302,500
Other Patient Related Income	3,381	226	213	(13)	2,995	3,175	180	3,600
Total Patient Related Income	305,666	27,500	27,404	(96)	254,761	254,633	(128)	306,100
Education & Training	15,528	1,314	1,301	(13)	12,949	13,165	216	15,750
Other Income	17,176	1,360	1,424	64	14,285	14,350	65	17,150
TOTAL INCOME	**338,370**	**30,174**	**30,129**	**(45)**	**281,995**	**282,148**	**153**	**339,000**
EXPENDITURE								
PAY								
Medical Staffing	(66,367)	(5,648)	(5,449)	199	(55,052)	(53,807)	1,245	(64,700)
Management	(12,661)	(1,142)	(1,046)	96	(10,555)	(9,742)	813	(11,850)
Administration & Estates	(24,816)	(1,962)	(1,902)	60	(19,338)	(18,404)	934	(23,920)
Healthcare Assistants & Support Staff	(10,262)	(872)	(886)	(14)	(8,572)	(8,230)	342	(9,850)
Nursing and Midwifery	(76,710)	(6,625)	(5,986)	639	(63,501)	(58,162)	5,339	(71,200)
Scientific, Therapeutic & Technical	(29,212)	(2,475)	(2,290)	185	(24,265)	(23,133)	1,132	(28,200)
Bank Staff	(325)	(62)	(673)	(611)	(287)	(5,707)	(5,420)	(6,700)
Agency Staff	(572)	(105)	(474)	(369)	(466)	(3,193)	(2,727)	(3,900)
Other Pay	(115)	2	37	35	19	(34)	(53)	(100)
TOTAL PAY COSTS	**(221,040)**	**(18,889)**	**(18,669)**	**220**	**(182,017)**	**(180,412)**	**1,605**	**(220,420)**
NON PAY								
Drugs and Blood Products	(19,685)	(1,839)	(1,853)	(14)	(16,572)	(16,806)	(234)	(20,150)
Medical Equipment & Consumables	(23,404)	(2,204)	(2,302)	(98)	(19,351)	(19,425)	(74)	(24,000)
Energy & Utilities	(8,351)	(710)	(731)	(21)	(7,237)	(7,228)	9	(8,550)
Hotel Service Costs	(3,654)	(344)	(331)	13	(3,008)	(3,087)	(79)	(4,300)
IT Equipment & Maintenance	(1,738)	(161)	(129)	32	(1,451)	(1,314)	137	(1,550)
Postage, Printing & Stationery	(2,438)	(207)	(199)	8	(2,035)	(2,001)	34	(2,300)
Other Costs	(29,500)	(3,666)	(3,519)	147	(26,109)	(26,065)	44	(27,444)
TOTAL NON PAY COSTS	**(88,770)**	**(9,131)**	**(9,064)**	**67**	**(75,763)**	**(75,926)**	**(163)**	**(88,294)**
TOTAL EXPENDITURE	**(309,810)**	**(28,020)**	**(27,733)**	**287**	**(257,780)**	**(256,338)**	**1,442**	**(308,714)**
EBITDA	**28,560**	**2,154**	**2,396**	**242**	**24,215**	**25,810**	**1,595**	**30,286**
P&L on Disposal of Fixed Assets	0	0	0	0	0	0	0	0
Depreciation	(15,965)	(1,330)	(1,330)	0	(13,304)	(13,304)	0	(15,965)
PDC Dividend	(8,831)	(736)	(736)	0	(7,359)	(7,359)	0	(8,831)
Interest Receivable	1,164	117	149	32	987	1,284	297	1,450
Interest Payable	(428)	(31)	(31)	0	(366)	(366)	0	(440)
Other Finance Costs	0	0	0	0	0	0	0	0
SURPLUS/(DEFICIT) *	**4,500**	**174**	**448**	**274**	**4,173**	**6,065**	**1,892**	**6,500**

Appendix B

Sandwell & West Birmingham Hospitals NHS Trust
DIVISIONAL VARIANCES TO 31ST JANUARY 2008

MONTH: January 2008	Anaesthetics and Critical Care £000	Imaging £000	Medicine A £000	Medicine B £000	Pathology £000	Surgery S £000	Surgery C £000	Surgery B £000	Women & Childrens £000	Nursing - Facilities £000	Estates £000	Operations £000	Corporate Services £000	Miscellaneous & Reserves £000
Income														
Patient Related SLAs	42	133	518	201	(198)	(62)	(544)	318	(380)	(11)	0	(53)	(763)	670
Other Income	1	(125)	41	57	77	(21)	28	(63)	187	(155)	(35)	174	272	(157)
Overall Position	**43**	**8**	**559**	**258**	**(121)**	**(83)**	**(516)**	**255**	**(193)**	**(166)**	**(35)**	**121**	**(491)**	**513**
Expenditure														
Pay	(162)	470	(590)	(13)	193	126	348	(246)	571	230	29	85	841	(277)
Non Pay	28	(180)	134	(152)	(59)	67	39	(118)	(154)	(19)	19	50	(197)	380
Overall Position	**(134)**	**290**	**(456)**	**(165)**	**134**	**193**	**387**	**(364)**	**417**	**211**	**48**	**135**	**644**	**103**
Net Surplus/(Deficit)	**(91)**	**298**	**103**	**93**	**13**	**110**	**(129)**	**(109)**	**224**	**45**	**13**	**256**	**153**	**616**

Note: There may be minor variances in totals due to roundings

Appendix C

Sandwell & West Birmingham Hospitals NHS Trust

BALANCE SHEET

		Opening Balance as at 1st April 2007 £000	Balance as at 31st January 2008 £000
Fixed Assets	Intangible Assets	509	390
	Tangible Assets	261,064	282,439
Current Assets	Stocks and Work in Progress	3,601	3,532
	Debtors & Accrued Income	20,779	15,343
	Investments	0	26,000
	Cash	987	4,765
Current Liabilities	Creditors and Accrued Expenditure Falling Due In Less Than 1 Year	(26,388)	(43,695)
Long Term Liabilities	Creditors Falling Due in More Than 1 Year	(4,500)	(4,500)
Provisions for Liabilities and Charges		(4,386)	(5,229)
		251,666	279,045
Financed By			
Taxpayers Equity	Public Dividend Capital	168,412	162,712
	Revaluation Reserve	70,841	97,855
	Donated Asset Reserve	2,923	2,923
	Government Grant Reserve	2,075	2,075
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(1,643)	4,422
		251,666	279,045

Sandwell & West Birmingham Hospitals NHS Trust

CAPITAL PROGRAMME 2007/2008

		Approved Programme 2007/08 £000	Actual Expenditure to 31st January	Forecast Outturn Position
Capital Resources				
Depreciation		15,063	12,553	15,063
Decontamination - Central Resources		84	84	84
Return of CRL from Previous Years re Short Stay Training Pilot		(500)	(500)	(500)
PACS/RIS Allocation		650	650	650
FIMS M7/Spring Supply Adjustment		(650)	(650)	(650)
Total Resources		**14,647**	**12,137**	**14,647**
Capital Expenditure				
Commitments Brought Forward	Retentions	400	425	425
	RIS	1,038		1,038
	Decontamination	284	167	282
Scheme Development Fees		300	23	300
IT Programmes		800	750	800
Equipment Programmes	Replacement Equipment (including Imaging)	700	427	700
	Imaging Equipment	975	50	975
	Digital Hearing Aids	600	732	750
	Camera System - General Surgery	67	76	76
	Tape Readers x 3	108		108
	EMG & Evoked Potential Machines	45	45	45
	EEG Equipment Upgrade	32	26	32
	Lung Function Testing Equipment	45	55	55
	Sonosite Scanner	29	33	33
	HPLC Analyser	30	26	30
	TPMT DNA Tests	30		30
	Slit Lamps (18 week target)	25	28	28
	Diathermy Machine (BTC)	7		7
	Haematology Analyser	76		76
Statutory Standards	Disability Discrimination Act Audit Action Plans	300	262	300
	Fire/Fire Alarms	400	306	400
	Legionella	300	175	300
	Medical Gasses	200	85	200
	Building Structures and Fabrics	175	100	175
	Falls From Heights	125	35	125
	Health & Safety Improvement Notices	140	50	140
	Electrical Services	150	75	150
	Building Management System	100	75	100
	Safe Hot Water Temperatures	100	40	100
	Improvements to Roads, Footpaths and Car Parks	95	109	109
	Other	35	19	35
Facilities Programmes	Lifts	300	253	300
	Plant Replacement	80		80
	Sandwell Imaging Electrical Supplies	125		125
	D6/MAU Mixed Sex	105	29	80
	Ward Access Security	150	11	150
	Increase in Security - Ward Access and Other	50	2	50
	Theatre A, BTC	126		126
	Cardiology Accommodation	20		20
	BTC Minor Ops Unit (Hysteroscopes/Cystoscopes)	75		75
	Isolation Strategy P3	30	21	30
	Sandwell Cardiovascular Unit P4	110	50	110
	Relocation of Orthotics Service	60		60
Reconfiguration	Sandwell Neonatal	1,200	1,201	1,201
	Sandwell Paediatrics	615	398	615
	City Paediatric Assessment Unit	220	110	220
	City Neonatal	850	241	832
	Pathology	1,200	182	1,115
Capitalisation of BTC Unitary Charge		500	333	500
Other	Hearing Services Centre Upgrade	100		75
	Neurophysiology	0		0
Contingent Items	Switchboard Modernisation	350		350
	Lift Refurbishment	200		200
	Minor Medical Equipment b/f 08/09	300		300
	Infection Control/Patient Environment Improvement	250	100	250
Slippage		(80)		(141)
Total Expenditure		**14,647**	**7,125**	**14,647**
Under/(Over) Commitment Against CRL		**0**	**5,012**	**0**

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

REVISED PLAN AND ACTUAL/FORECAST OUTTURN AT JANUARY 200

PLAN	April £000s	May £000s	June £000s	July £000s	August £000s	September £000s	October £000s	November £000s	December £000s	January £000s	February £000s	March £000s
Receipts												
SLAs	22,554	24,496	25,690	23,620	26,099	22,699	22,699	22,699	22,699	22,699	22,699	22,699
DoH Market Forces Factor	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463
Over Performance Payments							487			487		
Education & Training	1,314	1,252	1,302	1,366	1,293	1,293	1,293	1,293	1,293	1,293	1,293	1,293
BTC PFI Tapering									400			
Loans												
Interest	94	58	91	100	130	147	126	122	145	153	153	150
Other Receipts	3,175	3,302	1,916	2,383	1,735	1,735	5,735	1,735	1,735	1,735	1,735	1,735
Total Receipts	28,600	30,571	30,462	28,932	30,720	27,337	31,803	27,312	27,736	27,830	27,343	27,340
Payments												
Payroll	10,167	10,409	10,332	10,378	10,298	10,298	10,298	10,298	10,298	10,298	10,298	10,298
Tax, NI and Pensions	2,447	7,036	7,162	7,099	7,642	7,642	7,642	7,642	7,642	7,642	7,642	15,284
Non Pay - NHS	36	2,977	3,117	1,744	1,900	1,900	1,900	1,900	1,900	1,900	2,400	2,400
Non Pay - Trade	6,476	4,567	6,456	5,447	5,261	5,049	4,935	4,628	5,013	6,563	4,054	4,014
Non Pay - Capital	1,385	747	370		874	874	1,165	1,165	1,165	1,602	1,893	2,778
PDC Dividend						4,415						4,414
PDC Repayment												6,116
Repayment of Loans						2,250						4,250
Interest						241						187
BTC Unitary Charge	317	351	351	416	300	300	300	300	300	300	300	300
Other Payments	307	229	43	148	350	350	350	350	350	350	350	350
Total Payments	21,135	26,316	27,831	25,232	26,625	33,319	26,590	26,283	26,668	28,655	26,938	50,392
Cash Brought Forward	987	8,452	12,707	15,338	19,038	23,133	17,151	22,364	23,393	24,460	23,634	24,039
Net Receipts/(Payments)	7,465	4,255	2,631	3,700	4,095	(5,982)	5,213	1,029	1,067	(826)	405	(23,052)
Cash Carried Forward	8,452	12,707	15,338	19,038	23,133	17,151	22,364	23,393	24,460	23,634	24,039	987

ACTUAL/FORECAST OUTTURN	April £000s	May £000s	June £000s	July £000s	August £000s	September £000s	October £000s	November £000s	December £000s	January £000s	February £000s	March £000s
Receipts												
SLAs	22,554	24,496	25,690	23,620	28,316	25,196	23,460	22,969	29,142	23,228	22,699	22,699
DoH Market Forces Factor	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,701	1,463
Over Performance Payments												
Education & Training	1,314	1,252	1,302	1,366	1,363	1,147	1,151	1,489	1,217	1,398	1,293	1,293
BTC PFI Tapering												
Loans												
Interest	94	58	91	100	127	144	156	244	94	246	150	150
Other Receipts	3,175	3,302	1,916	2,383	3,275	1,752	1,904	2,214	12,058	4,564	27,735	1,735
Total Receipts	28,600	30,571	30,462	28,932	34,544	29,702	28,134	28,379	43,974	30,899	53,578	27,340
Payments												
Payroll	10,167	10,409	10,332	10,378	10,428	10,282	10,687	11,530	10,607	10,947	10,800	10,800
Tax, NI and Pensions	2,447	7,036	7,162	7,099	7,150	7,107	6,993	7,359	8,058	7,251	7,388	14,800
Non Pay - NHS	36	2,977	3,117	1,744	2,539	1,333	1,820	3,824	876	2,798	2,500	5,500
Non Pay - Trade	6,476	4,567	6,456	4,846	5,642	4,921	4,333	6,341	3,718	6,370	5,000	9,334
Non Pay - Capital	1,385	747	370	601	950	766	1,329	801	798	1,050	2,000	5,000
PDC Dividend						4,416						4,415
PDC Repayment									5,700			416
Repayment of Loans						2,250						4,250
Interest						242						186
BTC Unitary Charge	317	351	351	416	352	353	406	354	356	353	360	360
Other Payments	307	229	43	148	132	89	20,165	5,037	2	11,090	300	300
Total Payments	21,135	26,316	27,831	25,232	27,193	31,759	45,733	35,246	30,115	39,859	28,348	55,361
Cash Brought Forward	987	8,452	12,707	15,338	19,038	26,389	24,332	6,733	(134)	13,725	4,765	29,995
Net Receipts/(Payments)	7,465	4,255	2,631	3,700	7,351	(2,057)	(17,599)	(6,867)	13,859	(8,960)	25,230	(28,021)
Cash Carried Forward	8,452	12,707	15,338	19,038	26,389	24,332	6,733	(134)	13,725	4,765	29,995	1,974
Cash + Investments Carried Forward	8,452	12,707	15,338	19,038	26,389	24,332	26,733	24,866	28,725	30,765	29,995	1,974
Plan v Actual Carry Forward (including Investments)	0	0	0	0	3,256	7,181	4,370	1,474	4,266	7,131	5,956	987

The Actual/Forecast Outturn Table shows actuals to January in bold type and forecasts for February and March in light type.

Major Factors Generating Variances

August

Receipt of £3.4m from Heart of Birmingham PCT in respect of 2010 project not originally expected until later in year.

September

£0.5m re distinction awards and £0.5m BTC tapering received from Sandwell PCT expected until later in year. Duplicate payment re BTC tapering - will be recovered in future period.
Lower than planned payments to NHS bodies £0.6m

October

£20m invested in National Loans Fund with higher interest rate than PGO account
£4m anticipated from Sandwell PCT in respect of RAB circular flow - now likely to be received in December

November

£0.75m pay award arrears
£0.9m additional payments to NHS Litigation Authority
£1.9m additional trade creditors

December

Other Receipts includes £10m net reduction in investments with the National Loans Fund
£5.7m PDC repayment and £5.5m SLA income relates to circular cash flow with Sandwell PCT

January

Environmental Improvements £1.8m.
Other payments includes £11m net increase in investments with the National Loans Fund.

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – January 2008

Executive Summary and Key Performance Indicators

EXECUTIVE SUMMARY

• Actual YTD surplus at January is £6,065k against a target of £4,173k or £1,892k ahead of plan with a forecast outturn surplus remaining at £6,500k.

• In month surplus is £448k against a target of £174k, £274k ahead of plan

• Overall I&E performance is driven primarily by ongoing savings on pay budgets along with in month improvements in non pay although with a slight worsening in the overall income position.

• CIP performance has improved in month with a YTD actual of £11,788k against a plan of £11,693k, £95k ahead of plan

Key Financial Performance Indicators

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	274	1,892	> Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	242	1,595	> Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	220	1,605	< Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	67	-163	< Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	132	119	< Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	7,131	7,131	> = Plan	> = 95% of plan	< 95% of plan
CIP Actual v Plan £000	98	95	> 97½% of Plan	> = 92½% of plan	< 92½% of plan

Note: positive variances are favourable, negative variances unfavourable

Key Financial Issues and Risks

• There has been a small overall worsening in performance although with variable impacts on individual divisions

• Pay expenditure £220k under budget in month and £1,605k year to date

• Non pay performance has improved slightly ((£67k) in month but with ongoing higher levels of spend on drugs and consumables

•Overall cash holdings have increased to approx £30.8m with £26m invested over 7 days with the NLF. Significant in month receipts in respect of patient environment and other non recurrent schemes

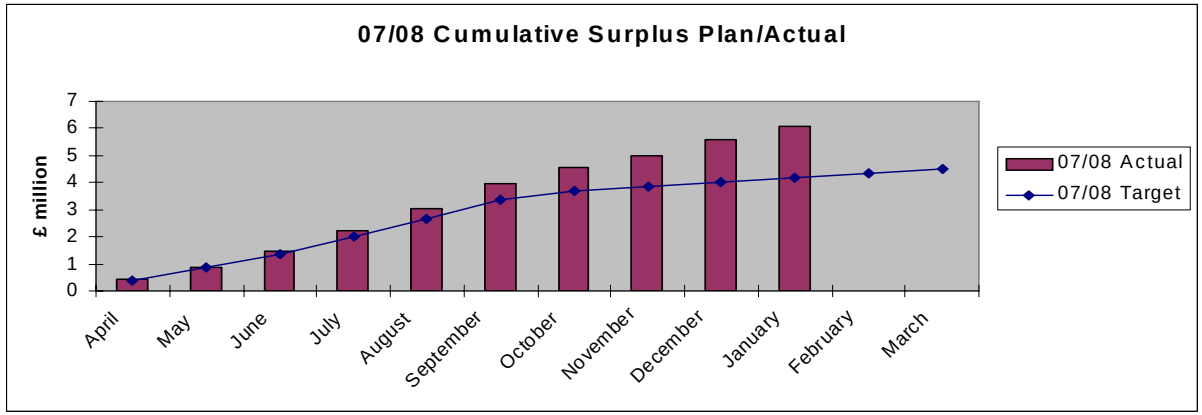
• The main areas with ytd deficits continue to be Surgery C, Surgery B and Anaesthetics & Critical Care

•YTD capital expenditure is £7,546k against an annual plan of £14,647k

•Small reduction in overall debtors and accrued income

•Bank and agency usage has risen in January closer to pre December levels

2007/2008 Summary Income & Expenditure Performance at 31st January 2008	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	305,666	27,500	27,404	(96)	254,761	254,633	(128)	306,100
Other Income	32,704	2,674	2,725	51	27,234	27,515	281	32,900
Operating Expenses	(309,810)	(28,020)	(27,733)	287	(257,780)	(256,338)	1,442	(308,714)
EBITDA	28,560	2,154	2,396	242	24,215	25,810	1,595	30,286
Interest Receivable	1,164	117	149	32	987	1,284	297	1,450
Depreciation	(15,965)	(1,330)	(1,330)	0	(13,304)	(13,304)	0	(15,965)
PDC Dividend	(8,831)	(736)	(736)	0	(7,359)	(7,359)	0	(8,831)
Interest Payable	(428)	(31)	(31)	0	(366)	(366)	0	(440)
Net Surplus/(Deficit)	**4,500**	**174**	**448**	**274**	**4,173**	**6,065**	**1,892**	**6,500**



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – January 2008

Executive Summary and Key Performance Indicators

Key Divisional Variances

Medical divisions have remained broadly stable with higher than planned income, but increased bank and agency costs in Medicine A and drugs and consumables costs in Medicine B.

Improvement in bottom line performance for Surgery C and Surgery B. Surgery S broadly stable. Improvement in income position on Surgery C and Surgery B but increased bank and agency costs. Poorer income position on Surgery S but offset by medical pay savings.

Women & Childrens and Anaesthetics & Critical Care improved in month mainly on nursing related pay savings.

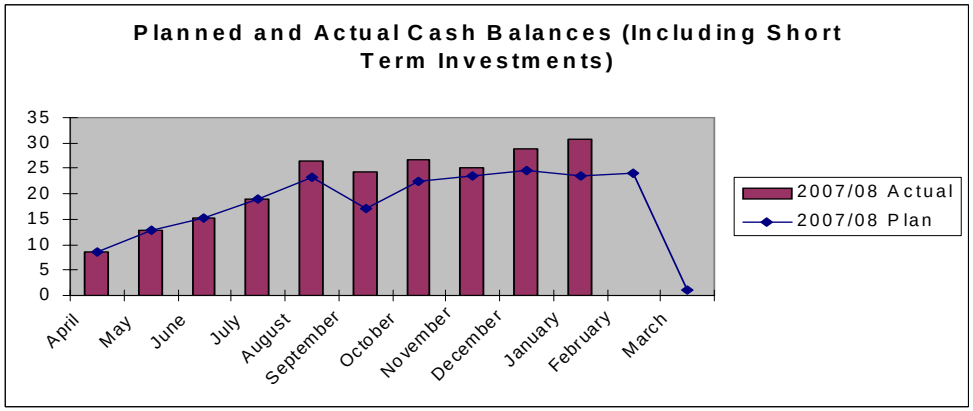
Corporate services continue to generate sizeable surpluses, primarily through holding of vacancies.

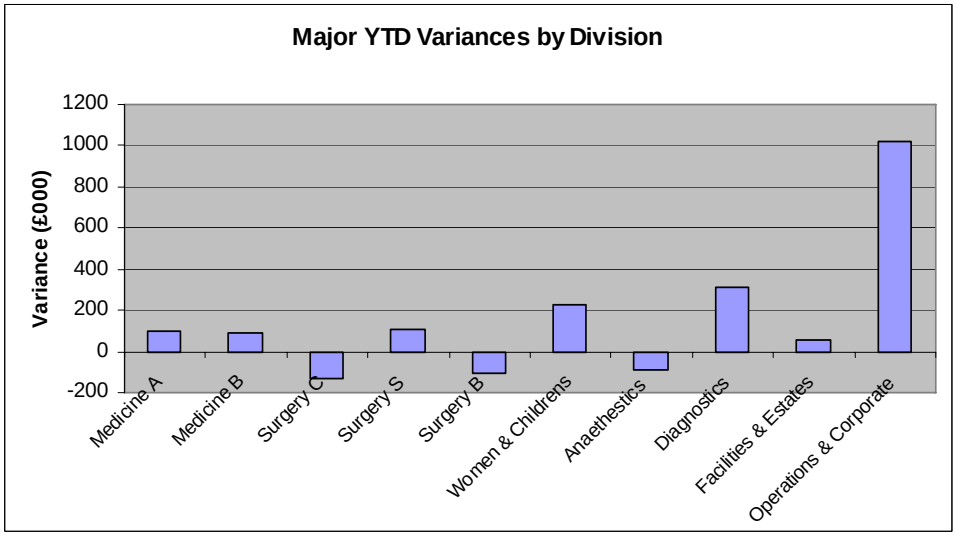
Balance Sheet, Capital and Cash

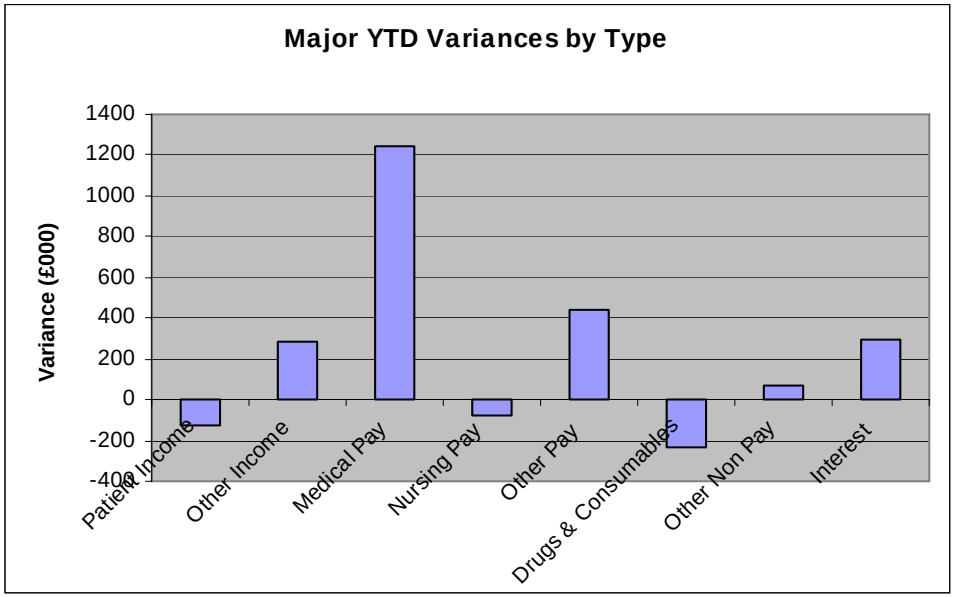
Debtors and accrued income has fallen slightly in month. High level of creditors and accrued expenditure reflects committed expenditure not yet paid.

52% of annual capital programme has been spent with continued progress on larger schemes

Cash and investments slightly higher than planned level at £30.765m.







Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – January 2008

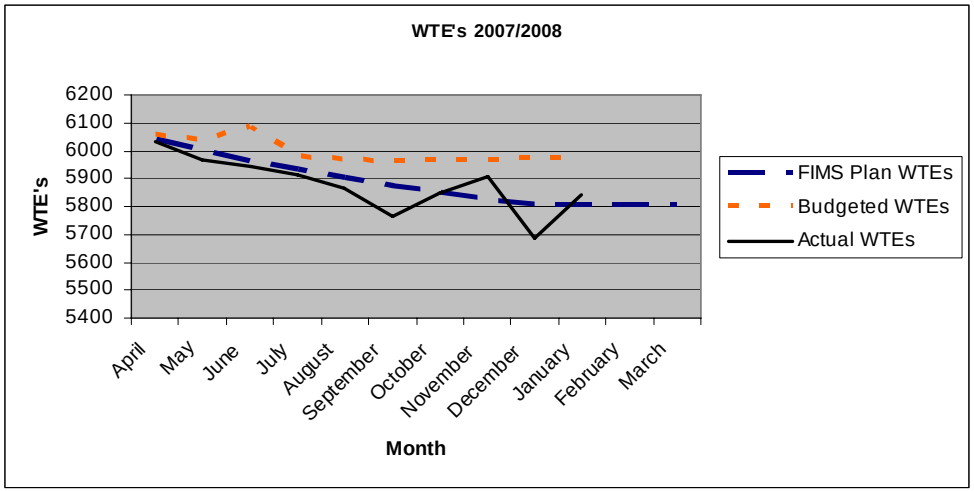
Executive Summary and Key Performance Indicators

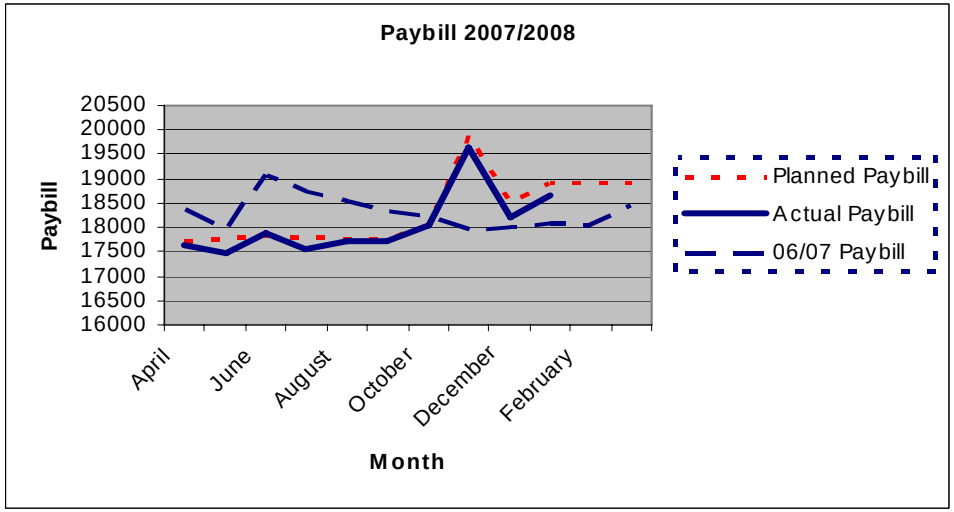
Workforce and Paybill

WTE numbers continue to be below planned levels although with an increase in month in bank staff which have returned closer to pre December levels.

Paybill has continued to be below budget in month although at a lower level than December as a result of the higher bank usage.

Overall ytd pay costs continue to be significantly lower than plan, primarily reflecting lower than planned wte's.





Risk Ratings

Key risk ratings as measured by the Long Term Financial Model are shown in the table below. Each "risk" is weighted and the total translated into an overall risk rating for the Trust which is also used to determine maximum borrowing limits.

The Trust's current strong financial performance and its high cash balances combine to produce a relatively good rating although this will change as the year progresses and cash balances are reduced with compensating movements on debtors and creditors.

Risk Ratings

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	10.1%	4
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	106.6%	5
Return on Assets	Surplus before dividends over average assets employed	5.9%	4
I&E Surplus Margin	I&E Surplus as % of total income	2.1%	4
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	2.8	1
Overall Rating			**3.3**

ENCLOSURE 3a

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD

6th March 2008

SUBJECT:	Complaints Quarterly Report
REPORT BY:	Kam Dhami, Director of Governance Development
AUTHOR:	Debbie Dunn, Head of Complaints and Litigation

PURPOSE OF THE REPORT:

To advise the Board on the handling of complaints received in the October to December 2007 quarter.

IMPLICATIONS:

Financial:	
Personnel:	
Healthcare/ National Policy:	Performance against national standards in the handling of complaints
Other:	

RECOMMENDATION(S):

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

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

OCTOBER TO DECEMBER QUARTERLY REPORT ON THE HANDLING OF COMPLAINTS

Introduction

Key indicators are included in the report, and more detailed information can be provided in response to specific requests.

Demographic information

The recording of demographic information has improved and details of the ages of patients at the centre of the complaints and the ethnic background of the complainants/patients are shown in Appendix A.

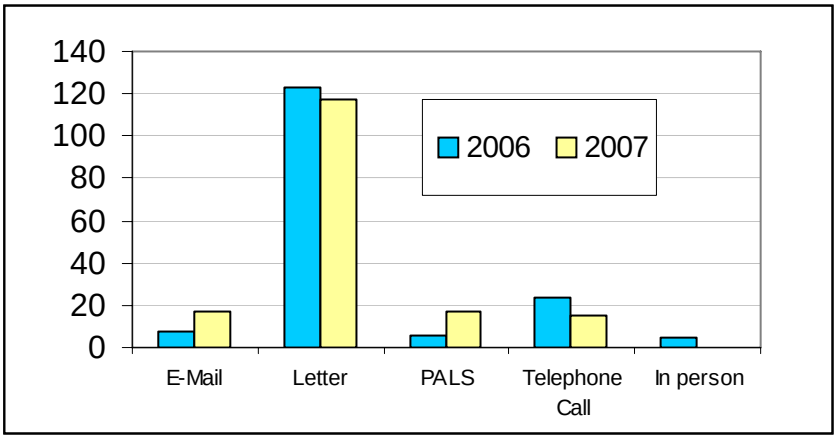
Response times

During October to December 2007, 166 complaints were received, compared with 165 in the previous quarter. The target response time was 25 working days and this was achieved in 81% of complaints, compared with 80% in the previous quarter. In the same quarter in 2006, 167 complaints were received and 78% were completed within the target response time. Monthly comparisons for this quarter are as follows:-

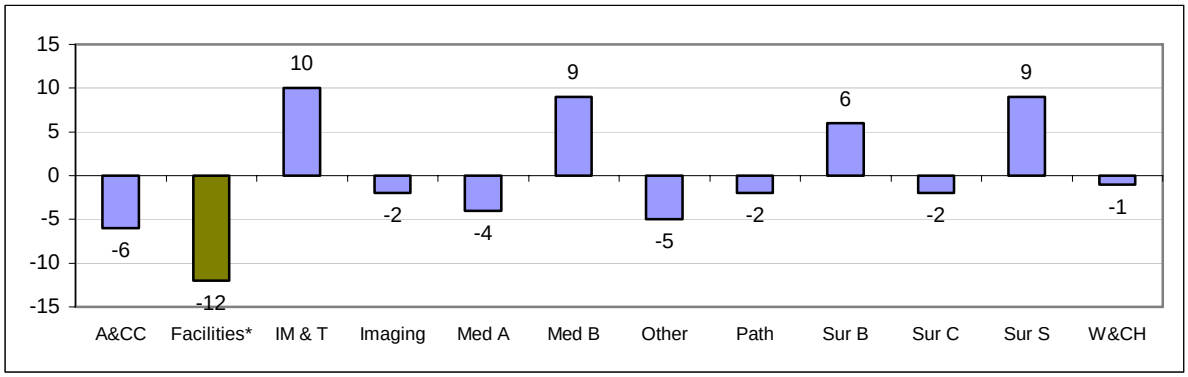
Month	Complaints received	Responses within the target time	Responses within 35 working days	Responses within 60 working days
October	56	75%	79%	86%
November	61	82%	89%	98%
December	49	86%	90%	100%

Details of the response rates from April 2004 onwards are shown in Appendix B, together with a breakdown by site for this quarter.

Patients and relatives can make complaints in a variety of ways and details for this quarter compared with the same quarter in 2006 are as follows:-



The percentage increase or decrease in complaints in the main Divisions /Departments is as follows:-

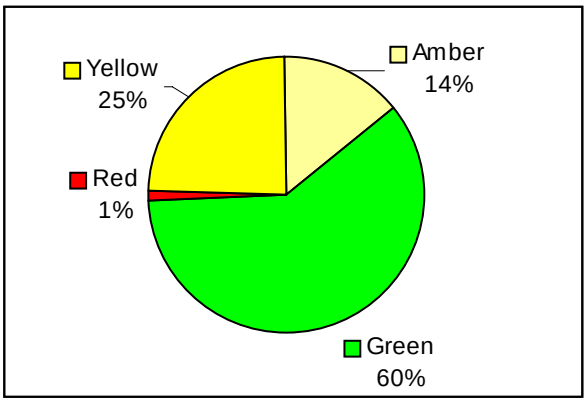


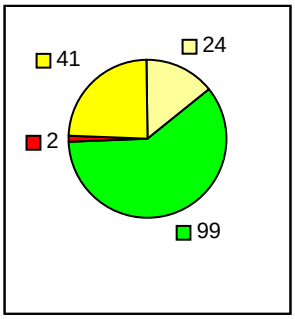
*Note – for the purposes of year-on-year comparisons "Facilities" incorporates all Facilities, Estates and Nursing and Therapies complaints.

Comparisons by Division are as follows:-

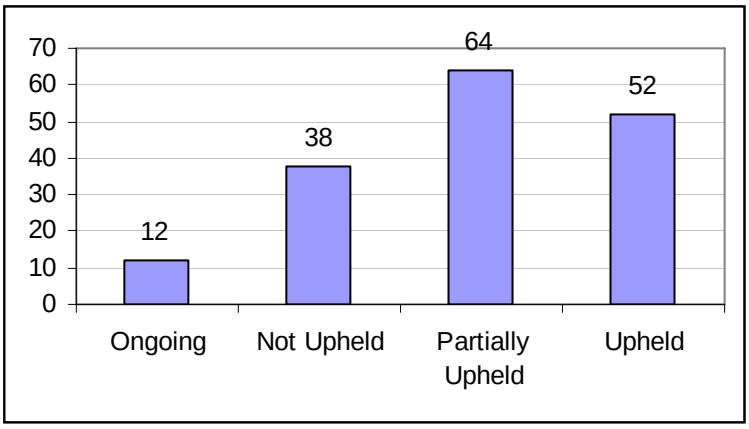
Division	**Number of complaints received and percentage completed within the target time**			
	Jan – March 07	**April – June 07**	**July – Sept 07**	**Oct – Dec 07**
Anaesthetics/Critical Care	2 (100%)	5 (80%)	2 (100%)	2 (100%)
Development/cancer	4 (75%)	1 (100%)	3 (67%)	0
Estates	0	3 (34%)	3 (100%)	0
Facilities	25 (96%)	0	0	0
Facilities/Nursing & Therapies	0	7 (100%)	11 (91%)	3 (100%)
Governance Development	0	1 (100%)	0	0
Finance	1 (100%)	0	0	0
IM&T	2 (100%)	3 (100%)	5 (100%)	15 (100%)
Imaging	1 (100%)	5 (100%)	3 (100%)	3 (100%)
Medicine & Emergency Care A	28 (93%)	26 (85%)	34 (82%)	25 (68%)
Medicine & Emergency Care B	28 (72%)	35 (63%)	34 (56%)	44 (80%)
Operations	4 (100%)	3 (100%)	4 (100%)	1 (100%)
Pathology	2 (100%)	4 (100%)	2 (100%)	3 (100%)
Surgery B	14 (93%)	22 (82%)	18 (95%)	23 (86%)
Surgery C	27 (74%)	18 (83%)	14 (93%)	14 (71%)
Surgery S	20 (85%)	13 (77%)	8 (88%)	15 (86%)
Women/Child Health	16 (88%)	23 (83%)	24 (66%)	18 (66%)

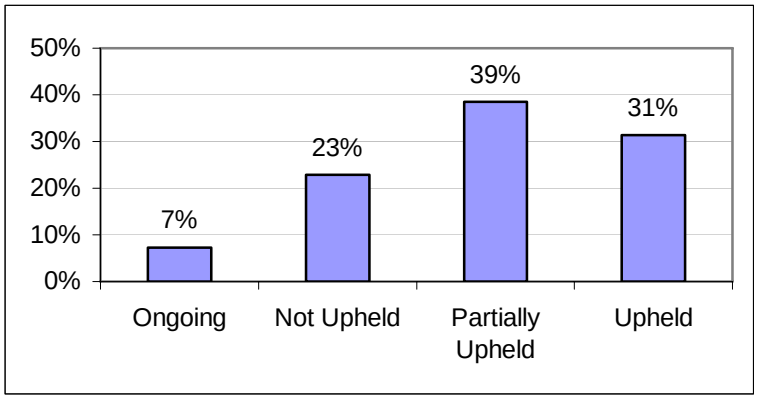
Complaints are graded according to their severity and potential future risk to patients and/or the Trust. The 166 complaints received were graded as follows:-





The outcomes for the 166 complaints are as follows:-





To date, 4% of the complainants remain dissatisfied with the response to their concerns and either a further response has been sent or a meeting has been arranged.

In August 2004 the independent review stage of the complaints procedure was changed, with responsibility for considering independent review requests being undertaken by the Healthcare Commission rather than one of the Trust's Convenors. If they remain dissatisfied after the investigation of their complaint at the local resolution stage of the procedure, complainants now have 6 months within which to contact the Commission and request an independent review. Nationally, the Commission received a number of requests and there had been some delay in allocating case managers to deal with the requests, although this has now improved. To date for this Trust, 134

complaints have been referred to the Commission. For the 134 requests, the outcomes are as follows:-

Investigated by the Commission	2
Commission to take no further action	19
Referred back and further local action completed	95
Referred back and further local action being taken	7
Withdrawn by complainant	4
Response awaited from the Commission	7

NB - the complaints referred to the Commission date back to July 2004 onwards and are not solely for this quarter.

Categories of complaint

The main category of complaint was dissatisfied with clinical care. The details are as follows:-

Category	**January – March 2007**	**April – June 2007**	**July – Sept 07**	**Oct – Dec 07**
Clinical treatment	41%	43%	45%	49%
Delays/cancellations	12%	18%	18%	16%
Communication	6%	8%	6%	6%
Staff attitude	18%	12%	10%	9%
Hotel services/food*	10%	4%	4%	2%

Details are shown in Appendix C.

Informal complaints/thank you letters

A number of complaints have been resolved without the need for the formal complaints process. In addition, thank you letters have been received praising the care and commitment of our staff. Details are as follows:-

	January – March 07	**April – June 07**	**July – Sept 07**	**Oct – Dec 07**
Informal complaints	47	55	20	28
Thank you letters	1069	1099	800	515

Issues/themes arising from complaints

The complaints received cover a wide range of issues and are spread over many wards/departments. Following investigation, the complaints are reviewed to identify any required action. Examples of actions arising from upheld complaints are as follows:-

- A&E staff to be reminded of the appropriate use of red patient identification wrist bands

- Option appraisal to be undertaken for the relocation of the Early Pregnancy Assessment Unit

- Patient referred to a different consultant for a second opinion

- Appointment times changed in Anticoagulant Clinic from every 10 minutes to every 15 minutes

- Self medication policy to be introduced at Rowley Regis Hospital

- General issues of record keeping, staff attitude and communication raised at ward meeting

Quarterly reports are also submitted to the Divisional Governance Groups to ensure that the issues arising from complaints are considered in conjunction with other indicators such as clinical and non-clinical risks.

Conclusions

- Response rates have remained stable, with a minimum of 80% being achieved in each of the last four quarters

- The Chief Executive and Director of Governance are now notified of every complaint that does not go out on time, the reason for the delay and any necessary action to expedite the response

- Discussions are being held with the Divisions with the lower response rates, to identify any problem areas and where improvements could be made

- Divisions/Departments will be reminded of the reporting arrangements for informal complaints and thank you letters, to ensure that they are adequately recorded

- Dissatisfied with clinical treatment remains the main category of complaint

- The number of complaints referred to the Healthcare Commission has reduced and there are currently 7 complaints being considered by the Commission, compared with 24 one year ago

Recommendation

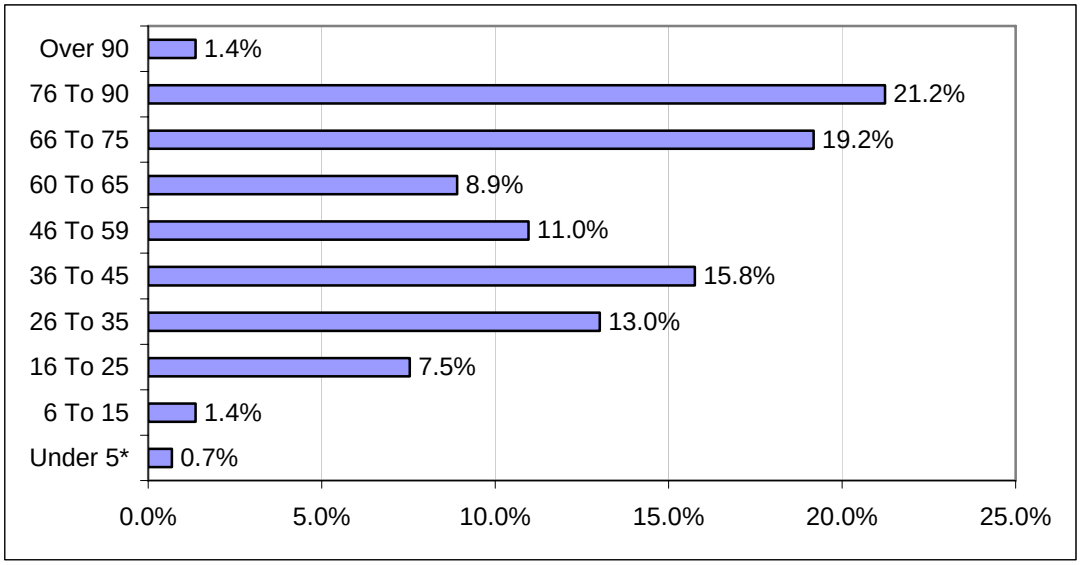
The Board is recommended to NOTE the report

APPENDIX A

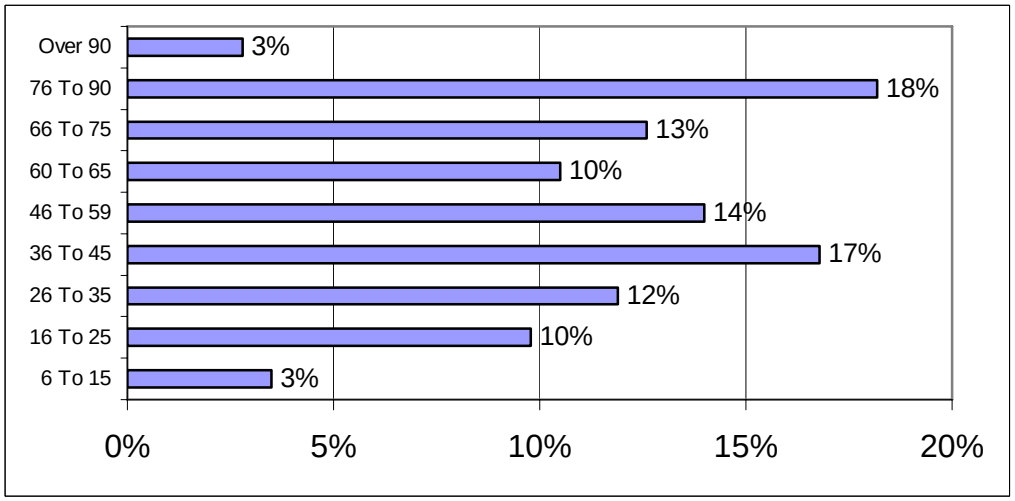
DEMOGRAPHIC INFORMATION

Age classification of patients at subject of complaint

Quarter 2 2007/08



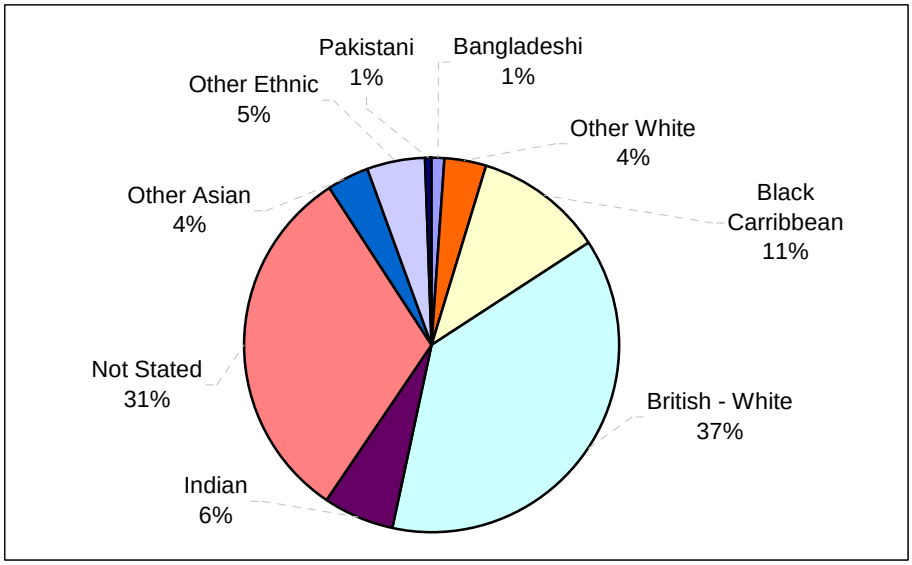
Quarter 3 2007/08



Note – percentages figures reflect known data only. “Under 5” figures may be under-represented, as maternity complaint data will usually relate to age of mother.

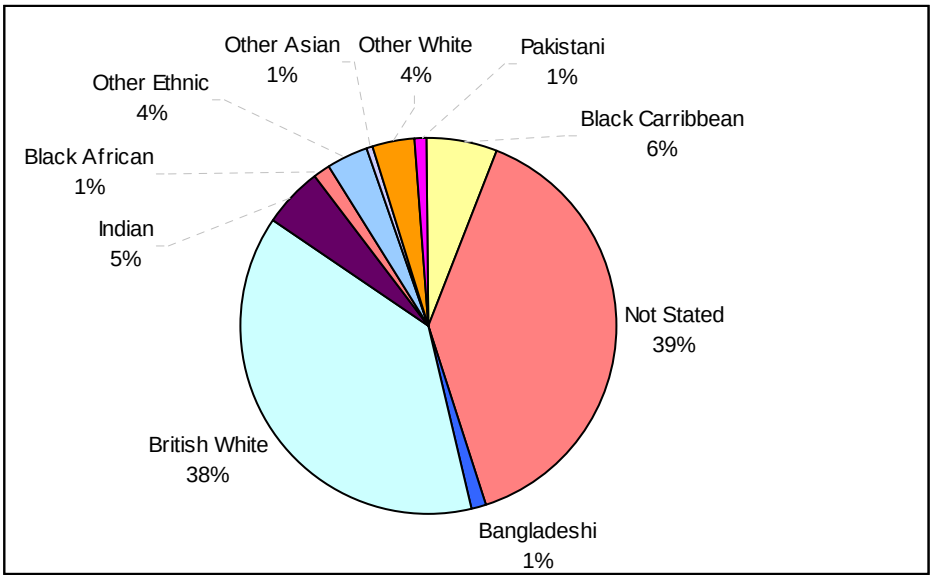
Ethnic classification of patients at subject of complaint

Quarter 2 2007/08



Note - Category “Black African” (0 complaints) has been replaced this quarter with “Other White” for display purposes. The graph should be treated with caution and only as a general approximation of the ethnicity of complainants. In particular, not all complaints relate directly to patients and thus the higher “not stated” figure may disguise the overall ethnicity findings.

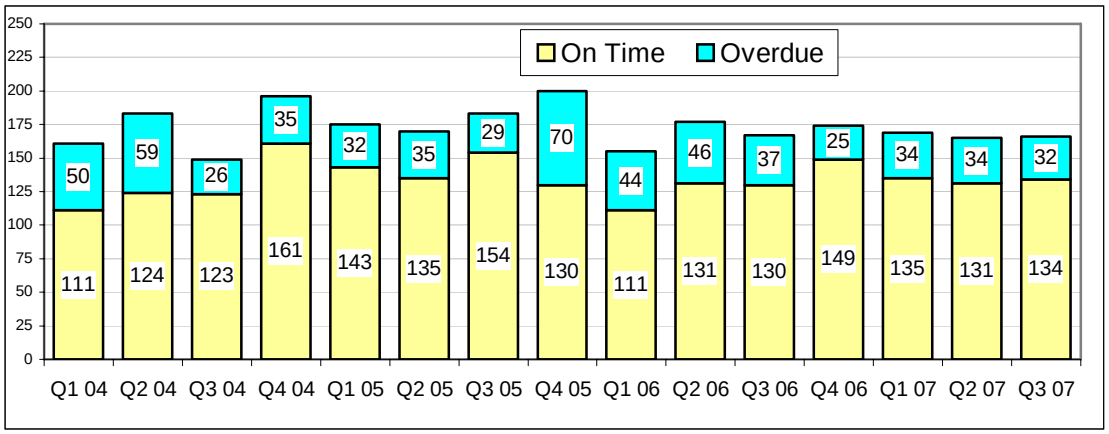
Quarter 3 2007/08

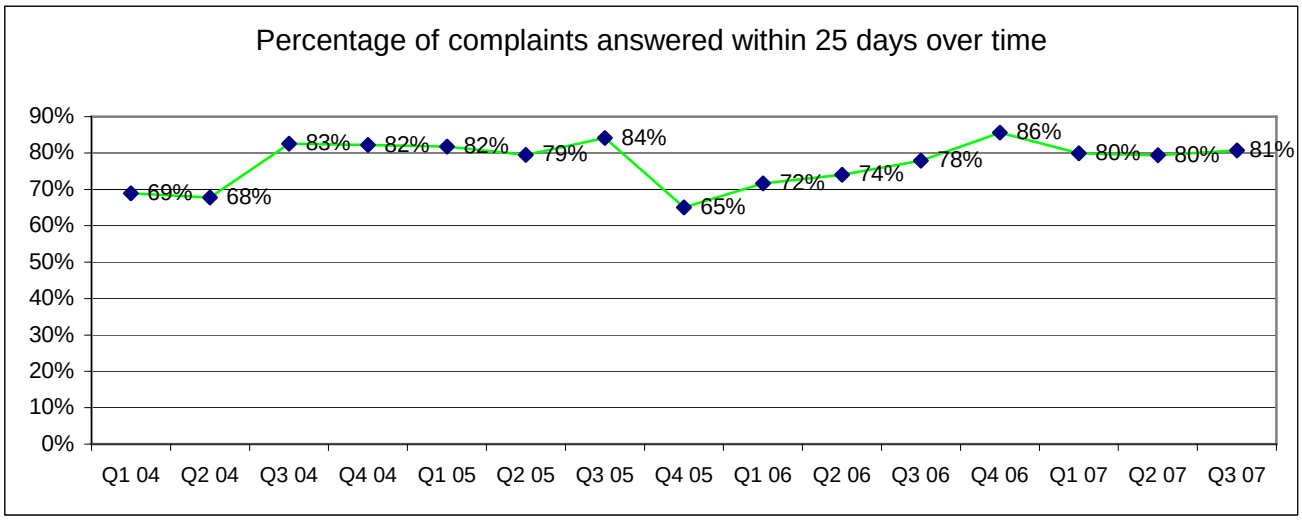


The graph should be treated with caution and only as a general approximation of the ethnicity of complainants. In particular, not all complaints relate directly to patients and thus the high “not stated” figure may disguise the overall ethnicity findings.

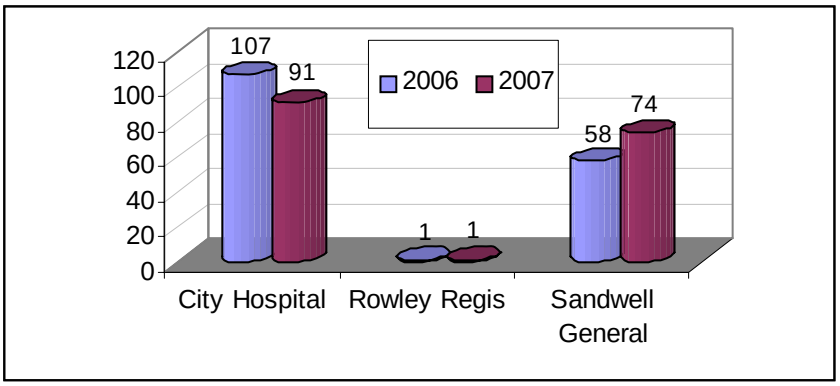
APPENDIX B

Complaints response rates July 2004 –December 2007





Site comparison for the October to December quarter in 2006/07 and 2007/08



APPENDIX C

LEAD COMPLAINT CATEGORIES (5 or more complaints)

Lead Complaint Categories	Jan – March 07	April – June 07	July – Sept 07	Oct – Dec 07
Attitude Of Staff (A.&C.)	5	0	1	1
Attitude Of Staff Medical	9	7	5	4
Attitude Of Staff Nursing	14	8	6	10
Breakdown In Communication	11	14	11	8
Cancelled App/oper/treatment	4	13	7	3
Car Park	8	3	2	1
Choose and book problems	*	1	1	11
Discharge Arrangements	4	5	7	4
Dissatisfied With Nursing Care	11	15	30	36
Dissatisfied With Treatment	39	41	34	37
Failure/delay In Diagnosis	6	7	8	9
Lack Of Care	14	13	0	0
Long Wait For Op/treat/bed	1	1	2	5
Long wait for results	9	1	0	0
Long Wait In Clinic	4	3	6	8
Out-Patient Appointments	2	1	5	0

ENCLOSURE 3b

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE PUBLIC TRUST BOARD

6th March 2008

Subject:	PALS Report (Quarter 3 – 1st October – 31st December)
Report by:	Rachel Stevens, Chief Nurse
Author:	Pauline Richards, Head of PALS

PURPOSE OF THE REPORT:

To inform the Trust Board of PALS Activity and progress throughout the Trust

IMPLICATIONS:

Financial:	
Personnel:	
Healthcare/National Policy:	Performance against PALS National Core Standards.
Other:	

RECOMMENDATION(S):

It is recommended that the Trust Board:

- Accept this report for information, and
- Ensures that the information will assist with the decision-making process with regards to service improvement and
- Ensures Director level support in progressing the concerns experienced by patients and visitors.

PATIENT ADVICE AND LIAISON SERVICE
TRUST BOARD REPORT

1.0 INTRODUCTION

During this quarter the Patient Support Centre [PSC] have continued to made great stride in providing health related information and advice whilst addressing the concerns of our service users. The team members working generically in the provision of a comprehensive one-stop service to our local patient population and continue to engage with staff across the organisation to assist in improving the patient/service user experience.

This report provides the Trust Board with information on PALS activity and trend analysis, across the sites within SWBH for the period 01/10/07 – 31/12/07. It highlights examples of service changes and identifies continuing areas of concerns.

2.0 HEALTH INFORMATION

The Health Information facility within the Patient Support Centre located in the Birmingham Treatment Centre [BTC] continues to be developed and is being accessed by patients, visitors and healthcare professionals alike, in its provision of free health related information, support groups and health workshops. Information is accessible in hard copy, intranet, internet, and by post.

During this quarter, the centre has provided a wide range of health related information, with the top 6 most accessed information being;

- Respiratory [**2797**]
- Arthritis [**1650**]
- Heart [**601**]
- Mental health [**617]**
- Help the Aged [**469**]
- Cancer [**453**]

The Health information service partnership with Health exchange outreach initiative to Rheumatology out patients' clinics every Thursday mornings has provided very positive feedback and a request to increase the service has been received.

The installation of Plasma Screen has been a welcomed addition and has enabled the promotion of self-care courses for Diabetes Type II and Arthritis as well as the health calendar of events within the local community.

The Kiosk is supported by Health Exchange Supporters and during the last three months they have dealt with 622 patients. In addition Health Exchange trainers provide one to one support for stop smoking, healthy eating and exercise.

3.0 VOLUNTEERS

The Trust Volunteers scheme remains an invaluable asset to the organisation and recruitment of volunteers for specific project areas have recommenced. All existing volunteers are being supported from the PSC with every effort being made to ensure retention remains high.

Area specific volunteers such as those working predominantly within PALS continue to spend time wards and departments befriending patients and assisting staff to meet the needs of patients in a supportive and individual manner.

4.0 PATIENT EXPERIENCE

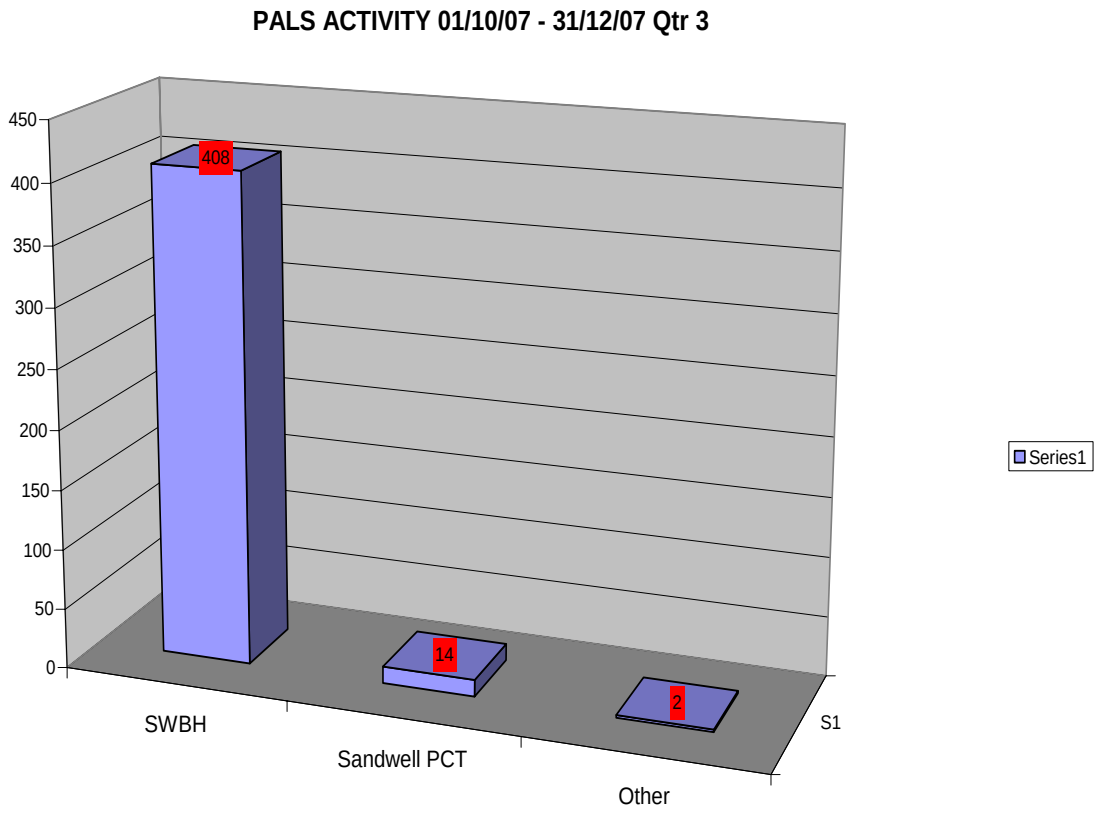
Generally patients' experiences across the organisation are positive; however PALS have supported patients on a number of issues which impacted on their experiences negatively. Examples of such issues relates to the appointment system, there has been an increased in formal complaints query and advice as a result of patients becoming more and more frustrated with the system and worried with the impact on their clinical health. Many site their loss of pay, day and travel expenses incurred, as avoidable problems, which the trust needs to address.

PALS ensure that Staff across the organisation receives with relevant information pertaining to patients issues in order that they can re addressed and change and development can be implemented as a result.

5.0 PALS ACTIVITY (Oct – October 2007)

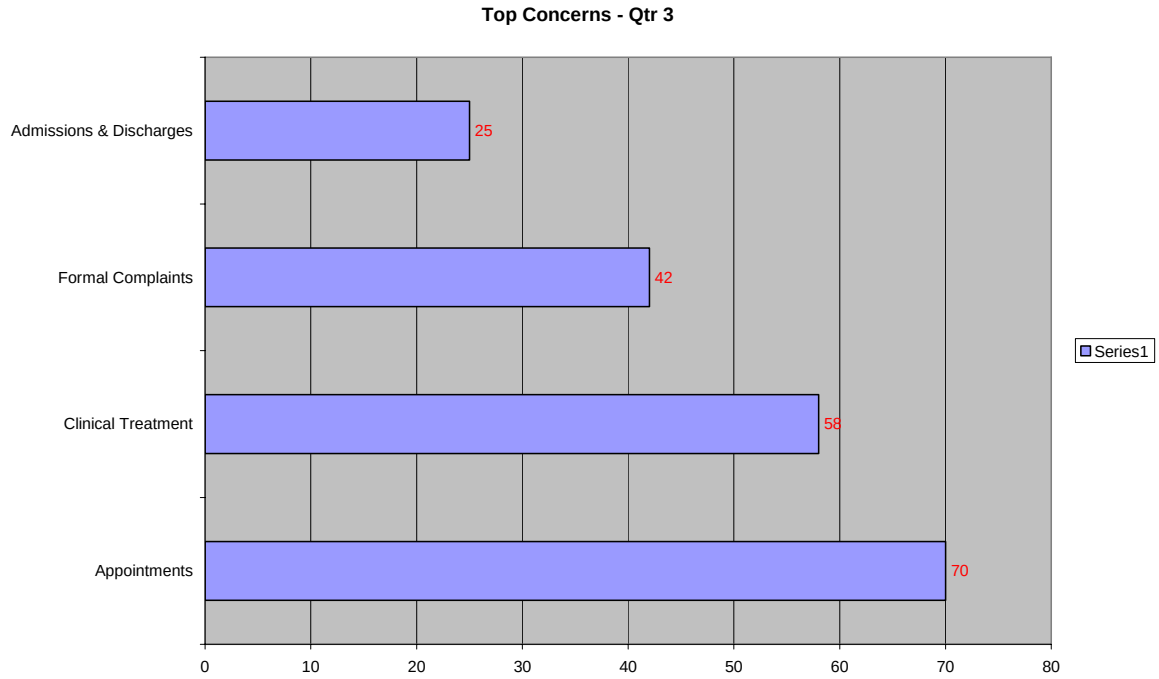
The Trust has received a total of 424 PALS queries in Quarter 3; this figure includes 16 which involved Sandwell PCT and out-of-area organisations.

The graph below outlines the total number of concerns broken down into organisations.



5.1 PALS TRENDS

The table below shows the category which received the highest number of concerns this quarter.



Clinical Treatment – includes issues around as nursing and medical care as well as clinical interventions, investigations and clinical outcomes for patients. PALS is aware that staff in clinical areas is working hard to address issues raised and using the data to improve patient care.

Appointments remain the most frustrating area for patients, as they continue to share their concerns relating to cancellation of appointments, re-scheduling of appointment, notification of appointments and the overall waiting time within the departments/clinics once they have arrived.

Staff and Department heads are notified of this issue and many areas are working to address the issues however, to reduce patients' frustration and negative experiences, more effort is needed by all concerned to find speedy resolutions.

5.2 TOP FIVE CONCERNS

The table below shows the top 5 concerns this quarter against those of the last quarter, in an attempt to demonstrate what progress is any, has been achieved in addressing these concerns for our patient population. There 408 concerns relating to City, Sandwell and Rowley Regis site and the percentage showed below relates to this total figure. It is important to note that there were 123 [29%] general enquires as part of the overall number of concerns dealt with during quarter 3.

Qtr 3 [October – December 2007]	QTR 2 (July – Sept 2007)
Appointments – 17%	**Clinical Treatment - (19.98%)**
Clinical Treatment – 14%	**Appointments - (19.30%)**
Formal Complaints – 10%	**Communication - (7.78%)**
Admission/discharge – 6%	**Attitude of Staff - (6.34%)**
Attitude of Staff – 5%	**Admission/discharge - (4.61%)**

5.3 COMPLIMENTS

PALS received a total of 3 compliments this quarter pertaining to clinical care and staff. All relevant areas have been informed of the compliments.

6.0 CONCLUSION

PALS continue to highlight the on-going concerns with key staff and at relevant meetings, however, it must be noted that to date a number of the issues have remained unresolved. For example the Trust appointment systems need to be revisited with some urgency to ensure that an effective and efficient method is put in place.

PALS therefore would ask the Trust board to recognise these areas as priority and to encourage and support partnership working in achieving resolution of issues. In our current climate of choice it is important that areas of service delivery that continues to adversely impact on patient experiences be given the support and attention needed to improve.

Pauline Richards
Head of PALS

ENCLOSURE 3c

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD

6th March, 2008

Subject:	Understanding the Patient Experience
Report by:	Head of Communications and PPI
Author:	Jessamy Kinghorn

PURPOSE OF THE REPORT:

Inform the Board of work in progress

IMPLICATIONS:

Financial:
Personnel:
Healthcare/
National Policy:
Other:

RECOMMENDATION(S):

1. NOTE the progress made on understanding the patient experience

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

UNDERSTANDING THE PATIENT EXPERIENCE

December 2007

1. INTRODUCTION

This is the fifth paper on Understanding the Patient Experience presented to the Trust Board.

Understanding the experiences patients have of our hospitals is central to providing high quality care. The Healthcare Commission has selected Patient Focus to be one of the seven domains it considers in monitoring standards for better health. With the introduction of patient choice, it is becoming increasingly important for Trusts to seek and respond to patient feedback.

Responding to Our Patients is a long-term strategic objective of the Trust. As part of our work on our strategic direction, we have stated: *We will seek to understand what our patients think about our services. We will seek to ensure services respond to patient needs including the needs of the diverse communities that we serve.*

A Patient Experience Taskforce (PET) has been looking at sources of patient views and the results of patient surveys to focus on areas for improvement. A sub-group of the PET has also met looking at specific areas of the patient experience that are of interest to PPI Forum members (red tray, protected mealtimes, volunteer feeding etc.)

The report on Understanding the Patient Experience is brought to the Board quarterly with the detailed action plan presented bi-annually. This report focuses primarily on work that has been taking place over the last three months.

2. PROGRESS SINCE LAST REPORT

Progress since the last report has been slower than previously as the Communications department's focus has been on preparing and delivering the consultation on NHS Foundation status.

Efforts in the last quarter have focused on attempting to establish the most effective way of gaining patient feedback. The table on the next page outlines the pros and cons that were found when each of the methods listed were tried for inpatient and outpatient surveys during the last quarter. The Head of Communications and Assistant Director of Nursing with responsibility for Patient Experience are planning a meeting to discuss the way forward.

Method	Pros	Cons
Issuing surveys while patients are in hospital and asking them to post them to an independent free-post address	- Independent so patients more responsive - Takes little time to hand out and can be carried out by various staff including ward staff - Received a discount on printing and have a number still in stock	- Relies on patients posting the survey once they have left hospital (poor return rate does not provide sufficient results to analyse) - Costly (£1 per survey plus printing and postage)
Ward staff conduct survey	- Patients respond to staff they know - Captures patients on site - Staff can often resolve issues immediately - Can be done as part of everyday job	- Ward staff do not have the time - Patients unwilling to complain while still being treated - Staff do not always agree with the content of the survey which causes delay
Surveying patients at home	- Patients can give overview of whole experience - Less labour intensive	- More costly - Poor response rate (Trust has one of lowest response rates to national surveys which is typical of similar local populations) - Requires ethical approval
Communications staff carrying out the surveys	- Ensures surveys are carried out - Captures patients on site	- Very labour intensive - Patients reluctant to complain - Language or communication barriers that staff are unaware of before they approach the patient - Patients want someone to talk to which results in low response rate for time put in (average of 3 surveys gathered each hour) - Relies on Communications staff being available to visit wards and outpatient areas on each site - Wards refuse entry if timing not convenient - Increases non clinical, non essential traffic on wards

3. PAEDIATRIC & NEONATAL SURVEYS

Agreement is being reached on the content of the inpatient paediatric survey after staff at Sandwell expressed concerns about some of the questions. Further work is being undertaken to carry out the survey and generate a significant enough sample to analyse.

Neonatal and paediatric outpatient surveys have been developed and distributed to the units on both sites.

4. TRAVEL SURVEY

A survey of staff, patients and visitors has been undertaken in the last quarter to find out:

- How staff, patients and visitors travel to hospital
- What their reasons are for using their chosen transport
- What might convince them to use public transport
- How they would access the new hospital at Grove Lane

It has also been used as an opportunity to raise awareness of the Trust's car sharing scheme and frequent visitor parking discounts.

1,070 patients and visitors responded. The staff response was less positive with 6,398 surveys distributed and 822 returned. A draft report has been received and further analysis work is being carried out. Once finalised, the full results will be taken to the acute hospital Project Board and published.

Visitors

As this Trust Board report concerns patient experience, some of the early findings are summarised below but it must be stressed that this is still work in progress. Of the 1,070 surveys returned, there was a mix of responses from visitors, emergency patients, out-patients and in-patients. Initial analysis is shown in the table below.

Figure 1

Site	Visitor Type	Number of Responses	Percentage of Responses
City Hospital	Visitor	162	16.1%
	Emergency Patient	71	7.1%
	In-patient	109	10.8%
	Out-patient	193	19.2%
Sandwell Hospital	Visitor	104	10.3%
	Emergency Patient	81	8.1%
	In-patient	82	8.2%
	Out-patient	204	20.3%
Total		1006	100%

457 postcodes were able to be plotted where the destination was City Hospital and 384 postcodes were able to be plotted where the destination was Sandwell Hospital.

Figure 2: How did you travel to the hospital?
Initial findings

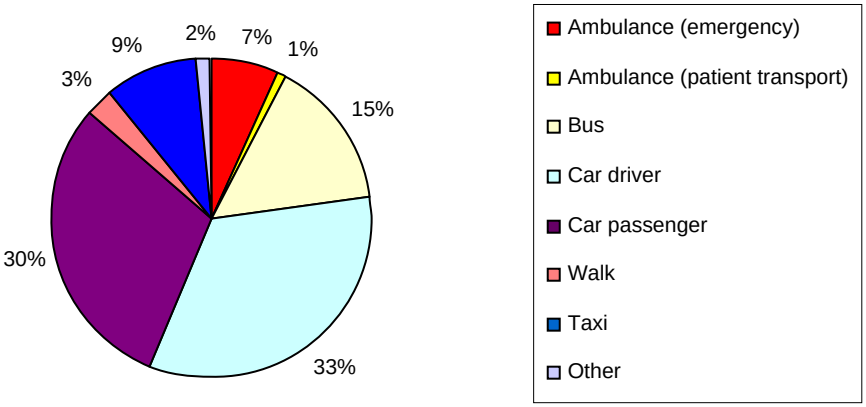
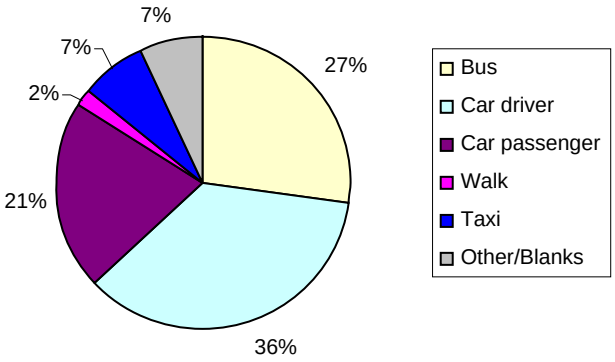


Figure 3: How do you think you would get to the hospital if it were located at Grove Lane?
Initial findings



In terms of what would persuade car drivers to use public transport, walk or cycle, the most popular responses are shown below based upon which site they were visiting.

Figure 4

Site	Reason	% Responses
City	More direct routes	43
	More frequent services	21
	More reliable services	11
Sandwell	More direct routes	51
	More frequent services	17
	More reliable services	11

In relation to car parking, visitors were asked where they parked and if they had difficulty finding a space.

Figure 5

Site	Difficulty Finding a Space?	% Response
City	Yes	18%
	No	46%
	Blank	36%
Sandwell	Yes	24%
	No	45%
	Blank	31%
Combined	Yes	21%
	No	45%
	Blank	34%

Figure 6

Where did you park?	In-patient %	Out-patient %	Emergency Patient %	Visitor %
Disabled parking bay at hospital site	7.9%	9.8%	8%	6.9%
Off site in a nearby car park	1%	2.9%	1.1%	3.5%
Off site in a nearby street	15.8%	19.6%	43.2%	35.1%
On hospital site but not in a designated space	2%	4.1%	1.1%	2.5%
On hospital site in the main barrier controlled car park	73.3%	63.7%	46.6%	52%

5. AUDIT OF DEPARTMENTAL SURVEYS

An audit of surveys being undertaken by individual departments is being carried out throughout March. This will help ensure that all patient views gathered by the Trust are reported centrally and feed into the Patient Experience group.

5. CONSULTATION

A lot of ad hoc patient and public feedback is being gained through the consultation on our plans for NHS Foundation status and the engagement events in relation to the New Hospital planning application. These comments are being collated throughout the consultation process and will be featured in the next report.

6. NATIONAL INPATIENT SURVEY 2007

The Trust has received the initial results of the inpatient survey 2007 and is awaiting the full management report. The final response rate was 49%. Nationally, for 40 Trusts

surveyed by the same company, the response rate varied from 78% to 39%. Several reminders and follow-up surveys are sent out to try and increase the response rate.

The management report will be presented to the Trust Board. It compares the Trust performance against the 40 Trusts surveyed by the same company but will not contain the full results covering every Trust that will be published by the Healthcare Commission.

Improvements made as a result of the recommendations from the Patient Experience Taskforce are unlikely to be shown in this survey as the patient sample was taken from early summer 2007, very early in the development of the Taskforce.

Work will now begin on analysing the data by site, specialty, gender and ethnicity. However, the response rate was quite low (402 inpatients across the whole Trust) so can only be used to indicate areas of strength and weakness not provide a definitive view (MORI recommends a sample size of at least 1,000).

41 respondents declared themselves to be Asian or Asian British, 36 Black or Black British, 1 Chinese, 2 Mixed and 292 White. 30 Patients did not declare their ethnicity.

Over half of patients responding were aged 55-84 with only 10 patients aged 16-24. Categories of less than 20 respondents have no statistical significance so will not feature in the analysis.

The specialties that received the largest response were General Surgery and Trauma and Orthopaedics. There were a number of specialties that did not receive enough responses to analyse.

7. A&E SURVEY

A new national A&E survey is due to take place from April 2008. The list of questions was not available at the time of writing this report. The national survey will be supplemented by an internal Trust survey that will draw on work undertaken by the Patient Experience Taskforce to improve the waiting experience in A&E.

8. PATIENT EXPERIENCE TASKFORCE

The Patient Experience Taskforce has been reviewed following the resignation of a patient member. Plans are being developed to create a broader group chaired by the Chief Nurse to receive patient views but maintain a more operational focus.

PPI Forum representatives have had recent updates on infection control, patient nutrition, waste food and catering, which were being monitored through the Taskforce action plan.

9. RECOMMENDATIONS

The Trust Board is asked to **NOTE** the progress being made.

ENCLOSURE 3d

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE GOVERNANCE BOARD

February 2008

SUBJECT:	Risk report
REPORT BY:	Kam Dhami, Director of Governance
AUTHOR:	Dally Masaun, Head of Health and Safety Ruth Gibson, Head of Risk Management

PURPOSE OF THE REPORT:

To present an update on recent risk activity and an overview of reported incidents for the period October – December 2007.

IMPLICATIONS:

Financial:	
Personnel:	
Healthcare/ National Policy:	
Other:	

RECOMMENDATION(S):

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

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Risk report - Quarter 3 2007-8

1. Executive Summary

This report highlights key risk activity including:

- Proposed improvements to the report format and content
- NHS Litigation Authority assessment pass at level 1 in January 2008 and plans to progress to level 2 during 2008/9
- Updated divisional risk registers to be presented to the March Governance Board
- Analysis of Quarter 3 incident data

2. Introduction

The quarterly risk report has traditionally consisted of an analysis of incident data for the previous quarter (ie Quarter 3). This format has been revised to provide further assurance as to risk activity within the Trust. The report now also includes an update of current and planned risk activity (ie Quarter 4 onwards).

Further, and in line with Integrated Governance and NHS Litigation Authority Risk Management standards, the report will also in future provide integrated data on incidents, complaints and claims. A report presenting the proposed integrated data format will be presented to the March Governance and Risk Management Committee.

3. Key Issues

3.1 Key developments in risk for quarter 4 and 2008/9

3.1.1 NHS Litigation Authority Risk Management Standards (previously called CNST)

General - A successful visit against the new level 1 standards took place in January 2008 and this is planned to be followed by a level 2 visit during 2008/9.
Maternity - An application to take part in the pilot of the new maternity standards during 2008/9 has been made. This would result in an assessment at our current level (ie level 1), which, if successful, could be followed by a level 2 visit later in the year.

A detailed project plan against the general and maternity standards will be presented to the March Governance and Risk Management Committee.

3.1.2 Risk register development

A review of all divisional risk registers is being undertaken, with updates of amber and red risks to be presented at the March Governance Board. This links with work to demonstrate continued assurance for core standard C20a around Health and Safety risk assessments.

3.1.3 Development of a Patient Safety framework with linked objectives

Patient Safety has been specifically included within the 2008/9 Corporate Objectives and forms a major part of key national requirements (ie Standards for Better Health, CNST, National Patient Safety Agency's 7 Steps).

To ensure a co-ordinated approach to patient safety, a framework is being developed to set out and provide a monitoring mechanism for relevant workstreams. The framework is planned to be presented to the March Governance Board, to the March Governance and Risk Management Committee and to the April Trust Board.

3.1.4 Introduction of an web-based reporting system for incidents

Incidents arising within the Trust are currently reported on paper three-part forms. This system causes duplication of effort as forms have to be written by the reporter then inputted manually within Risk. It also can result in delays in reporting as forms need to be checked by various gatekeepers (ie area managers, risk co-ordinators) and forms can go missing.

Reporting via a link on the Trust intranet home page is planned to improve the speed of reporting and escalation of incidents. An electronic form is being developed in conjunction with the database suppliers, Ulysses. This will be trialled within the Risk Department and then within a pilot area before being rolled out across the Trust. The launch is planned for Quarter 1 2008/9.

3.1.5 Feedback to divisions/specialist committees

The Risk Department has recruited 2 new Risk Facilitators, who started in post in January 2008. This will ensure that increased support can be given to divisional and specialist groups. A review of reporting requirements is also being undertaken so that targeted feedback data from the Incident Reporting Database can be provided on a regular basis.

3.2 Review of Quarter 3 Incident Data

3.2.1 Incident data analysis

Detailed comment on issues raised and steps taken, together with relevant data is attached at appendix 1.

3.2.2 Key issues highlighted within the report

- Total incidents: 1461 (1448 in Q3 2006/7), a 1% increase (Graph 1).
- Clinical incidents: 1067 (976 in Q3 2006/7), an increase of 9%.
- Health and Safety incidents: 394 (472 in Q3 2006/7), a decrease of 17%.
- Red incidents: 56 (18 in Q3 2006/7) an increase of 118%. 78 reported to Trust Board in monthly reports
- Most frequently reported incidents: Medical equipment (187), patient accidents (153), admission/discharge/transfer/missing patient (130) compared with Q3 2006/7 patient accident (178), aspects of clinical care (133), admission/discharge/transfer/missing patient (119).

4. Recommendations

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

Appendix 1

Incident Data Analysis

Quarter 3 2007/8

The Trust has established an organisation-wide culture of incident reporting. On receipt of a completed incident form, information is centrally inputted onto Safeguard, an electronic database, against 1 of 28 categories (cause groups). This report is based on data from Safeguard and looks at incident trends from cause groups and associated sub-cause groups.

Key indicators are shown below and more detailed information can be provided in response to specific requests. All amber incidents are investigated and action plans monitored at divisional level. Red incidents are investigated and monitored centrally, with action plans being reviewed at the Adverse Events Committee, chaired by the Chief Executive.

Sections 1-3 set out comment on data and the relevant data is within section 4.

1 Overview of incident data (Graphs 1-2 and Table 1)

The total number of incidents recorded for Quarter 3 2007/08 is 1461 (1448 in Q3 2006/7), a 1% increase (Graph 1). Numbers of reported clinical incidents rose from 976 in Q3 2006/7 to 1067 in Q3 2007/8, an increase of 9%. Increases in reporting can be due to factors such as increased awareness of an issue and does not necessarily represent an increase in risk levels. Numbers of reported health & safety incidents decreased from 472 in Q3 2006/7 to 394 in Q3 2007/8, a decrease of 17%.

Reporting in eleven cause groups increased on Q3 2006/07. In three clinical cause groups this increase was by more than 60% (Blood Transfusion, Equipment-Medical, and Maternity). As only 10 incidents relating to Blood Transfusion were received, all of which were rated as low risk, this increase is not considered to be significant. The increases relating to medical equipment and maternity are considered below in more detail.

2 Risk grades and red incidents (Graphs 3a and 3b and Table 1)

Whilst overall levels of numbers of incidents gives information about patient safety activity, a breakdown by grade (graphs 3a and 3b) indicates whether staff are managing risks proactively. The most desirable trend is for high numbers of yellow/green incidents, with lower numbers of amber incidents and relatively few red incidents.

The overall number of reported red incidents in Q3 2007/8 was 56 (Graph 3a). This is a 211% increase from 18 in Q3 2006/7. The number of reported red incidents as a proportion of the total number of incidents is 0.038%.

The number of red clinical incidents reported on a monthly basis to Trust Board (78 for Q3) and the total in this report do not correlate as not all areas generate incident forms for incidents escalated as red (although these are chased by the risk department).

This is most often the case for ward closures due to Infection Control outbreaks, MRSA bacteraemias and deaths where C difficile is referred to on the death certificate. For example, of 12 bacteraemias during this period forms have only been received to date for 3. Incidents

are still reviewed in the absence of an incident form and areas are reminded of the need to complete incident forms.

3 Analysis of Specific Cause Groups

Patient Accidents are one of the most frequently reported incident types nationally due to the large number of in-patient falls. It is noted that the number of patient falls reported in Q3 2007/8 has slightly dropped (142 to 140) compared to Q3 2006/7 (Graph 4).

Benchmarking against figures produced by the National Patient Safety Agency from the National Reporting and Learing System (NRLS), shows the Trust reports significantly fewer patient falls as a proportion of total incidents. This is in part as a result of a decision taken to ask areas to report only falls resulting in injury.

The most up to date NRLS feedback report covers October 2006-March 2007. 19.6% of the Trust's clinical incidents related to patient accidents, as opposed to 40.7% within the benchmarking group. As a result of this, the previous reporting strategy has been revisited. Whilst there was merit in highlighting incidents resulting in injury, it was considered this may diminish the importance of near-miss falls to staff. To counteract this, the Chief Nurse is ensuring that the launch and embedding of the Patient Falls Policy approved in 2007 highlights reporting of patient falls even where there is no injury to try to bring this figure into line.

The trend for increasing numbers of **missing patients** has continued (graph 5), although the Q3 figure (79) is lower than those for Q1 (99) and Q2 (81). Whilst there has been a drop in total incidents reported under the category of **Aspects of Care** (Graph 6) from 133 in 2006/7 to 109 this year, there has been an increase in reported incidents in relation to providing planned care, which will be fed back to the divisions. There were 5 red and 27 amber incidents, with the remaining 76 falling into the low risk categories.

Graph 7 shows **medication errors**, which have increased from 76 in 2006/7 to 86 in 2007/8. This data has been supplied to the Pharmacy department and will be included as part of required national audits for the National Patient Safety Agency.

Medical Equipment (Graph 8). The increase in incidents relating to the unavailability of equipment around the B Braun change which was reported in Qs 1 and 2 2007/8 has slowed. This has fallen from 115 in Q2 to 38 in Q3. This is more in line with quarters in previous years.

Maternity incidents by area reporting and by trigger list category (Graphs 9a and 9b) are required reports for maternity CNST. Work is underway to ensure maternity incidents by grade of staff reporting are also included, if not reported through other lines. Areas which report lower numbers of incidents are being reminded to ensure incidents are always reported in line with policy as this helps embed an open learning culture. Post partum haemorrhage and shoulder dystocia are well reported and a number of action plans are in place to improve management of these and other obstetric issues.

Moving and Handling (Graph 10) demonstrates improvement of 46% from 39 Q3 2006/07 to 21 Q3 2007/08.

Sharps (Graph 11) A total of 37 sharp injuries were reported under this Health & Safety category (*previous Q3: 46; 24% decrease*). 51% (19) of the incidents should have been avoidable because they occurred during disposal or from discarded sharps. 20% (9) incidents of the total reported in this category are simply about sharp finds (i.e. no injury occurred).

Verbal/Aggression (Graph 12) A total of 104 incidents were reported under this Health & Safety category (*previous Q3: 111; 6% decrease*).

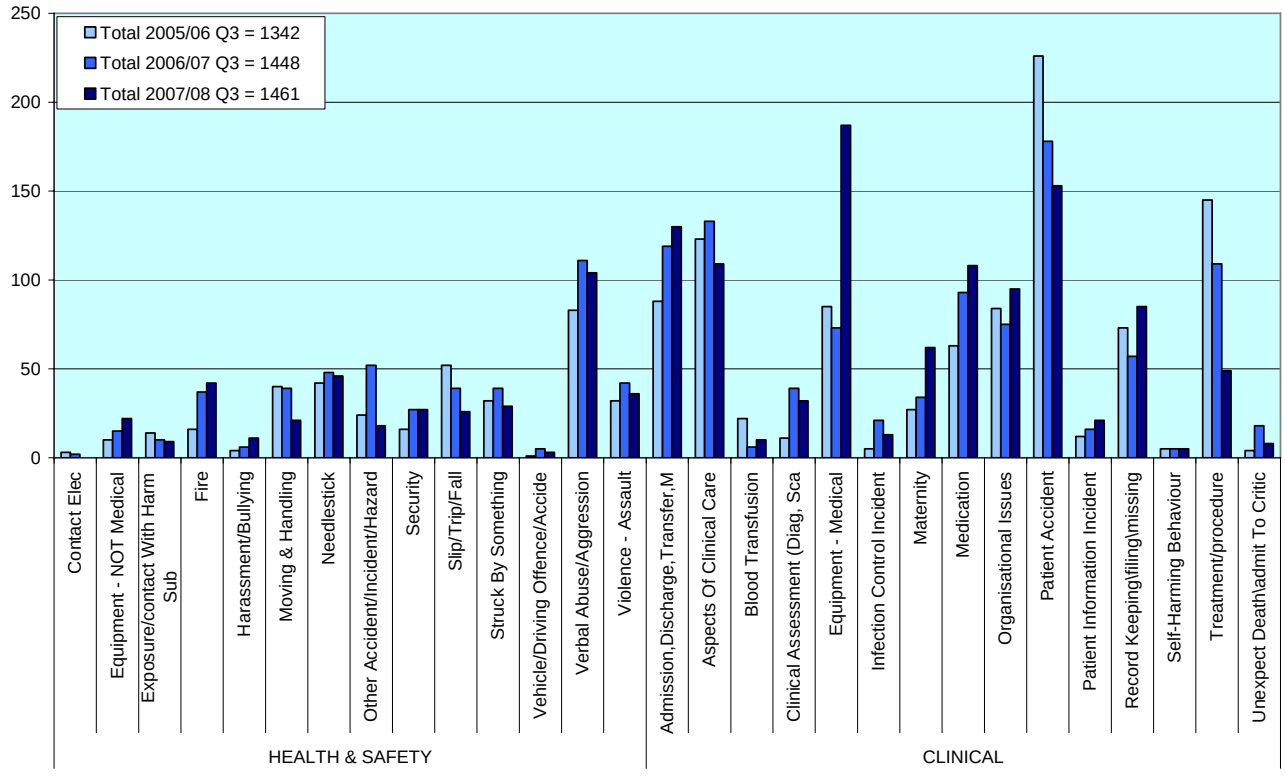
Violence/Assault (Graph 13) A total of 35 incidents were reported under this Health & Safety category (*previous Q3: 42; 20% decrease*).

Security (Graph 14) data has now been cleaned-up. All security activity is now excluded from this category. A total of 27 incidents were reported under this Health & Safety category (*previous Q3: was also 27*).

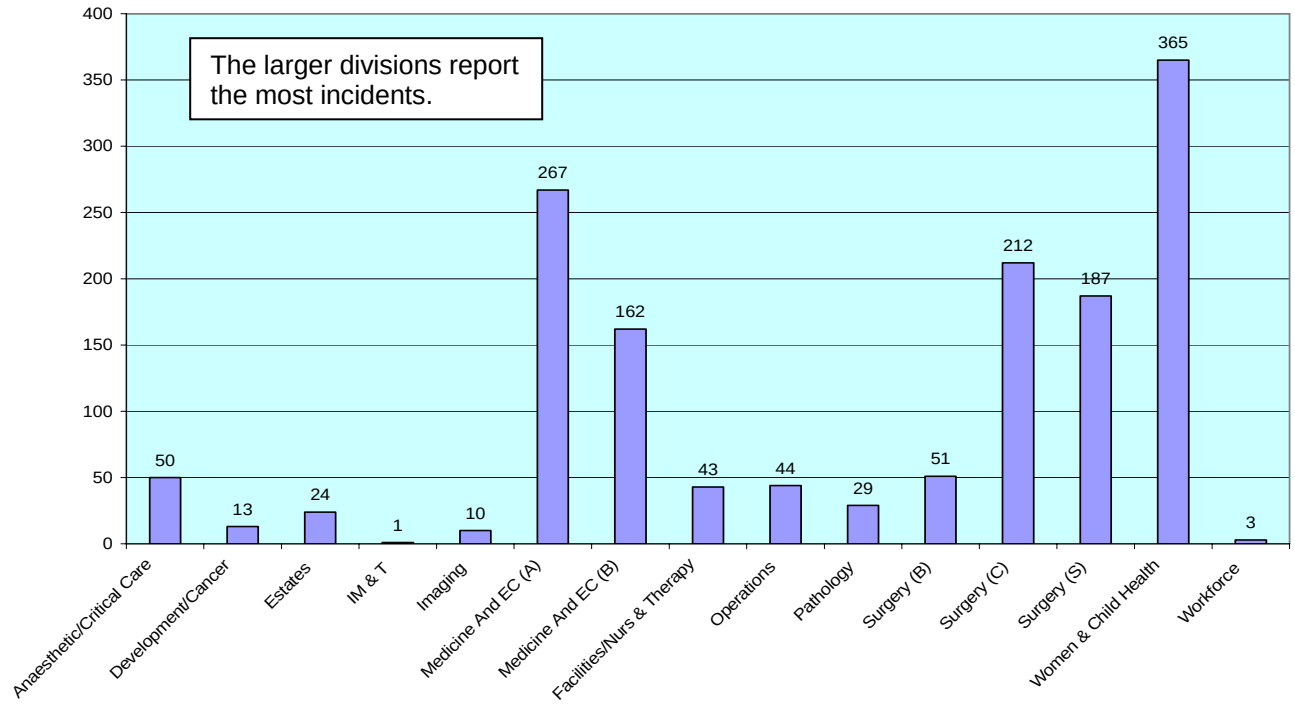
Fire (Graph 15) A total of 42 incidents were reported under this Health & Safety category (*previous Q3: 37; 12% increase*). Six actual fires reported this quarter (increase of 100% on previous quarter) and false alarms continue to be an issue.

4. Performance Monitoring Data

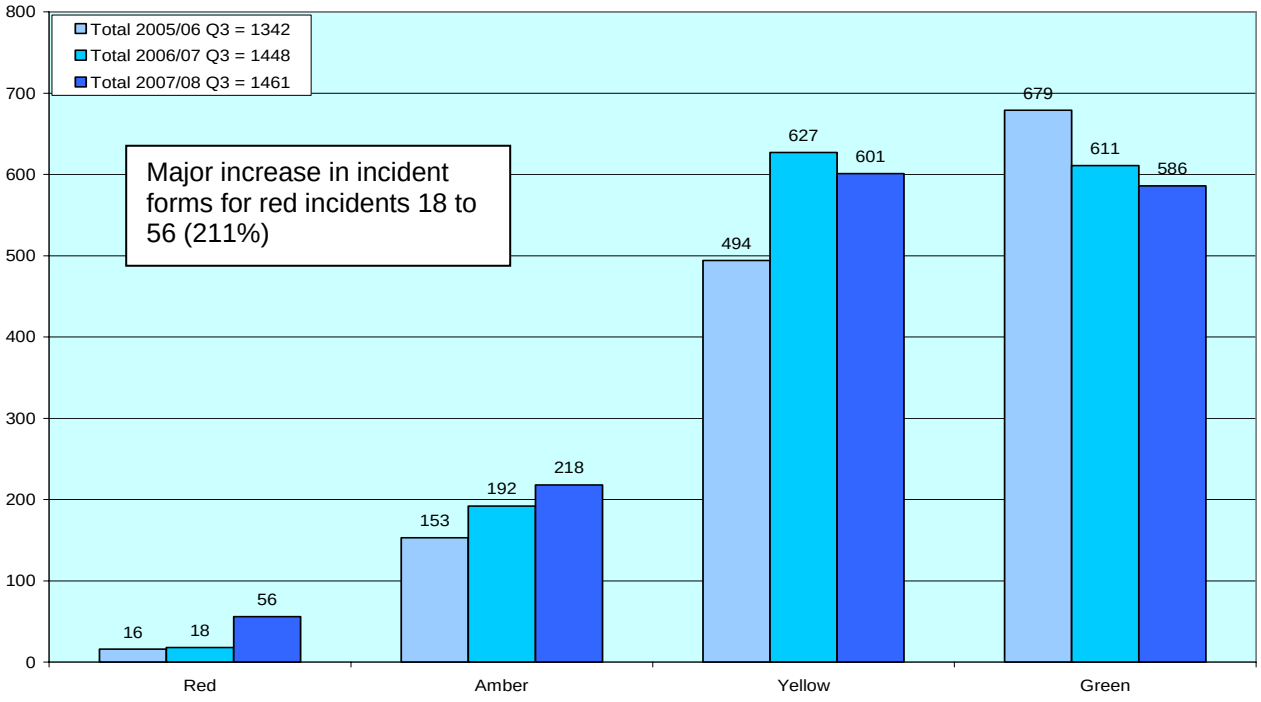
Graph 1: **Incident Trends (Trust) Q3 2005/6 – 2007/8**



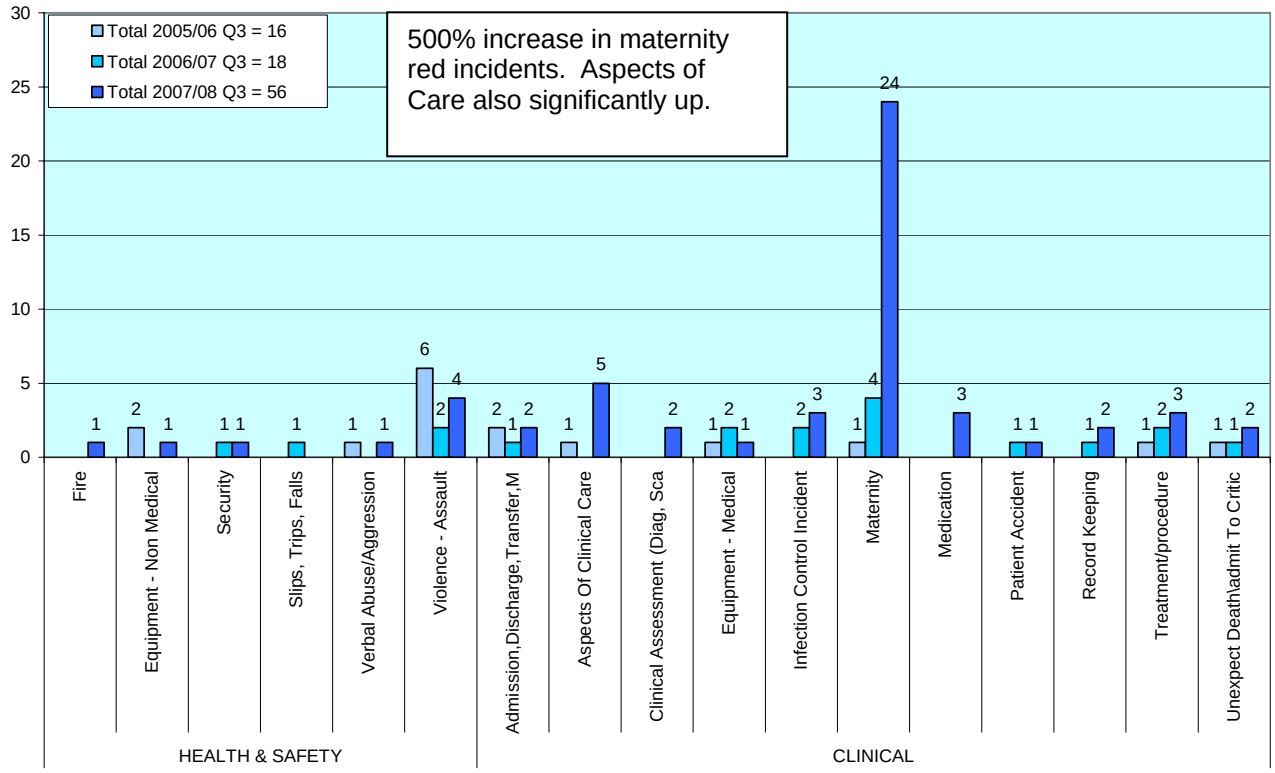
Graph 2: **Incidents by Division Q3 2007/8**



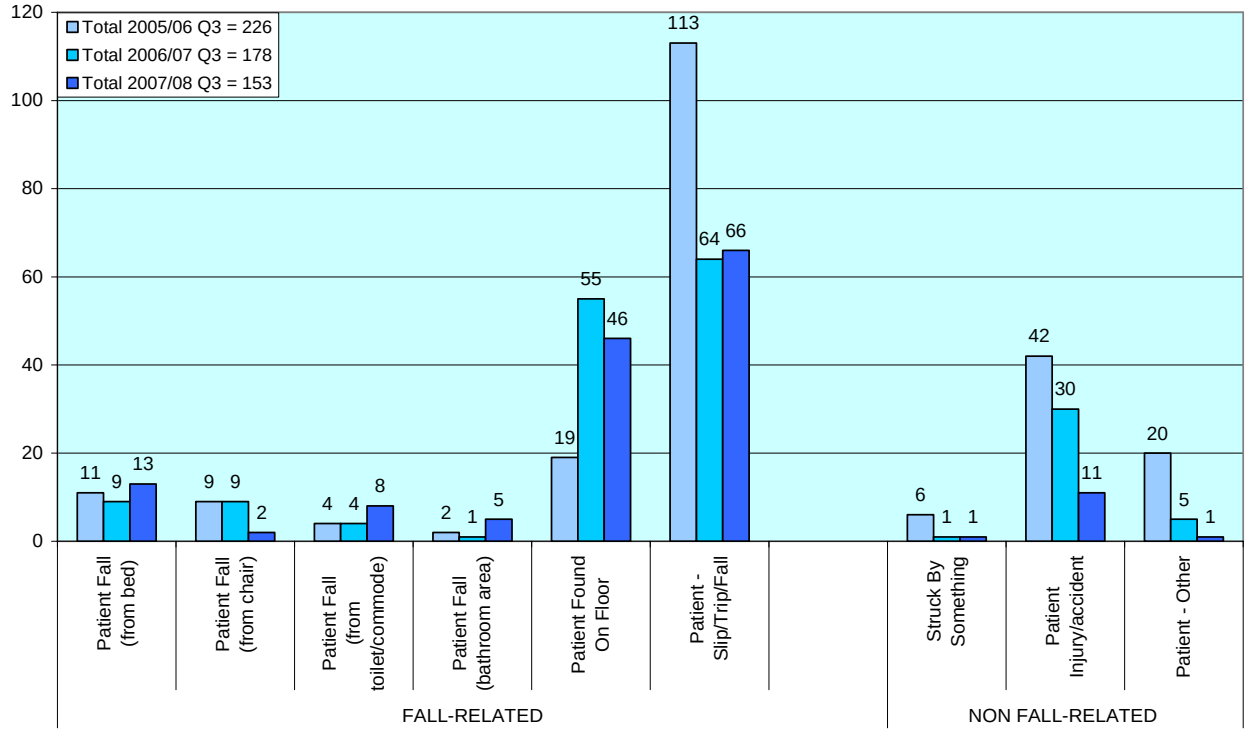
Graph 3a: **Risk Rating Trends Q3 2005/6 – 2007/8**

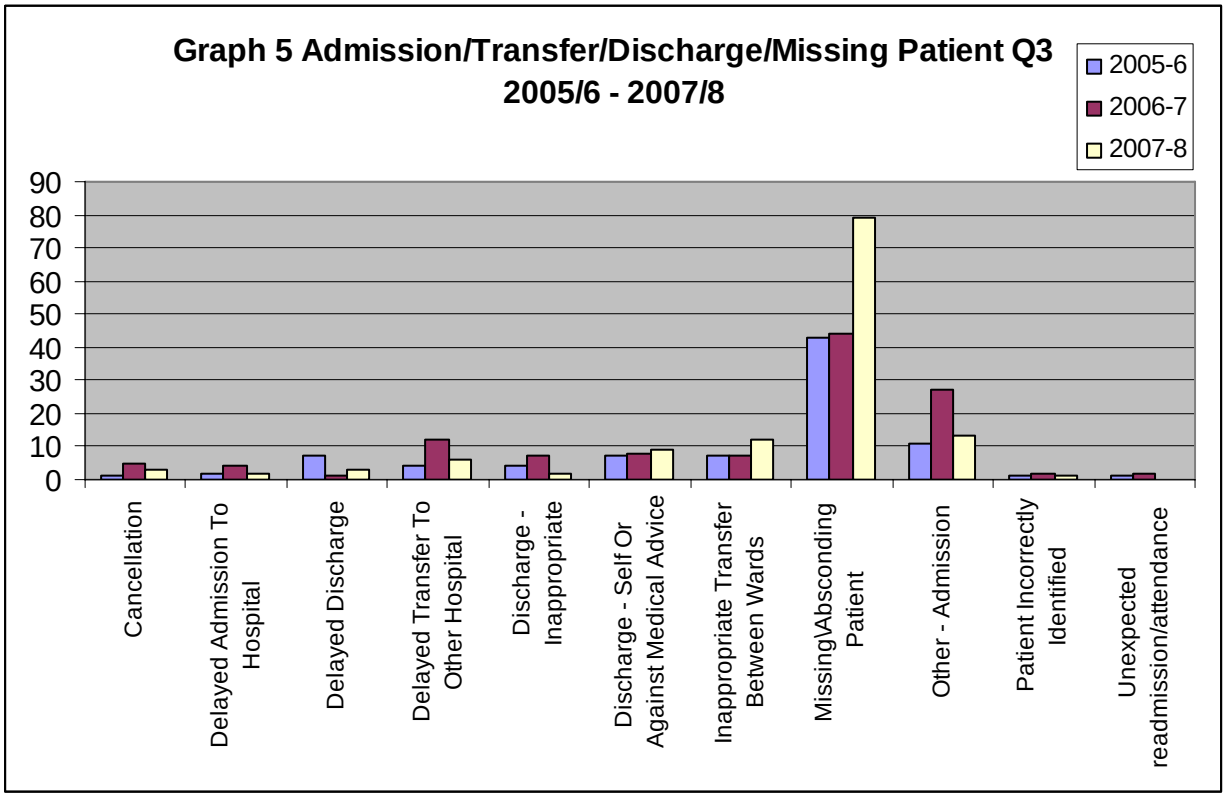


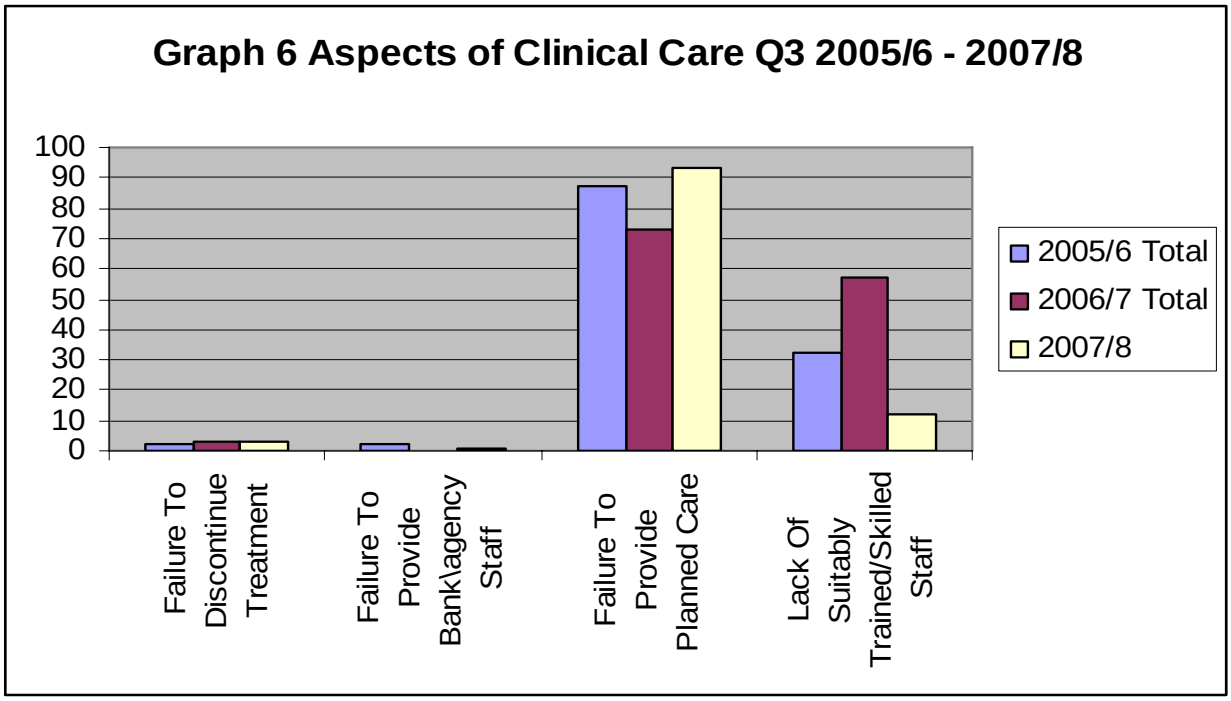
Graph 3b: **Red Incidents by Cause Group Q3 2005/6 – 2007/8**

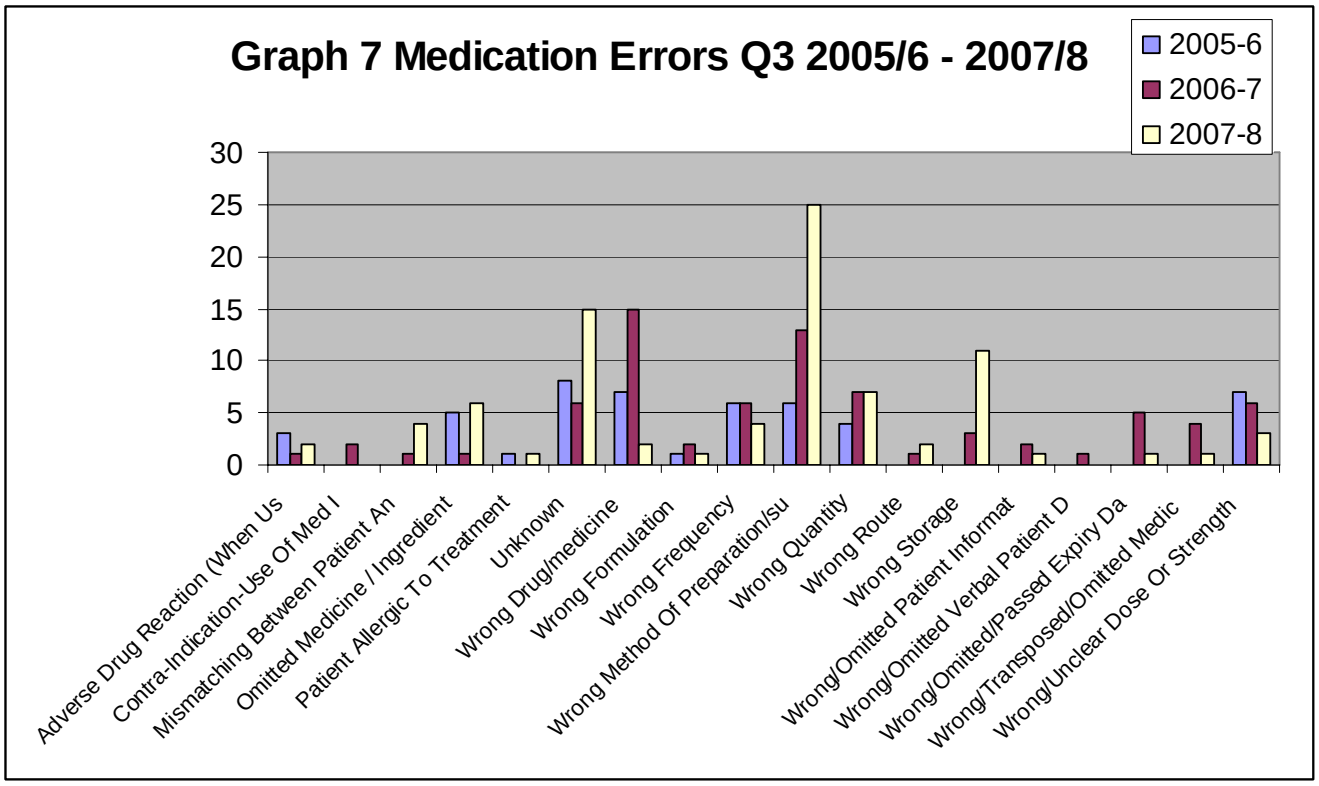


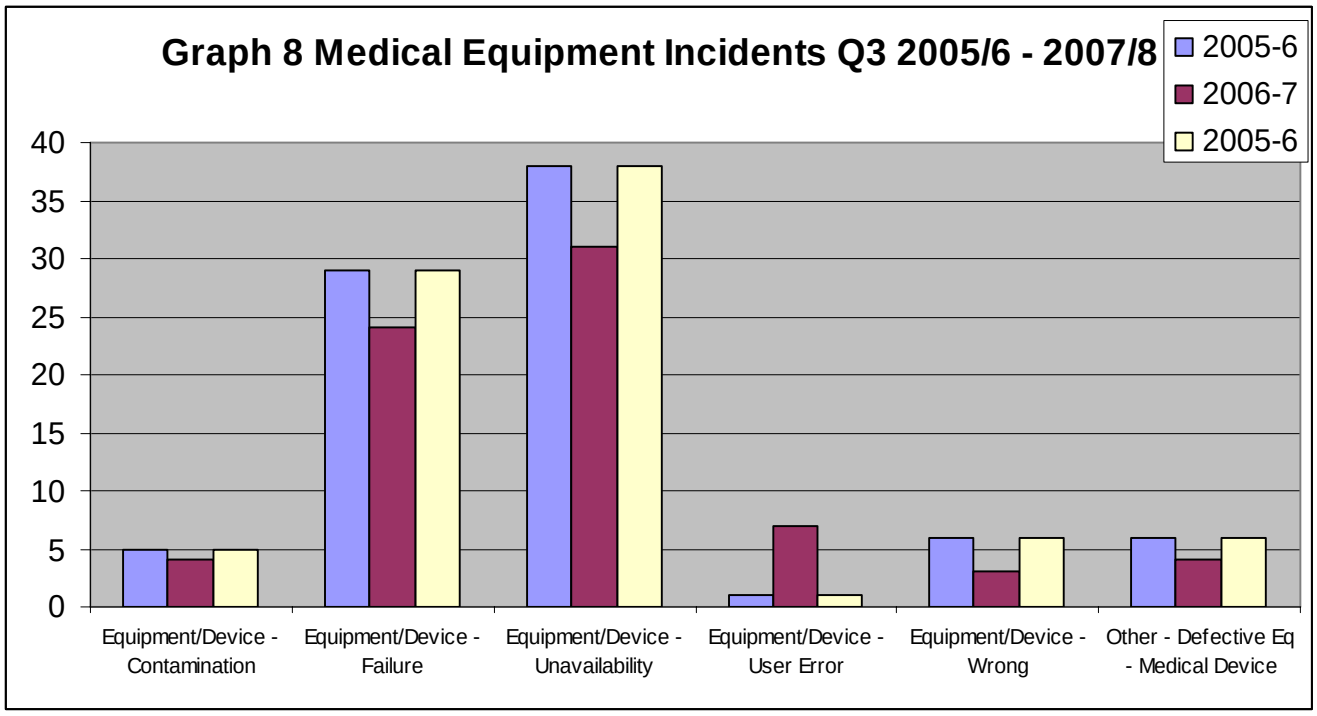
Graph 4: **Patient Accident (Trust) Q3 2005/6 – 2007/8** *(Non-injurious falls are documented in the patient notes and managed locally, rather than reported as incidents).*

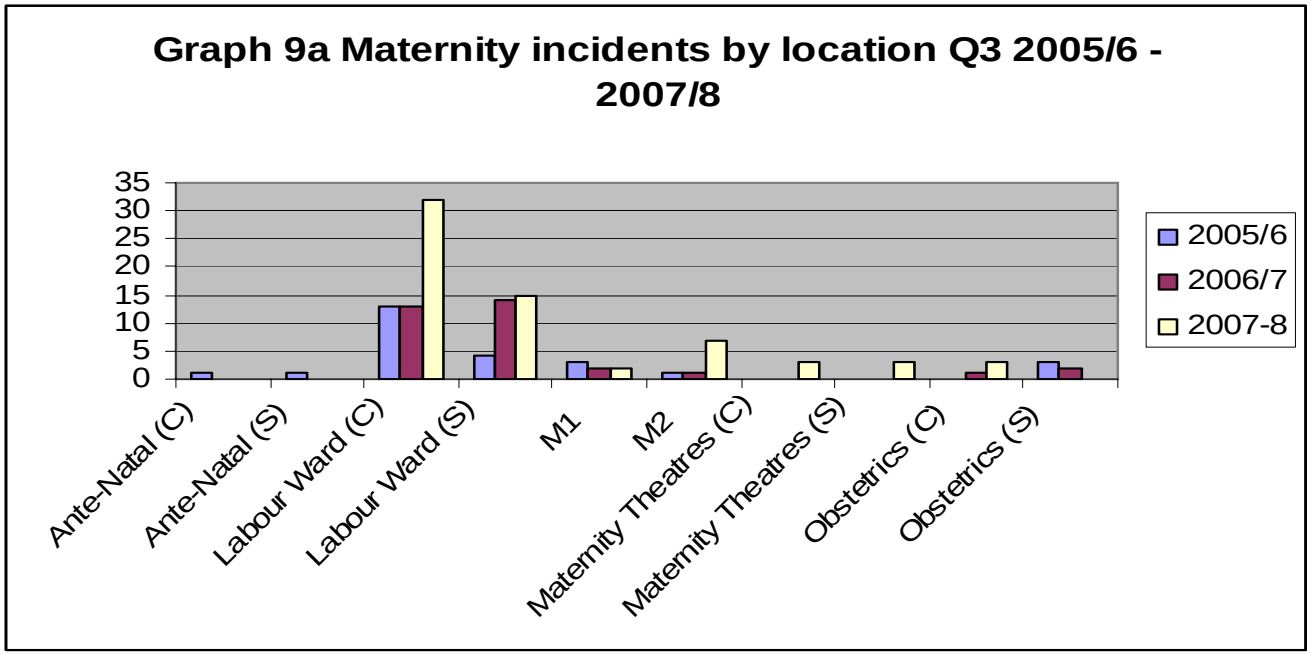


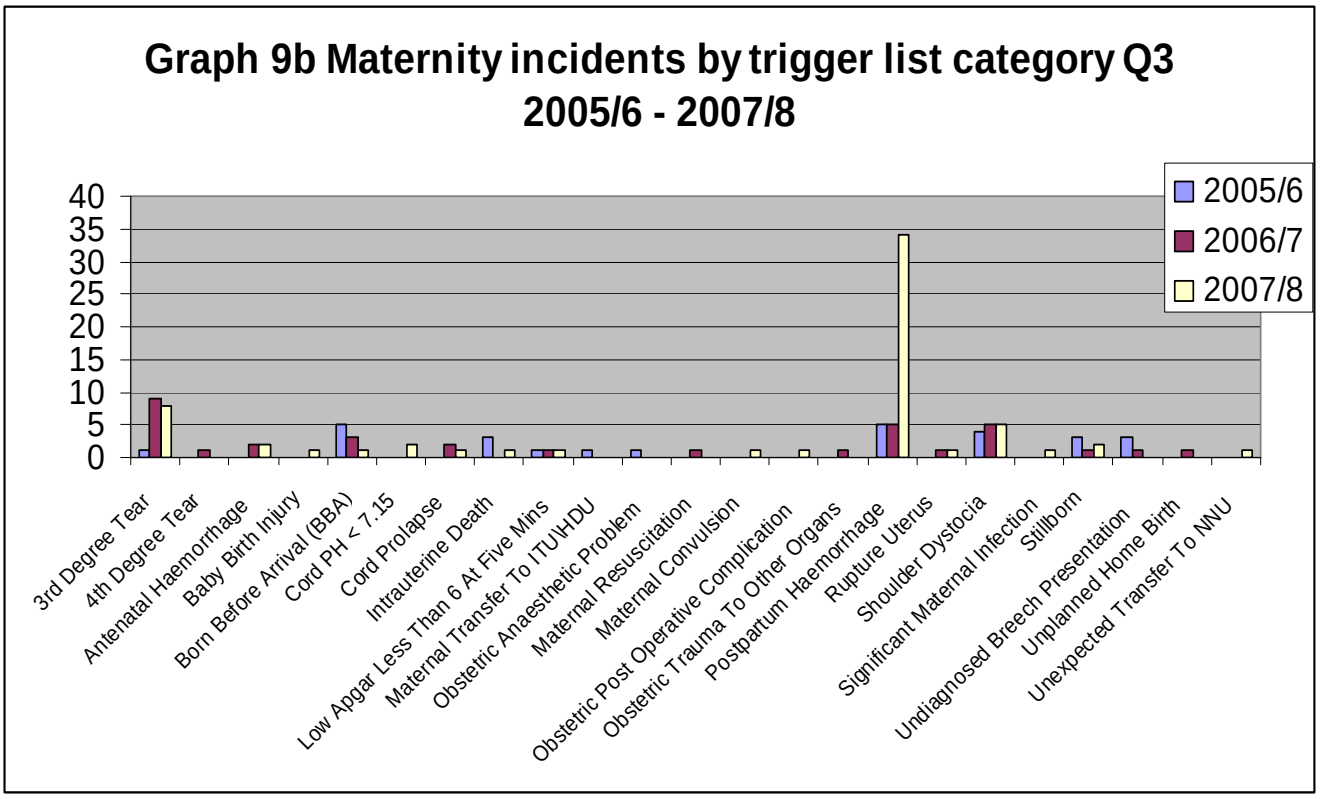

Graph 5 Admission/Transfer/Discharge/Missing Patient Q3 2005/6 - 2007/8
2005-6
2006-7
2007-8
90
80
70
60
50
40
30
20
10
0
Cancellation
Delayed Admission To Hospital
Delayed Discharge
Delayed Transfer To Other Hospital
Discharge - Inappropriate
Discharge - Self Or Against Medical Advice
Inappropriate Transfer Between Wards
Missing\Absconding Patient
Other - Admission
Patient Incorrectly Identified
Unexpected readmission/attendance


Graph 6 Aspects of Clinical Care Q3 2005/6 - 2007/8
100
90
80
70
60
50
40
30
20
10
0
2005/6 Total
2006/7 Total
2007/8
Failure To Discontinue Treatment
Failure To Provide Bank\agency Staff
Failure To Provide Planned Care
Lack Of Suitably Trained/Skilled Staff

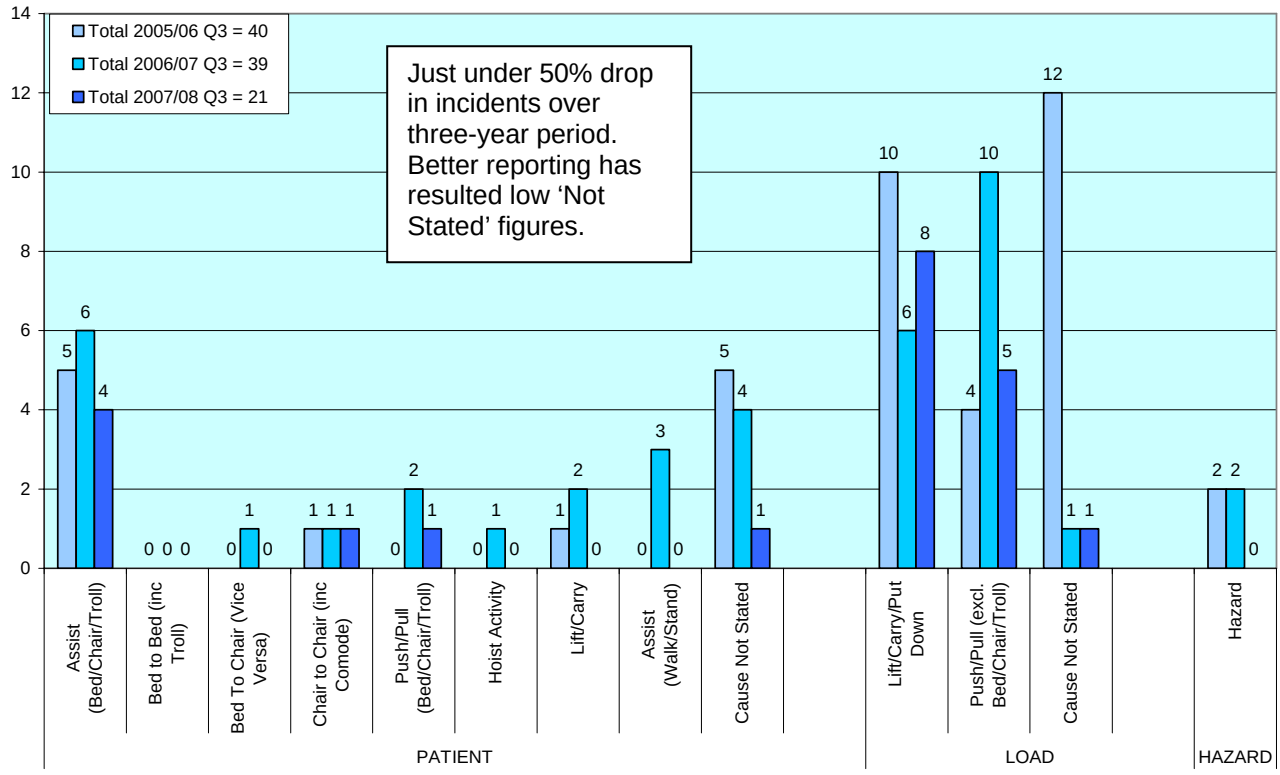

Graph 7 Medication Errors Q3 2005/6 - 2007/8
2005-6
2006-7
2007-8
30
25
20
15
10
5
0
Adverse Drug Reaction (When Us
Contra-Indication-Use Of Med I
Mismatching Between Patient An
Omitted Medicine / Ingredient
Patient Allergic To Treatment
Unknown
Wrong Drug/medicine
Wrong Formulation
Wrong Frequency
Wrong Method Of Preparation/su
Wrong Quantity
Wrong Route
Wrong Storage
Wrong/Omitted Patient Informat
Wrong/Omitted Verbal Patient D
Wrong/Omitted/Passed Expiry Da
Wrong/Transposed/Omitted Medic
Wrong/Unclear Dose Or Strength


Graph 8 Medical Equipment Incidents Q3 2005/6 - 2007/8
2005-6
2006-7
2005-6
40
35
30
25
20
15
10
5
0
Equipment/Device - Contamination
Equipment/Device - Failure
Equipment/Device - Unavailability
Equipment/Device - User Error
Equipment/Device - Wrong
Other - Defective Eq - Medical Device

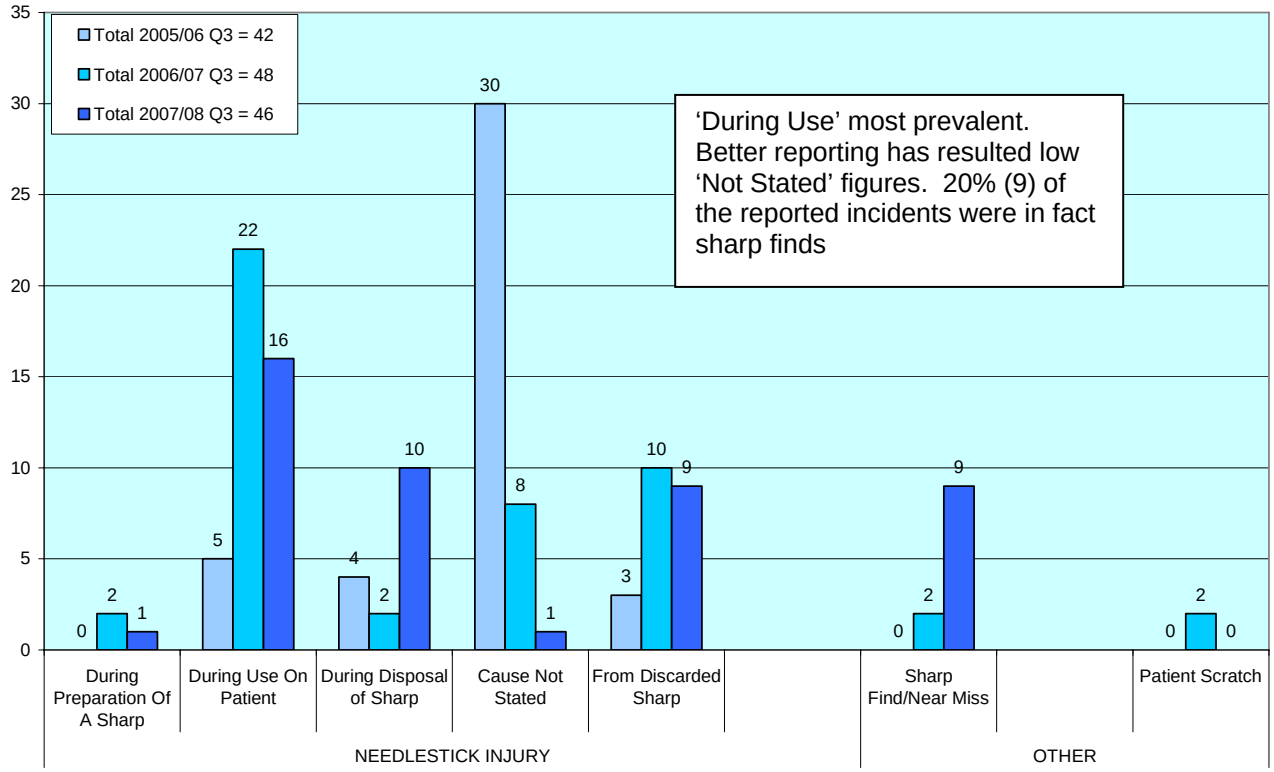

Graph 9a Maternity incidents by location Q3 2005/6 - 2007/8
35
30
25
20
15
10
5
0
2005/6
2006/7
2007-8
Ante-Natal (C)
Ante-Natal (S)
Labour Ward (C)
Labour Ward (S)
M1
M2
Maternity Theatres (C)
Maternity Theatres (S)
Obstetrics (C)
Obstetrics (S)


Graph 9b Maternity incidents by trigger list category Q3 2005/6 - 2007/8
40
35
30
25
20
15
10
5
0
2005/6
2006/7
2007/8
3rd Degree Tear
4th Degree Tear
Antenatal Haemorrhage
Baby Birth Injury
Born Before Arrival (BBA)
Cord PH < 7.15
Cord Prolapse
Intrauterine Death
Low Apgar Less Than 6 At Five Mins
Maternal Transfer To ITU\HDU
Obstetric Anaesthetic Problem
Maternal Resuscitation
Maternal Convulsion
Obstetric Post Operative Complication
Obstetric Trauma To Other Organs
Postpartum Haemorrhage
Rupture Uterus
Shoulder Dystocia
Significant Maternal Infection
Stillborn
Undiagnosed Breech Presentation
Unplanned Home Birth
Unexpected Transfer To NNU

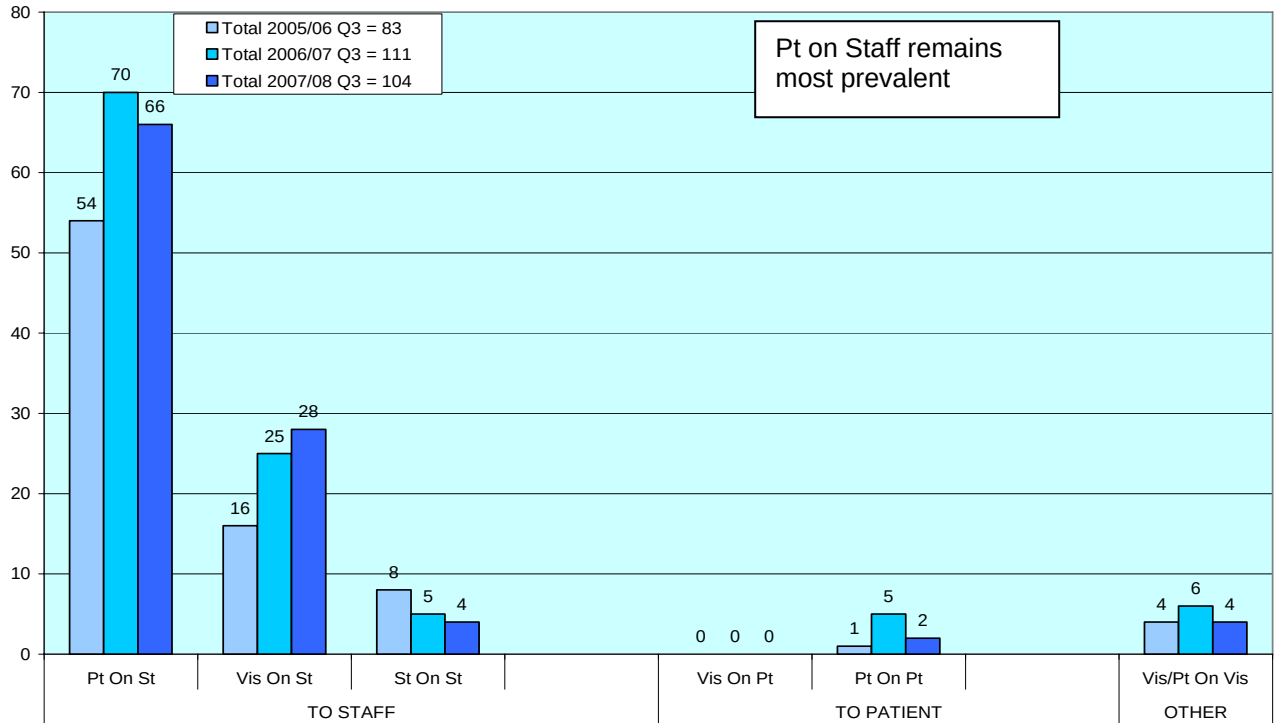
Graph 10: **Moving & Handling (Trust) Q3 2005/06 - 2007/08**.



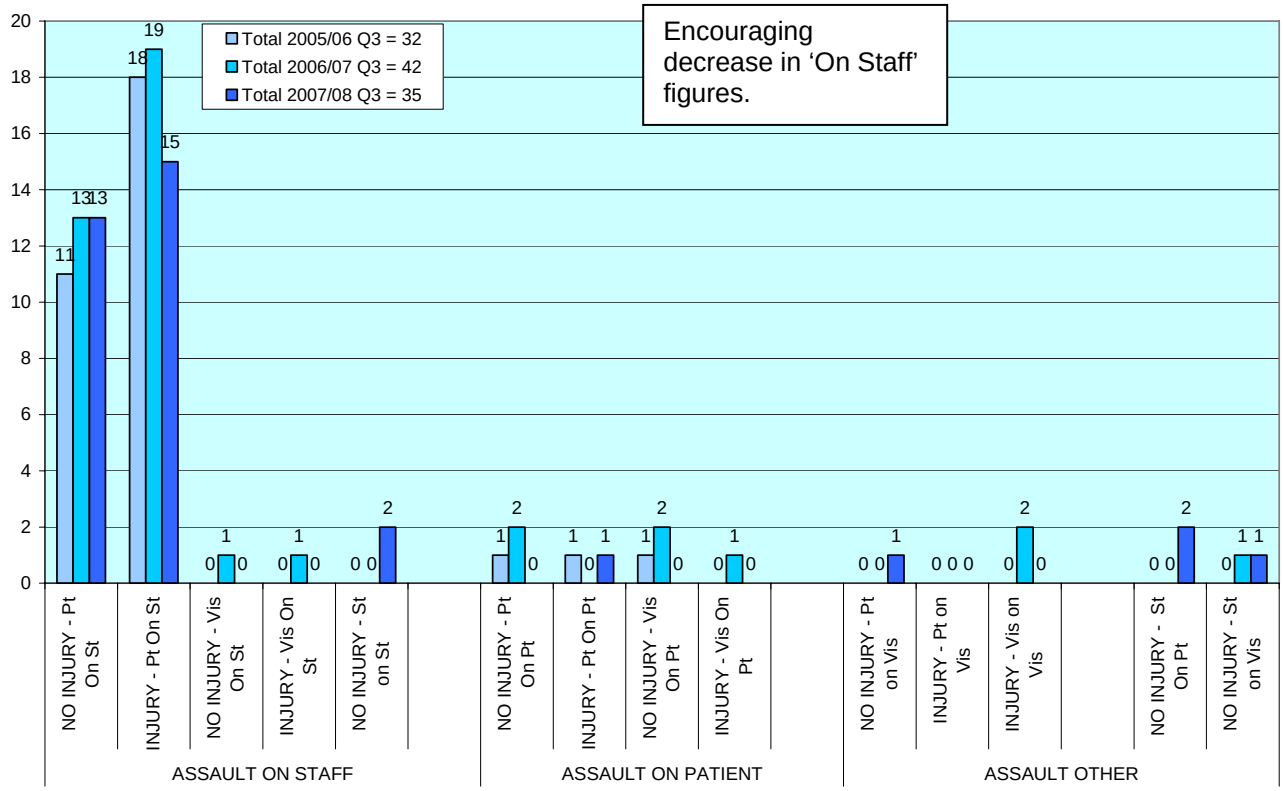
Graph 11: **Sharps (Trust) Q3 2005/06 - 2007/08**.



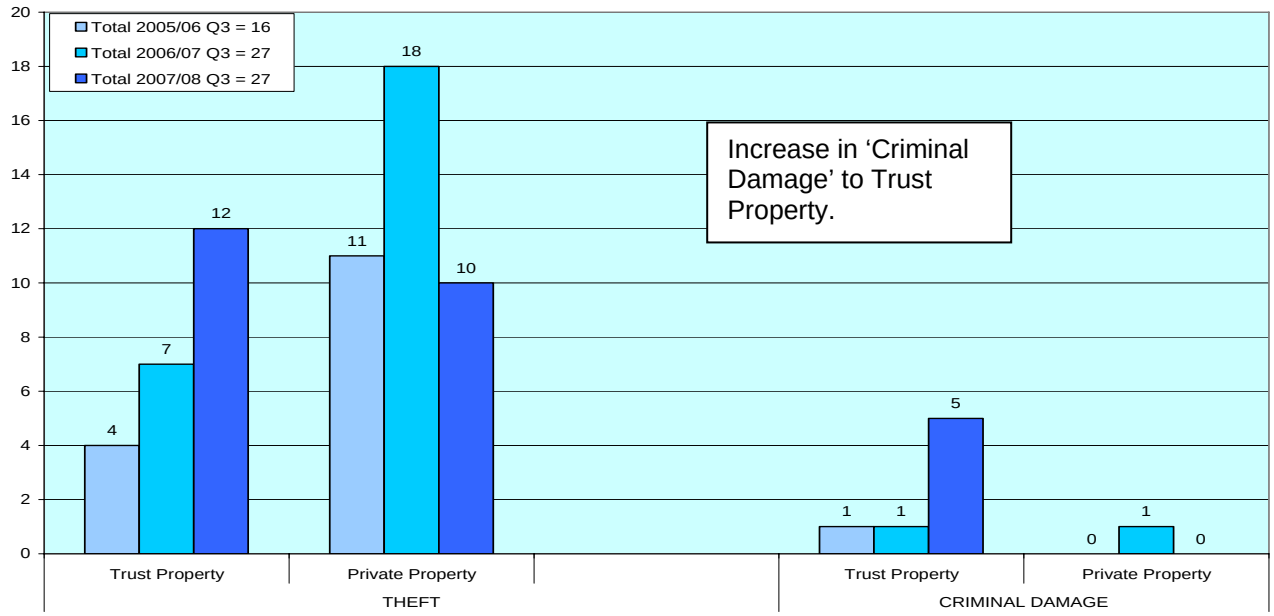
Graph 12: **Verbal/Aggression (Trust) Q3 2005/06 - 2007/08**.



Graph 13: **Violence Assault (Trust) Q3 2005/06 -2007/08**



Graph 14: **Security (Trust) Q3 2005/06 -2007/08**.



Graph 15: **Fire (Trust) Q3 2005/06 -2007/08**.

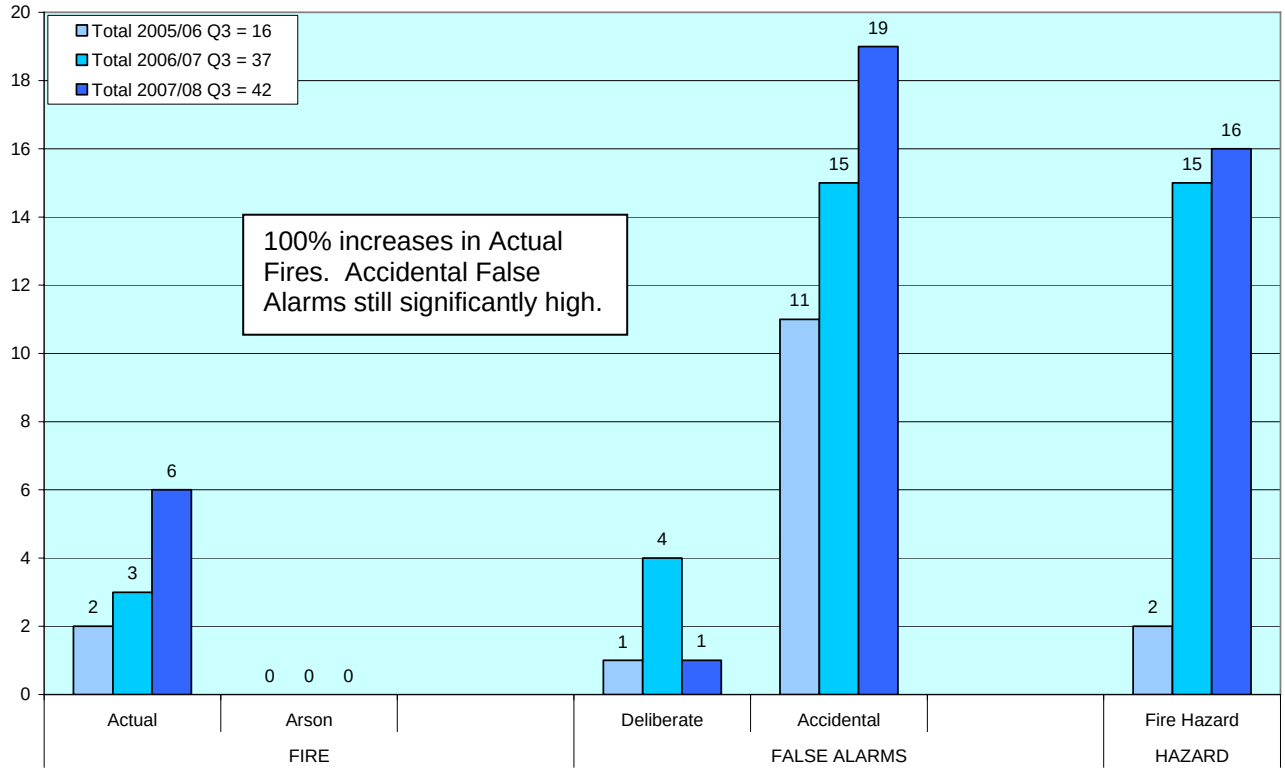


Table 1: **Reported Incidents (Cause Group and Risk Rating & Division) Q3 2007/08**

	A&CC	Dev	Est	IM&T	Imag	Med A-EC	Med B-EC	N,T & F	Ops	Path	Surg B	Surg C	Surg S	W&CH	WF/F	Total
Electricity (Contact)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Equipment (Other)	0	2	1	0	0	6	1	3	1	0	0	2	1	5	0	**22**
Exposure Substance	0	0	1	0	0	1	0	1	0	3	1	0	1	1	0	**9**
Fire	1	0	11	0	0	9	2	4	3	2	2	3	3	2	0	**42**
Harassment/Bullying	0	0	0	0	0	1	2	1	0	0	0	0	2	5	0	**11**
Moving & Handling	3	0	1	0	0	2	0	5	0	1	0	1	5	3	0	**21**
Needlestick	1	0	1	0	0	9	6	2	2	0	2	5	7	10	1	**46**
Other Incident/Haz	3	0	1	0	0	0	1	4	0	0	0	4	2	3	0	**18**
Security	0	1	0	0	0	7	2	2	3	0	5	2	1	4	0	**27**
Slip, Trip, Fall	0	1	2	0	1	2	6	3	2	1	0	2	1	3	2	**26**
Struck By Something	1	0	2	0	1	1	3	4	0	2	2	6	1	6	0	**29**
Vehicle	0	0	0	0	0	0	0	1	0	0	0	0	0	2	0	**3**
Verbal Abuse	2	0	1	0	1	47	12	3	2	0	1	13	1	21	0	**104**
Violence - Assault	1	0	0	0	0	19	6	0	0	0	2	5	1	2	0	**36**
Admission	3	0	1	0	0	63	8	1	0	0	0	31	6	17	0	**130**
Clinical Care	7	1	0	0	1	15	6	3	3	0	3	15	9	46	0	**109**
Blood Transfusion	0	0	0	0	0	2	0	0	0	3	1	1	1	2	0	**10**
Clinical Assessment	0	0	0	0	1	4	1	0	0	9	0	5	1	11	0	**32**
Equipment (Medical)	9	1	0	0	0	4	4	1	0	0	13	36	93	26	0	**187**
Infection Control	2	0	0	0	0	3	0	0	0	0	0	2	2	4	0	**13**
Maternity	0	0	0	0	0	1	0	0	0	0	0	0	0	61	0	**62**
Medication	5	1	0	1	1	22	27	1	8	0	3	10	9	20	0	**108**
Organisational	1	2	2	0	0	11	4	0	3	0	1	16	13	42	0	**95**
Patient Accident	5	0	0	0	2	26	66	3	2	0	5	21	9	14	0	**153**
Patient Information	0	0	0	0	0	2	1	0	2	0	0	5	1	10	0	**21**
Record Keeping	2	2	0	0	0	2	1	0	11	8	10	16	12	21	0	**85**
Self-Harming	0	0	0	0	0	2	0	0	0	0	0	2	1	0	0	**5**
Treatment/procedure	4	2	0	0	2	4	2	1	2	0	0	9	4	19	0	**49**
Unexpect Death\CC	0	0	0	0	0	2	1	0	0	0	0	0	0	5	0	**8**
Total	**50**	**13**	**24**	**1**	**10**	**267**	**162**	**43**	**44**	**29**	**51**	**212**	**187**	**365**	**3**	**1461**
	Risk Rating															
Red	3	0	2	0	0	15	5	0	0	0	0	4	0	27	0	**56**
Amber	5	6	7	0	1	50	11	3	8	1	8	27	27	63	0	**218**
Yellow	10	3	3	1	6	126	73	11	17	20	18	65	72	175	1	**601**
Green	32	4	12	0	3	75	73	29	19	8	25	116	88	100	2	**586**
Total	**50**	**13**	**24**	**1**	**10**	**267**	**162**	**43**	**44**	**29**	**51**	**212**	**187**	**365**	**3**	**1461**

ABBREVIATIONS

Directorates

A&CC	Anaesthetics & Critical Care
Dev	Development
Est	Estates & Capital Projects
F	Finance
WF	Workforce
IM&T	Information Management & Technology
Imag	Imaging
Med A-EC	Medicine A & Emergency Care
Med B-EC	Medicine B & Emergency Care
N,T & F	Nursing, Therapies & Facilities
Ops	Operations
Path	Pathology
Surg B	Surgery B
Surg C	Surgery C
Surg S	Surgery S
W&CH	Women & Child Health

Cause Groups

Admission	Admission, Discharge, Transfer, Miss Patient
Clinical Care	Aspects of Clinical Care
Blood Transfusion	Blood Transfusion
Clinical Assessment	Clinical Assessments (Diag, Scans, tests)
Contract Electricity	Electricity – contact with
Equipment (Medical)	Equipment – Medical
Equipment (Other)	Equipment – Non Medical
Exposure Substance	Exposure\contact with harmful substance
Fire	Fire
Harassment/bullying	Harassment\bullying
Infection Control	Infection Control Incident
Maternity	Maternity
Medication	Medication
Moving & Handling	Moving and Handling
Needlestick	Needlestick
Organisational	Organisational Issues
Other Incident/Haz	Other Accident\incident
Patient Accident	Patient Accident
Patient Information	Patient Information Incident
Record Keeping	Record Keeping\filing\missing notes
Security	Security
Self-Harming	Self harming behaviour
Slips, Trips & Falls	Slips, trips and falls
Struck by Something	Struck by something
Treatment/procedure	Treatment procedure
Unexpect Death\CC	Unexpected Death\ admit to Critical\Neonatal
Vehicle	Vehicle\Driving Offence\Accident
Verbal Abuse	Verbal Abuse\Aggression
Violence (Assault)	Violent assault

ENCLOSURE 3e

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD

6 March 2008

SUBJECT:	Trust Risk Register
REPORT BY:	Kam Dhami, Director of Governance
AUTHOR:	Executive Team

PURPOSE OF THE REPORT:

The Trust Risk Register has been updated to reflect the latest position on the risks identified. Updates are shown in *blue italics.* The residual risk scores in the far right hand column have been adjusted in the light of the updated position and therefore reflect the Executive Team's current assessment. Original risk scores have *not* been adjusted.

IMPLICATIONS:

Financial:	
Personnel:	
Healthcare/ National Policy:	Implementation of Trust Risk Management Strategy
Other:	

RECOMMENDATION(S):

The Board is recommended to APPROVE the updated Trust Risk Register

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST RISK REGISTER – June 2007

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [1a]	All	Risk of non-delivery of financial plan. Comprehensive control systems in place as described in the Assurance Framework *Month 10 performance £6.065m surplus. Forecast surplus increased from £4.5m to £6.5m.*	3	5	15	Control systems as described in Assurance Framework	None	Chief Executive	Ongoing to 31/3/08	Financial Recovery Board, Operational Management Board, Finance and Performance Ctte, Trust Board	Monthly	1	3	3
	2007/08 Corporate Objectives [1b]	All	Risk of non-delivery of Cost Improvement Programme *Month 10 delivery rate at 100.08% so target achieved*.	3	5	15	Control systems as described in Assurance Framework	Capital resources c £500K (included in capital programme)	Chief Executive	Ongoing to 31/3/08	Financial Recovery Board, Operational Management Board, Finance and Performance Ctte, Trust Board	Monthly	1	3	3

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [1c]		**Failure to develop a robust medium term financial plan as linked with an overall recovery plan and agreed with key stakeholders** Current Controls include a timetable to produce an up to date Financial Plan supported by Financial strategy and recovery plan A robust financial planning process ensures the master plan is backed-up by divisional plans Detailed cash management plan to support overall revenue and capital budgets	3	4	12	Ensure fundamental risks are covered in the financial plan and that agreed financing strategies are clearly communicated to Trust Board, PCTs. Provision of additional supporting information to auditors to ensure the substance of material transactions are understood and properly accounted for.	Within financial planning resources	Finance Director	31 March 2008 ongoing	External Audit, SHA review of financial performance	July 2007	3	2	6

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [1c]		**The adverse impact of Resource Accounting and Budgeting (RAB) on the Trust's cumulative deficit is ignored** Current controls include agreed income and financing changes to service level agreements. Financing solutions incorporated into Overall plans monitored by SHA *The 2006/07 accounts have been completed including the surplus reported, enabling funds and RAB adjustments in deficit. The 2007/08 financial plan sets out to achieve cumulative breakeven by March 2008.*	3	4	12	Present evidence of financing solutions to Finance committee, Board and external auditor FIMS and LTFM (long term financial model) updated and reconciled to budget book Signed agreements with PCTs on file, basis of transactions being reviewed as part of 06/07 audit and future plan Plans submitted to FPC, monthly returns require Chair and CE approval	Within Budget	Finance Director	31 March 2008, ongoing	Management Letter, SHA approval of plan	September 2007	1	3	3

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [1d]		**Failure to implement corporate financial governance improvement recommendations** **Failure to recruit to key vacancies in financial services and systems** Reporting to Audit Committee on progress with improvement recommendations and FPC on revised financing structures *Oct 07 – Rating of "Fair" received – an improvement from rating of "Weak" last year.*	3	4	12	Submission of Improvement Plan (with specifically timed and assigned actions) to Audit Committee and reporting on progress with recommendations Revised financial structures and resourcing plan	£100k - £150k (within project based funds, funded vacancies and financial plan)	Finance Director	September 2007	Audit Committee on ALE, Fit for purpose finance review F&PMC	October 2007	1	3	3

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [2a + 2b]		Failure to achieve 18 week referral to treatment milestones by March 2008 **and** SHA milestones for maximum outpatient (5 weeks), diagnostic (6 weeks) and inpatient (11 weeks) waits due to: • Sufficient funding to achieve target. • Increase in referrals • PCT triage schemes do not reduce demand as forecast • Inability to recruit the additional staff to meet the target • Increasing emergency workload competing for the same bed and theatres resources • Robust information data collection system in plan A range of controls are in place including: Additional funding has been secured via the LDP from the PCTs. • Weekly and monthly monitoring systems are in place • *In October there were only 3 admitted patients who had waited more*	2	5	10	Continue robust monitoring of activity and referral trends as well as performance Develop enhanced plans at speciality level Review and liaison with PCT & PBC commissioning representatives	Linked to activity within LDP agreement	Chief Operating Officer	March 2008	WL Group, Operational Management Board, Finance and Performance Ctte, Trust Board, SHA.	Monthly	2	4	8

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [2c]		Failure to achieve national access targets in A&E and Cancer due to: **A&E Performance** Increased demand for A&E attendances and emergency admissions Level of delayed transfers of care Reduced bed capacity PCT admission avoidance schemes fail to deliver Urgent Care Centres do not deliver Temporary bed closures due to infection outbreaks Daily, weekly and monthly monitoring control systems in place. *A&E patients treated within 4 hours now just above 98% with strong recent performance..Extensive remedial action in recent weeks.*	2	4	8	Continue robust monitoring of performance	None	Chief Operating Officer	March 2008	Operational Management Board, Finance and Performance Ctte, Trust Board, SHA	Monthly	1	4	4

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [2c]		**Cancer Services** Significant change in demand for cancer services affects achievement of cancer targets. *Performance remains in excess of 99% for all 3 national cancer targets.*	1	4	4	Continue existing successful arrangements for ensuring achievement of the target.	None	Cancer Services Manager	March 2008	Performance Dashboard. Peer Review	March 2008	1	3	3

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [2d]		Inability to achieve GUM target due to: Insufficient capacity: • Increased demand • Inability to recruit additional medical and nursing staff A range of controls are in place including: • Additional funding has been secured via the LDP from the PCTs • Weekly and monthly monitoring systems are in place In December 89% of patients were offered an appointment within 48 hours	2	4	8	Continue robust monitoring of activity and referral trends as well as performance Review and liaison with PCT & PBC commissioning representatives	Linked to activity within LDP agreement	Deputy Chief Operating Officer	March 2008	Operational Management Board, Finance and Performance Ctte, Trust Board, SHA	Monthly	2	3	6

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [3a]		Failure to deliver proposals for interim reconfiguration as a result of either: • challenge to validity of public consultation process, or • challenge to decision making process used by the Trust. *The Trust completed the formal public consultation on interim reconfiguration at the end of 2006/7. The Trust Board took a decision to proceed with amended plans in the light of the consultation and further work at its meeting in May 2007.*	2	4	8	Trust presented project plan for consultation to SHA and Joint OSC prior to consultation. Decision making undertaken in public following extensive review by steering groups and project board.	None	Director of Strategy	May 2007	SHA review of proposals in light of consultation.	September 2007	1	3	3

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [3b]		Failure to implement service reconfiguration proposals due to • challenges to the Trust decision delaying implementation of changes; • complexity of implementation task leads to delay or failure in implementation; • required capital not available to support changes; • proposals have unexpected consequences and need to be amended in light of experience. *Paediatric changes took place in Nov 2007. Project Plan agreed for neo-natal and pathology changes during 2008/9. Planning continues for urology and breast. Timetable for emergency surgery agreed following the IRP review.*	3	4	12	Implementation plans in each of the four service areas (pathology, paediatrics, neo-nates and surgery) will be presented to the project board for approval.	£10m capital and £0.6m revenue. Included in Trust Financial Plan for 2007/8 and 2008/9.	Director of Strategy	Varies according to project.	Progress reports from Project Board to Trust board	September 2007	2	3	6

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [4a]		Failure to develop 2010 community beds at Rowley Regis Hospital and with HoB PCT at City Hospital, with Sandwell PCT, due to an inability to agree model of care. Project teams in place reporting monthly to the 2010 Project Board *City – A Project Group is in place and a revised Stroke Pathway supported by an integrated community team is due to start once the accommodation upgrade is complete* *Rowley Regis – 12 beds have now been allocated to the scheme and medical cover is provided by GPs commissioned by Sandwell PCT*	3	3	9	Project team in place reporting to the 2010 Project Board	Part-linked to LDP agreement and some funding will be required from PCT	Chief Operating Officer	September 2007 – March 2008	Project team meetings 2010 Project Board	March 2008	2	3	6

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [4b]		Failure to develop approaches to urgent care at City and Sandwell Hospitals, with HoB and Sandwell PCTs, due to an inability to agree funding for the development Project teams in place reporting monthly to the 2010 Project Board *City – UCC service has started with a 7 day 10:00 to 23:00 hour service in place from August. Capacity further expanded from Oct 07.* *Sandwell – The service has been running since October and sees about 11% of A&E activity. Very few patients are diverted to the GP referral centres from A&E and the project team is seeking ways of improving the use of these facilities for this scheme*	3	3	9	Provide senior project management and support to schemes	Part-linked to LDP agreement and some funding will be required from PCT	Chief Operating Officer	September 2007	Project team meetings 2010 project board	March 2008	2	3	6

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [4c]		The Trust fails to deliver redesigned services in diabetes due to • not responding adequately to the commissioner's service specification. • differences of approach between the Trust's two main commissioners delaying implementation; • failure to resolve financial issues delays or prevents implementation. *Initial community clinics have been delivered in HoB and Sandwell to test the model. Plan agreed to move service onto mainstream new arrangements from February 2008. Work continues on how to integrate with HoB community diabetes service.*	1	4	4	Project plans for implementation developed for each PCT setting out detail of approach.	None	Deputy Director of Strategy	March 2008	Progress reports to Towards 2010 Partnership		1	3	3

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [4d]		Inability to launch new renal partnership between SWBH, HoB and UHB because: • Withdrawal of funding for service • Unable to recruit suitable staff • Clinical model does not meet the objectives Controls in place include: • Business case approved by all partners and funding in place in LDP • Recruitment of staff commenced and consultant employment made • Project group in place *The first Consultant has been appointed and started seeing patients in August 07. Now in the process of recruiting the 2nd Consultant and nurse specialist.*	2	2	4	Project teams in replace. Progress reporting via Divisional Review and PCT commissioning meetings.	Funded via the LDP agreement	Chief Operating Officer	October 2007	Project team meetings, Divisional Review and PCT commissioning meetings	March 2008	1	2	2

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [5a]		Failure to submit the Outline Business Case for the new hospital due to the following: That the DH PFU review of the T2010 Programme leads to significant delays or changes to programme these risks are related to project strategy/affordability test/design requirement issues *PFU review stages 1 and 2 successful. Strong support for scheme overall.*	4	3	12	Engage with local PFU representative to agree action to mitigate impact on programme of issues raised. Control capital cost to within parameters agreed with PFU	Within project resource £3.4m	Project Director	Ongoing	Project Board	ongoing	1	3	3
	2007/08 Corporate Objectives [5a]		As a consequence of changes in procurement regulations the current DH OBC requirements are under review. *Changed requirements addressed in project and resourcing plan*	4	3	12	There is no clear indication on how the review will develop. Meetings have been held and will continue to be held with PFU and DH Estates	Within project resource £3.4m	Project Director	ongoing	Project Board	ongoing	1	3	3

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [5a]		That the timetable for the production of the OBC is too ambitious in view of the Trust's other priorities *Linked in to FT LTM and IBP*	4	2	8	Management of project in line with project execution plan	Within project resource £3.4m	Project Director	ongoing	Project Board	ongoing	2	2	4
	2007/08 Corporate Objectives [5a]		That the Trust is unable to work with its PCT partners to produce a set of primary care development plans that match the planned changes to the hospital facilities. *No significant issues at this time but remains potential risk around affordability of community premises*	4	4	16	The Trust's plans are based on a clearly agreed health economy service strategy.	Within project resource £3.4m	Director of Strategy	ongoing	Project Board	ongoing	2	3	6

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [5a]		Unable to secure outline planning permission on site. Principal risks are:- • requirement for intrusive surveys • owner objections • lack of appropriate planning framework incompatibility with local industry • LA requirements more onerous than planned *Complex issues related to CPO and wider area development remain in discussion*	5	4	20	Representatives of project team have engaged with local planning authority. Site owners approached to allow access. Respond to Area Action plan consultation. Development of land OBC to acquire land voluntarily/ compulsory purchase	Within project resource £3.4m	Project Director	ongoing	Project Board	ongoing	3	4	12
	2007/08 Corporate Objectives [5a]		Failure to achieve approval of Land OBC will impact on planning permissions (as outlined above) and will lead to cost uncertainty in OBC. *Linked to above*	5	4	20	Develop OBC and submit to Trust and SHA boards	Within project resource £3.4m	Project Director	ongoing	Project Board	ongoing	3	4	12

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [5a]		An affordable OBC cannot be produced *Affordability assessment in progress but not yet complete*.	3	4	12	Early assessment of affordability in accordance with project plan	Within project resource £3.4m	Project Director	ongoing	Project Board	ongoing	3	4	12

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [6a, 6c + 6d]		Inability to (1) increase proportion of surgery done as day case and minimal stay (2) Reduce pre-operative elective length of stay (3) Reduce acute hospital length of stay due to: • Insufficient day case/short stay theatre capacity • Clinicians unable/unwilling to change practice • Performance management not robust • Theatre infrastructure and capacity inadequate • Delays in implementing new Theatre Management System • Delays in the roll-out of the new decontamination service • Increase in delayed discharges • Insufficient reduction in long stay patients • Requires changes in how PCT services are provided. • Capital funding to support developments	3	3	9	Weekly and monthly performance reports Divisional reviews	Develop-ments have been funded by the Divisions and from Trust capital	Chief Operating Officer	March 2008	Operational Management Board, Finance and Performance Ctte, Trust Board	Monthly	1	3	3

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [6a, 6c + 6d]		Controls include: • Monthly performance monitoring reports. • Dr Foster data provides an external reference source • Investments made to increase day case/short stay theatre capacity • Monthly Divisional Reviews • Weekly and monthly meetings with social services team and their management • Regular meetings in place including project teams for some projects to manage the whole community schemes • 07/08 funding has been agreed for the capital schemes to support LoS reduction *Day case rates up to 77.5%. Minimal stay surgery up to 90.3%. Significant reductions in LOS.*												

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [6b]		Failure to Increase theatre utilisation for the following reasons: • No improvement to DNA rate and same day cancellations • Poor information systems • Delays in implementing new Theatre Management System • Clinicians unwilling/unable to change practice Controls in place include: • Monthly performance reports • Daily and weekly reports being developed • Investments made to improve pre-operative assessment • Monthly Divisional Reviews • BTC Theatre Board in place • Theatre Utilisation Group in place • BMEC KPMG Project Board in place *The new Theatres system has been fully implemented at City and the Sandwell roll-out has started. Outstanding is the routine production of a new set of Theatres reports. This has been delayed due to major IT system go-lives.*	3	3	9	Weekly and monthly performance reports Divisional reviews	Develop-ments have been funded by the Divisions	Chief Operating Officer	March 2008	Operational Management Board, Finance and Performance Ctte, Trust Board	Monthly	3	2	6

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [7a]		The following risks are associated with the Core and Developmental standards components of the Annual Health Check: Failure to provide assurance on Core Standard 4b (staff competence in use of medical devices) Change in status of any of the core compliant standards Failure to demonstrate progress in relation to the selected developmental standards (yet to be announced by the Healthcare Commission). *Medical Devices compliance achieved. Self-assessment against the Core Standards completed Proposed declaration to be presented to the March G&R Ctte. Developmental standards no longer assessed.*	3	4	12	Actions plans to address any areas for improvement identified through the self-assessment process and via cross-check against the information sources relied upon by the Healthcare Commission.	None	Director of Governance Development	March 2008	Progress reports to the G&RMC and the Trust Board	October 2007	3	3	9

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [7b]		Risk of low compliance to Saving Lives Action Plan. Controls – strong reporting structures from clinical to Trust Board level. Screening of at risk patients. *MRSA bacteraemias have now exceeded the year target. Clostridium difficile rates continue on a downwards trend and are within target parameters. Now directly linked to Ft application.*	4	3	12	Continue existing control system arrangements to ensure IC is seen as a Trust priority.	None	Chief Nurse	On-going	Saving Lives Action Plan Executive IC Group. IC Committee OMB Trust Board	Monthly	5	3	15

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [7c]		Inappropriate nurse staffing levels and skill mix to meet patient need. Controls – monitoring Trust position using local validated skill-mix tool and nationally RCN policy unit and Audit Commission recommendations. *A workforce plan for nursing and midwifery is being developed and will be available in February. The senior nursing structure has been reviewed. A performance management framework for nursing has been developed with core objectives.*	5	4	20	Ensure fundamental risks are identified in the division action plan. Corporate reporting to the Nursing Taskforce.	Workforce analysis to be completed via Taskforce £200k investment identified to date	Chief Nurse	On-going	Develop nursing action plan to develop key targets. Reviews reported to Nursing Taskforce, divisional Governance Group and Board.	Bi-monthly	3	3	9

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [7d]		Availability of resources to meet national cleaning standards compliance. Controls – monitoring against organisational reviews PEAT, NPSA, PPI. IC Executive Group. *The Trust is delivering a major cleanliness programme including a deep clean, additional maintenance and decorating work and a review of key areas including toilets, showers, sinks and curtains.*	4	4	16	Continue successful controls. Trust wide cleaning schedules.	£200 allocated within the Financial Plan for cleaning	Chief Nurse (Deputy Director – Facilities)	On-going	National Standards of Cleanliness Audits. Internal inspections. National reviews as requested.	Locally monthly/nationally annually	1	3	3

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [7e]		Compliance within divisions to undertake Essence of care audits and develop action plans. Controls – corporate and local systems in place. *The next Essence of Care audit is planned for March. A performance management framework for nurses has been agreed and includes objectives against all key nursing standards. A new Senior Nurse Forum has been established.*	4	3	12	Continue successful controls through Nursing division. Support divisions in the action planning process.	None But linked to 7c	Chief Nurse	On going	Continue ward reviews. Report to Nursing Taskforce and divisional corporate governance structures.	Bi-monthly	2	3	6

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [8a]		The following may hinder the production of an updated Trust Medical Workforce Development Plan: Lack of capacity/expertise within the Medical Staffing Department. Current national medical workforce initiatives may pose difficulties in making future predictions. Lack of engagement with the medical workforce planning exercise due to competing priorities. *Audit of consultant job planning and appraisal completed and the findings circulated to Divisional Directors. A Protocol for Consultant job planning being drafted*	2	3	6	Restructuring of existing groups and creation of new ones to establish an 'Organisational Framework for Corporate Medical Workforce Matters'. Progress to be reported bi-monthly to the Medical Workforce Executive Committee and SDB. Proposals to be presented to SDB in July for approval	None	Director of Governance Development	March 2007	Progress reports to the Medical Workforce Executive Committee and SDB	September 2007	3	2	6

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [8b]		Failings of the national system (MTAS) The problems with MTAS have led to a delay in recruitment to run through training posts which commence on 1 August 2007. The Trust will not be advised which posts have been appointed to posts until mid June 07. This delay will place pressure on the Medical Staffing and Occupational Health Departments to ensure pre employment checks are undertaken. Current estimates from the Deanery are that only 70% of posts will be filled at that stage. *MTAS problems successfully resolved by local action.*	4	4	16	Medical Staffing department and Occupational Health department working together to ensure pre-employment checks completed speedily and prior to induction date. Once Round 1 completed in mid June contact all junior doctors in the trust who have not yet been successful in acquiring posts to ascertain if they wish to remain in trust employment in short term fixed term capacity to assist with any staffing problems we might encounter in August/September 2007. Also identify those doctors who already have experience within the Trust who might not require corporate induction.	None	Deputy Medical Directors	June 2007	Medical Workforce Executive Committee Strategic Development Board West Midlands Deanery	July 2007	1	3	3

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [8b]		Induction programme in August 2007 for new StRs need to be comprehensive but must be completed as quickly as possible so that service provision is not unduly affected. *New induction system successfully introduced.*	3	3	9	Look to undertake as much of junior doctor induction programme prior to commencement of employment eg replace lectures with handouts where appropriate and consider development of Electronic Induction Programme for Junior Medical staff to reduce time spent in Corporate Induction programme in August 2007.	£4k to purchase Electronic induction	Deputy Medical Directors	July 2007	Medical Workforce Executive Committee Strategic Development Board West Midlands Deanery	July 2007	1	2	2

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [8b]		Lack of clinical engagement threatens the effective implementation of MMC. *Clinicians engaged as required.*	3	3	9	Regular newsletter from Trust MMC group to keep clinicians advised of current developments of MMC within the Trust. Ensure Postgraduate Clinical Tutors and College Tutors are rolling out key messages to consultants and trainees. Strengthen Trust's links with Specialty Training Committees to be co-ordinated by Postgraduate Clinical Tutors. Distance the MTAS problems from the underlying principals of MMC providing a structured, competency based approach to training of junior doctors.	None	Deputy Medical Directors	On-going	Medical Workforce Executive Committee Strategic Development Board West Midlands Deanery	On-going	1	2	2

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [8b]		Lack of resources to undertake educational components of MMC *Still in progress – no immediate issues.*	3	3	9	Deputy Medical Directors to work with Postgraduate Clinical Tutors to establish what resources required to deliver educational components of MMC eg additional PA for college tutor subject to delivery of MMC. Look to develop an E-learning portfolio package so that MMC requirements can be delivered using electronic system.	To be determined	Deputy Medical Directors	01/07/2007	Medical Workforce Executive Committee Strategic Development Board West Midlands Deanery	15/07/2007	2	2	4

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [8b]		Less control over appointment of junior medical staff. The Trust has no control over timing of recruitment to training posts and there is a potential quality control issue with new appointments that have not been interviewed by Trust representatives. Trust also cannot request previous experience in the specialty which will lead to problems in a number of specialties. *The 2008 recruitment round is due to be completed by 16 May 2008. Systems have been set up to manage attendance at interviews. The Trust has not yet received details of the posts for August 2008.*	5	3	15	Once appointees to StR posts are known undertake a skill/experience assessment of new appointees prior to commencement date to identify `hotspots' where trainees not as experienced as pre MMC. Identify service implications and where necessary identify and address training requirements of new trainees.	To be determined (£150k possible expend-iture to mitigate against skills gap)	Deputy Medical Directors	30/06/2007	Medical Workforce Executive Committee Strategic Development Board West Midlands Deanery	15/07/2007	3	3	9

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [8b]		Management of FTSTA post removal by 1 August 2008. 44 FTSTA posts currently exist and will be appointed to via MTAS for 1 August 2008. These posts are likely to be removed (with the deanery funding) from 1 August 2008. *Significant impact now evident on anaesthesia.*	4	4	16	Trust has to decide how to manage the removal of these posts and consider the merits of the options e.g. rebadge to GP or F2 posts, use as Trust doctor posts, use funding released to create other posts to assist with new ways of working, Hospital at Night scheme etc). Letter and proforma going to Divisional Directors/Deputy Divisional Directors/Divisional General Managers requiring Divisions to indicate their preferred use of FTSTAs.	To be determined (£1.5m is the approx figure that the Deanery currently funds of the 44 FTSTA posts)	Deputy Medical Directors	31/07/2007	Medical Workforce Executive Committee Strategic Development Board West Midlands Deanery	30/08/2007	4	3	12

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
			Failure or delayed implementation of H@N project due to:						Director of Governance Development						
	2007/08 Corporate Objectives [8c]		Wireless network black spots across City and Sandwell sites - unreliable communication system. Control: Negotiating extension to wireless network coverage. Use of existing bleep system if coverage insufficient for project needs.	4	3	12	Extent of wireless network coverage to be determined. Costs and timescale TBC by head of IM&T. Revised bleep policy.	500000 estimated	Head of IM&T H@N Project manager.	February 2008	Report to H@N Steering Committee.	May 2007	2	2	4

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [8c]		Inadequate data on which to base/inform decisions, lack of medical engagement / acceptance of new roles. Control: Planned baseline audit, consultation with medical staff. *Hospital at Night project continues to work on baseline audits of night-time activity and developing service models and clinical roles to ensure success of Hospital at Night model.*	4	4	16	Analysis of baseline audit data to inform H@N team model. Communication plan. Consultation with affected staff. Reporting mechanism up and across organisation.	30000	Project steering group.	July 2007	H@N project plan, project structure. Progress assessed against project plan.	July 2007	2	2	4
	2007/08 Corporate Objectives [8c]		Reduction in junior doctor training posts & MTAS recruitment delays due to MMC Control: Links to EWTD, MMC groups. *See above*	4	4	16	Analysis of baseline audit data to inform medical rotas and H@N team model. Up-skilling/training of H@N nursing staff	Unknown	Project steering group.	September 2007	Report to H@N Steering Committee.	Monthly	2	2	4

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [8c]		Lack of nursing engagement / acceptance of new roles, insufficient numbers of appropriately trained nurses, need to recruit and / or train staff. Control: Consultation with affected staff. Engagement of staff-side representation. *See above*	3	4	12	Competence assessed against national standard. Formulation of new JD's. Gap analysis. Communication plan. Reporting mechanism up and across organisation.	unknown	H@N Project Manager. Matron/Senior nurses – night teams.		Report back to project boards. Progress assessed against project plan. Report to MWDG	Monthly	2	2	4
	2007/08 Corporate Objectives [8c]		Inadequate resources to fund project. Control: Negotiation with relevant departmental heads to provide support to project. *Funding allocated in plan*	3	4	12	Costs of nurse training Numbers of staff and timescale to be IT trained	TBC To be met within existing resource	H@N Project Manager. Project medical leads Departmental heads	February 2008	Progress assessed against project plan. Report to MWDG	July 2007	1	3	3

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [9a]		The Trust fails to launch a successful Foundation Trust application due to: • failing to convince the SHA that it is a suitable candidate for FT status on the agreed timetable; • delays in the New Hospital Project delay a successful FT application; • the Trust not identifying management capacity to deliver the application. *The Trust has agreed its PID and project plan for the FT application. The public consultation stage of the application commenced on 21st January 2008. However, interactions with OBC an HCAI remain.*	3	4	12	The Trust will develop a detailed project plan and project management structure for its SHA application.	£250k included in the Trust Financial Plan	Director of Strategy	Plan in place by September 2007	SHA decision to recommend Trust proceed to apply.	September 2007	3	3	9

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [9b]		The principal risk involved is the possibility of not being able to exploit all of the ESR functionality. Whilst the payroll has now been transferred to ESR decisions need to be made about benefits realisation. Much of the functionality can be achieved without the need for significant additional financial resources however this is not so in all cases. There is no identifiable source of funding. This includes the project team post 07/08. *The first phase which was to transfer payroll activity has been completed successfully and on time. The second phase to agree and implement required additional functionality is at the planning stage.*	3	3	9	To determine the benefits to the Trust of the functionality not yet implemented and to develop and implement a plan for the areas agreed to be pursued.	£150K	Director of Human Sources		ESR Group OMB		2	2	4

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [9c]		Failure to gain full benefits from new PAS and other systems introduced at end of 2006-07/early 2007-08 for the following reasons: • Delays in systems going live • Benefits plan not in place • Benefits plan delivered Controls in place include: Monthly reporting in place Project structure in place to manage projects Benefits plans in place *The City campus went live as planned on October 15th and the Rowley/Sandwell sites on November 18th. There have been a range of unexpected problems however by the end of December these have settled*	5	3	15	Monthly reporting in place Project structure in place to manage projects Benefits plans in place	Funded via LDP and Trust capital	Chief Operating Officer	October 07-March 2008	Trust Board, SHA CfH	Monthly	3	3	9

Reference Number	Source of Risk (e.g. NICE, Incident, CNST, ,Statutory etc)	Directorate/Division	Summary description of risk and current controls	Probability	Severity	Risk Score (P x S)	Summary of Risk Treatment plan	Anticipated resource implication (£)	Who responsible for implementing the plan?	Expected date of completion	Source of internal/ external review	Date of Review	Probability	Severity	Residual risk Score
	2007/08 Corporate Objectives [9d]		The Trust does not get the benefit of a more co-ordinated approach to service improvement due to: • lack of capacity in the service improvement team to deliver programme; • failure to structure programme in way that engages Trust operating divisions. *The Trust's service improvement programme for 2007/8 has been presented to the Trust Board. Work continues in the key project areas including ophthalmology, dermatology and catering to deliver improvements.*	3	3	9	Proposals for delivery of service improvement programme to be presented to OMB in June for approval.	None	Deputy Director of Strategy	March 2008	Reports to OMB on progress of plan.	September 2007	2	3	6

ENCLOSURE 4a

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD

March 2008

SUBJECT:	COMMUNICATIONS AND ENGAGEMENT STRATEGY
REPORT BY	Head of Communications
AUTHOR:	Jessamy Kinghorn

PURPOSE OF THE REPORT:

To update the Board on progress made.
To seek Board approval for the updated aims and priorities for the Communications and Engagement Strategy which have been revised in line with the 08/09 Corporate Objectives.

IMPLICATIONS:

Financial:	None
Personnel:	None
Healthcare/ National Policy:	Various
Other:	Supports delivery of Corporate Objectives

RECOMMENDATION(S):

NOTE progress made on the existing communications action plan.
AGREE the proposal to review and consult on the strategy
COMMENT ON the proposed aims for the strategy
AGREE the strategy be renamed to Communications and Engagement Strategy

Contents

1. Introduction

The Trust's Communications Strategy was approved in September 2005 and contained a series of aims and priorities with an associated action plan. This report provides an update on the progress made and seeks Trust Board approval for a set of revised aims and priorities that have been developed in line with the 2008/09 corporate objectives.

2. Overview

The Trust has undergone a significant amount of challenge and change since the launch of the strategy 2 ½ years ago. The Communications department itself has had its resources reduced on two occasions, loosing 3.5 WTE posts and taking on the Towards 2010 communications agenda. The Trust had not produced it's Strategic Agenda and plans for Interim Reconfiguration were not on the agenda when the strategy was developed – Improving Working Lives and Agenda for Change were high priorities – and 'Towards 2010' and the whole NHS environment has moved on significantly.

Even so, a substantial amount has been achieved over the last two years. Where progress hasn't been quite as fast as had been anticipated, there has still been a considerable amount accomplished. In the last few months, resources have been coming together from different sources to invest in the department and make further improvements, particularly in relation to new hospital engagement, marketing related activities, the website and the Trust's Foundation application.

Immediate priorities for the Trust include preparing for NHS Foundation status and planning for the new hospital, along with the shift of care closer to home as part of the 'Towards 2010' model.

Some activities listed in the original action plan are no longer relevant and newer, more appropriate activities have taken their place. In light of the changed environment and the Trust's strategy direction, it is necessary to draft a set of new aims and priorities for the Trust's Communications strategy and to revisit the strategy itself.

3. Aims

The aims of the Strategy approved by the Trust Board on 1st September 2005 were to:

1. Ensure staff have access to adequate information to enable them to effectively carry out their work, as well as information about a wide range of Trust activities, policies, practices and staff benefits that will improve their working life helping them achieve an appropriate work-life balance, feel they are a valuable part of the organisation and improve staff morale

2. Provide support and direction to Trust staff to help them communicate effectively with patients, carers the public and each other

3. Enable a two-way dialogue between the Trust and its staff, patients, GPs, stakeholders and local population, helping us improve the service we provide, the general health of the local population as well as access to services on an equal basis regardless of age, culture, race or disability, to improve the patient experience and to drive up standards of care

4. Ensure GPs have access to adequate information about the Trust so SWBH is a strong contender when patients are offered choice on where to receive hospital treatment

5. Ensure patients have access to adequate information about the Trust to enable them to make an informed choice on where to have treatment, to support their healthcare needs and make their stay in hospital easier, generally improving their experience of our hospitals. The information should be clear and easily understood, and appropriate, culturally sensitive methods used for different groups, including non English speaking and sensory impaired patients

6. Develop a recognizable identity for the Trust, building brand loyalty and a strong reputation that will help ensure business success for the Trust in the light of Choice and Payment by Results

7. Ensure the 2010 agenda is rigorously pursued, leading the Communications and Engagement plans, offering support and direction when necessary and ensuring our staff, patients, carers, public and stakeholders are kept informed and have the opportunity to become involved with the Towards 2010 Programme

8. Build closer relationships between the Trust, patients, carers, public and stakeholders, providing support to patients and the public through the PPI Forum and other means to enable them to make a difference and ensuring stakeholders such as the Strategic Health Authority, MPs and Overview and Scrutiny Committee are kept up to date with Trust activities

9. Develop an appropriate reporting, monitoring and communicating mechanism for PPI and communications activities with accountability to deliver on targets.

4. Priorities for delivery

In order to achieve the above aims and assist in the delivery of the corporate objectives, priority was allocated to the following projects:

- Developing robust GP communications
- Developing the Trust's website in support of patient choice
- Improving communications with stakeholders
- Developing comprehensive patient information
- Managing the reputation and publicising the successes of the Trust
- Ensuring staff are well-informed through staff communications initiatives
- Providing a PR strategy in support of plans for the Birmingham Treatment Centre
- Devising and delivering the communications and engagement plan for Towards 2010
- Supporting Trust infection control initiatives
- Supporting the Agenda for Change process
- Supporting Trust initiatives to improve the patient experience

Specific priorities for 2006/07 and 2007/08

- 2010 – ensuring staff, patients and stakeholders understand the 2010 proposals and support delivery of 2010 during and after public consultation
- Getting ready for 2010 – communicating the Trust's medium term strategy to staff, patients, public and stakeholders and engaging and consulting with them
- Undertaking robust internal and external communications around the Trust's financial plan
- Achieving compliance for the Annual Healthcheck core standards relating to communications and patient and public involvement
- Supporting the Trust's preparations for moving towards NHS Foundation Status
- Delivering communications, marketing and patient involvement plans to support the Patient Choice initiative
- Ensuring patients have access to information
- Reviewing response processes to comments and suggestions

5. Progress

The report below summarises the activities undertaken to achieve the priorities outlined above and gives an indication as to how on track the Communications team are with delivering the objectives by the end of March 2008.

Developing robust GP communications	G
Developing the Trust's website in support of patient choice	A
Improving communications with stakeholders	G
Developing comprehensive patient information	A
Managing the reputation and publicising the successes of the Trust	G
Ensuring staff are well-informed through staff communications initiatives	G
Providing a PR strategy in support of plans for the BTC	G
Delivering the communications and engagement plan for Towards 2010	G
Supporting the Trust in gaining IWL Practice Plus accreditation	G
Supporting Trust infection control initiatives	G
Supporting the Agenda for Change/KSF process	G
Supporting Trust initiatives to improve the patient experience	G

Developing robust GP communications	G

Since the launch of the Communications Strategy, GP Focus and GP Hotline have been launched. Email communications with GPs has improved and there have been regular surveys of GPs. There has been a GP open day at the BTC which was well attended and at Sandwell which was less well attended by GPs. All GPs in Sandwell and HOB have been visited and meetings have taken place with PBC clusters. GPs are regularly sent corporate information such as the annual report and consultation documents and receive letters and leaflets about important information such as service reconfiguration.

Currently in production are the next issue of GP Focus, a portfolio featuring every specialty and an introduction to the Trust for GPs outside our immediate patch.

In 2006, a GP Liaison and Communications Manager was appointed to oversee the development and implementation of GP Communications. The position has been vacant for almost 12 months during which time the Business Development and Communications Departments have restructured the Trust's approach to Marketing and GP liaison. Four new posts have been created, a Business Development Co-ordinator and a Web Officer who both started at the end of February 2008, and a Marketing Manager and Business Development Manager who will start in April. These posts will ensure greater responsiveness to GPs and draw on the specialist skills of business development, marketing and website design with administrative support to arrange GP visits, respond to their queries and ensure the GP Hotline is responded to promptly.

GP communications activities have now been incorporated into the Marketing plan which is reviewed by the Finance and Performance Committee three times a year.

Developing the Trust's website in support of patient choice	A

The Trust's website was redesigned and re-launched and comprises a range of latest news, corporate, recruitment, patient and visitor information. Particular features include bus routes, on-line Foundation Trust membership application and consultation responses, and from March 2008 the facility to find out more about the people who access the website and how they access it.

The website is kept up to date by the External Communications Manager but there have been some difficulties in getting hold of accurate information to publish and technical problems primarily as a result of managing the site through a third party. To overcome these, a new Web Officer joined the Trust at the end of February 2008 with a technical background in website design. He is currently reviewing the existing site with a view to redesigning it over the next few months.

Choose and Book and Connecting for Health have been supported by the Communications Team and nhs.uk is monitored by the team.

Improving communications with stakeholders	G

A database has been set up with more than 2,000 community and voluntary groups including hard to reach groups, healthcare providers, commissioners and other stakeholders, places of worship, schools, doctors, dentists, pharmacists, retired NHS staff, volunteers, interested members of the public. Birmingham and Sandwell Local Authorities assist the Trust in distributing a further 8,000 copies of printed material and Sandwell and HOB Primary Care Trusts assist in distribution of between 500 and 5,000 copies each and incorporate Trust messages in their email bulletins. Corporate information, such as the annual report, consultation documents etc. is sent via these methods. Monthly stakeholder updates were issued during the 2010 and Interim Reconfiguration Consultations and on other occasions, such as implementation of paediatric reconfiguration. Stakeholders have been invited to the GP events at the BTC and Sandwell, the Foundation Trust launch event, New Hospital engagement events and specific briefing events, press have been invited to pre-Trust Board briefings and departments, such as imaging, have held open days. A new Foundation recruitment drive is underway.

Developing comprehensive patient information	A

An audit of existing patient information has been carried out and the Patient Information policy has been revised and approved by Governance Board. Information has been developed around the paediatric and neonatal services, breast service and other Trust services. The process for developing and approving patient information is being streamlined and Medical Illustration taking a more active role. Additional graphics support and training is being arranged and the patient information template re-designed.

Meetings have taken place with the hospital radio stations to explore the potential for patient information via the radio and in audio versions.

Meetings have taken place with some hard to reach communities to better understand their communications needs and some useful feedback has been used to improve communication and engagement.

A proposal for a patient magazine was developed but is cost-prohibitive. It is planned to look at this as part of the membership strategy for NHS Foundation status. Site maps have been updated and new welcome to hospital leaflets produced. The latest version of these includes an A4 site map and a membership form.

The Trust has made significant improvements in clinical information with the purchase of a databank of information leaflets and the introduction of the Health Exchange at the BTC. There has been a big improvement in the amount of information available in different languages and accessibility of telephone handsets for interpreting.

Managing the reputation and publicising the successes of the Trust **G**

The Trust operates a daily press cuttings service and has daily contact with journalists from a broad range of local, regional, national, trade, community and BME media. Press comments, releases and statements are prepared and issued on most days.

Since the strategy was developed in 2005, the Trust reputation appears to have improved significantly. This has corresponded with improved financial and operational performance which we have promoted through the media and through public involvement.

We are increasingly approached by trade press to share best practice in a range of specialties, have featured in research and development, information technology and Department of Health reports and have had several features during the last two years in national and local press.

Recent research into the Trust's web presence has involved running searches through a well known search engine. Trusts were searched for by Trust name and individual hospital names and the results aggregated. The results do not identify whether the reference was good, bad and neutral and there is likely to be a variety for all organisations. They give a fairly crude analysis of internet presence.

Trust	Hospitals in search	Hits (to the nearest 500)
Dudley Group of Hospitals	Russell's Hall (with and without apostrophe), Wordsley and Corbett	59,000
Heart of England	Heartlands, Solihull and Good Hope	109,000
Royal Wolverhampton	New Cross	29,000
Sandwell and West Birmingham	City, Sandwell and Rowley Hospitals, Birmingham Treatment Centre and BMEC	160,000
Walsall Hospitals	Walsall Manor	16,500
University Hospital Birmingham	Queen Elizabeth and Selly Oak	110,000

The Trust won the Nexus award for the best acute Trust 2003/04 annual report and was short listed for the 2004/05 report. The 2006/07 annual report was commended by the auditors as an example of best practice.

The communications team was shortlisted for media handling at the Association of Healthcare Communications awards 2007 and has won awards at each of the previous awards ceremonies, including for staff communications and public involvement.

The Trust's major incident policy and provisions have been revised to improve the ability of the Trust to manage communications during an event.

Communications and engagement is embedded in all strategic planning with the Head of Communications sitting on each of the Trust's key Project Boards.

The Trust has received very good publicity for infection control and was praised for its handling of the media in relation to blockages to oxygen cylinders and an incident involving a gunman at City Hospital. There have been challenges in relation to Interim Reconfiguration and the new hospital.

Whilst there is still room for further improvement, the green rating reflects the extent of the achievements to date.

Ensuring staff are well-informed through staff communications initiatives	**G**

Heartbeat and Your Right to Be Heard, team brief and back to the floor are well established. With the exception of Heartbeat, these have all been the subject of review in the last few months.

A new staff awards scheme and Chair's Awards have been launched and the Chief Executive's Team Brief is produced in video form each month. A new staff engagement programme is being developed.

Providing a PR strategy in support of plans for the Birmingham Treatment Centre	**G**

A PR strategy was developed and implemented for the launch of the Birmingham Treatment Centre and various promotional activities undertaken during its first 18 months including an official opening and open day.

A Birmingham Treatment Centre logo and associated literature was produced.

Promotional activities for the Birmingham Treatment Centre will be reviewed and developed by the Trust's new Marketing Manager.

Delivering the communications and engagement plan for Towards 2010	G

The Head of Communications chairs the 2010 communications and engagement group, which meets monthly, and provides reports to the 2010 Partnership. Following a public consultation where members of the Trust Board attended over 200 meetings, a new 2010 Communications and Engagement Strategy has been developed which is being co-ordinated by the Trust. A 2010 newsletter has been circulated to over 30,000 people, a website created and various other activities taken place.

The new hospital communications and engagement plan was adopted by the Project Board in the summer 2007 and staff and public engagement events have taken place including a week of extensive engagement about the planning application in January 2008. Towards 2010 is a regular feature in Heartbeat and on team brief

Supporting the Trust in gaining IWL Practice Plus accreditation	G

The Trust undertook extensive work to promote IWL including a creative poster campaign, regular newsletters and other internal communications initiatives.

Supporting Trust infection control initiatives	G

The communications team has provided ongoing support to the Be Betty's Mate and clean your hands campaigns through internal and external communications initiatives, which included the design of a mascot and a children's competition.

Infection control successes and messages have been extensively promoted through the press, in Heartbeat and team brief.

Supporting the Agenda for Change/KSF process	G

The Trust undertook extensive work to promote Agenda for Change including regular newsletters and promotion through Heartbeat and team brief.

Supporting Trust initiatives to improve the patient experience	G

A report on Understanding the Patient Experience has been on the Trust Board agenda quarterly since March 2007 and picks up on the views that have been gathered from patients through a variety of methods.

A Patient Experience Taskforce has been established to review public and patient feedback and suggest areas for action.

Improvements made to the Patient Experience are promoted internally and externally. Strong relationships exist with the PPI Forum and the Trust has agreed to provide interim support during the transition to LINks.

A staff award for Patient Involvement has been created and there were a number of high caliber entries in 2007 that were promoted in the local press. Car parking concessions have been further developed and are promoted to patients before they arrive in hospital.

Fundraising activities are routinely promoted. The Trust is currently involved in a fundraising campaign with ASDA which is raising money for City Hospital's neonatal unit. The staff lottery is being rolled out to raise funds for staff to apply for that could benefit staff or patients.

A suggestion scheme has been reviewed and is being incorporated into the Foundation Trust membership strategy.

6. Communications and Engagement Strategy 2008-2011

It is proposed to revise the Communications Strategy, creating a Communications and Engagement Strategy to reflect the Trust's Strategic Direction, and recently approved Vision, Values and Corporate Objectives. The Strategy will be expected to last for a further three years.

It is intended to develop the strategy at the start of the financial year and circulate it for consultation from May 2008. It is important that our stakeholders can have input into the strategy and that it is aligned to the Towards 2010 Communications and Engagement Strategy.

It is then proposed to present the final strategy for approval at the September meeting of the Trust Board.

6.1 Proposed aims

It is proposed that the aims should stay largely consistent with the original aims of the strategy.

The proposed aims of the strategy are to:

1. Ensure staff have access to adequate information to enable them to effectively carry out their work, as well as information about a wide range of Trust activities, policies, practices and staff benefits that will improve their working life helping them achieve an appropriate work-life balance, feel they are a valuable part of the organisation and improve staff morale

2. Provide support and direction to Trust staff to help them communicate effectively with patients, carers the public and each other

3. Enable a two-way dialogue between the Trust and its staff, patients, GPs, stakeholders and local population, helping us improve the service we provide, the general health of the local population as well as access to services on an equal basis regardless of age, culture, race or disability, to improve the patient experience and to drive up standards of care

4. Ensure GPs have access to adequate information about the Trust so SWBH is a strong contender when patients are offered choice on where to receive hospital treatment

5. Ensure patients have access to adequate information about the Trust to enable them to make an informed choice on where to have treatment, to support their healthcare needs and make their stay in hospital easier, generally improving their experience of our hospitals. The information should be clear and easily understood, and appropriate, culturally sensitive methods used for different groups, including non English speaking and sensory impaired patients

6. Develop a recognizable identity for the Trust, building brand loyalty and a strong reputation that will help ensure the Trust succeeds in the light of Choice and Payment by Results and as an NHS Foundation Trust.

7. Ensure the 2010 agenda is rigorously pursued, playing a key role in developing and implementing the Communications and Engagement plans, offering support and direction when necessary and ensuring our staff, patients, carers, public and stakeholders are kept informed and have the opportunity to become involved with the Towards 2010 Programme

8. Enable those who are interested to have a say in the design and planning of the new hospital through extensive staff and public engagement, ensuring two-way communications.

9. Gather the views of patients, carers, public and other stakeholders to improve services, ensuring stakeholders are kept up to date with Trust activities.

10. Monitor and report on communications and engagement activities.

11. Effectively manage the membership of the NHS Foundation Trust, ensuring members are as involved as they wish to be and that opportunities for communications and engagement through Foundation Trust membership are pursued.

Feedback on the aims of the strategy will be sought as part of the consultation on the overall strategy. An action plan outlining the priorities for delivery will then be developed.

7. Recommendations

The Trust Board is asked to:

NOTE progress made on the existing communications action plan.
AGREE the proposal to review and consult on the strategy
COMMENT ON the proposed aims for the strategy
AGREE the strategy be renamed to Communications and Engagement Strategy

FT Application - Progress Against Deliverables **Feb-07**

Workstream	Deliverables	By When	Task Owner	Completed	Notes
Engagement (JK)	Communication Plan	15-Nov	JK	Yes	Final version to go to project board in January
	Standard Information Pack / Corporate Presentation	30-Nov	JK	Yes	
	Look and Feel for IBP	1st cut 14/10/2007	JK	Yes	
	Consultation Plan	03-Dec	JK	Yes	Meetings populated with names on ongoing basis
	Consultation Documentation	21-Dec	JK	Yes	
	Consultation Process	11-Apr	JK	n/a	21/1/08 to 11/04/08
	Appendix IBP :Documented Outcome of Consultation Process including issues raised and applicants response	18-Apr	JK	n/a	

FT Application - Progress Against Deliverables **Feb-07**

Workstream	Deliverables	By When	Task Owner	Completed	Notes
Strategy	Agreed version 4 activity model	12-Oct	RK		Version 4 activity now agreed. Trajectory to be updated to take account of latest 2007/8 forecast outturn and 2008/9 LDP
(RK)	Signed specialty service plans initial	23-Nov	RK	Yes	Summary plans agreed at divisional meetings
	Initial list of issues to be resolved	23-Nov	RK	yes	
	Resolution of issues / input from reviews	31-Jan	RK	partial	
	Final specialty service plans	31-Jan	RK	no	
	Chapter 1 IBP - Executive Summary	V1 - 14th Dec, V2 - 5th Mar, Vfinal - 8th April	DL	IBP1 partial	Executive Summary not updated for IBP1
	Chapter 2 IBP- Trust profile	V1 - 30th Nov, V2 - 22nd Feb, Vfinal - 1st April	DL	IBP1,2 yes	
	Chapter 3 IBP- Strategic Goals	V1 - 30th Nov, V2 - 22nd Feb, Vfinal - 1st April	RK	IBP1,2 yes	
	Chapter 4 IBP- Market Assessment	V1 - 7th Dec, V2 - 29th Feb, Vfinal - 4th April	RK	IBP1,2 yes	
	PEST(LE) analysis	30-Nov	RK/DL	IBP1,2 yes	
	Marketing Strategy	21-Nov	RK/JK	Partial	Draft exists - needs updating
	Chapter 5 IBP - Service Development Plans	V1 - 7th Dec, V2 - 29th Feb, Vfinal - 4th April	RK	IBP1,2 yes	
	SWOT	30-Nov	RK	IBP1,2 yes	
	Information/ IT Strategy	Jan /Feb	TA/SW		
	Estates Strategy	Jan/Feb	GS		
	Completion of Monitor checklist	03-Nov	DL	Yes	
	Check outstanding actions from FT diagnostic done	03-Nov	DL/RK	Yes	

FT Application - Progress Against Deliverables **Feb-07**

Workstream	Deliverables	By When	Task Owner	Completed	Notes
Finance (RW)	LTFM	V1 - 14th Dec, V2 - 29th Feb, Vfinal - 4th April	AW	IBP1 yes	
	Chapter 6 IBP -Finance	V1 - 20th Dec, V2 - 5th Mar, Vfinal - 8th April	AW	IBP1 yes	
	Chapter 7 IBP - Risk	V1 - 14th Dec, V2 - 5th Mar, Vfinal - 8th April	AW/ Plus relevant FT Project Team input	IBP1 Partial	need risk work shop
	Service Line Reporting Plan	14th Dec 2007	TW/IK	Yes	
	Service Line Reporting Implementation ?	2008/9	TW/IK	n/a	
	Agreed list protected assets	4th April 2008	AW/ Plus relevant FT Project Team	n/a	Draft list produced for V2 then final version for Vfinal
	Agreed list protected services (with commissioners)	4th April 2008	AW/ Plus relevant FT Project Team	n/a	Draft list produced for V2 then final version for Vfinal
	Schedule 2 - mandatory health services workbook	Jun-08	AW/ Comm team input	n/a	
	Schedule 3 - mandatory education and training services workbook	Jun-08	AW/ Comm team input	n/a	
	Mandatory health services workbook Attachment 1:	Jun-08	AW/ Comm team input	n/a	

FT Application - Progress Against Deliverables **Feb-07**

Workstream	Deliverables	By When	Task Owner	Completed	Notes
	Legally binding contracts	Jun-08	AW/ Comm team input	n/a	
	Agreed list of Key business risks	V1 - 14th Dec, V2 - 5th Mar, Vfinal - 8th April	AW/ Plus relevant FT Project Team	IBP1 Partial	IBP1 updated for words and formats only.
	Risk mitigation strategies	V1 - 14th Dec, V2 - 5th Mar, Vfinal - 8th April	AW/ Plus relevant FT Project Team	IBP1 Partial	IBP1 updated for words and formats only.
	Agreed modelling scenarios	V1 - 14th Dec, V2 - 5th Mar, Vfinal - 8th April	AW/ Plus relevant FT Project Team	IBP1 Partial	IBP1 updated for words and formats only.
	Board statement on working capital accompanied by professional opinion	Jun-08	AW/TW	n/a	
	Board Memorandum on working capital	Jun-08	AW/TW	n/a	
	Board statement on financial reporting procedures accompanied by professional opinion	Jun-08	AW/TW	n/a	
	Applicants should establish whether they can secure the necessary Working Capital facilities from commercial banks.	End of Jan 2008	AW/TW	n/a	

FT Application - Progress Against Deliverables **Feb-07**

Workstream	Deliverables	By When	Task Owner	Completed	Notes
HR (HR)	Chapter 8 IBP - HR and Workforce	V1 - 7th Dec, V2 - 29th Feb, Vfinal - 4th April	CH	IBP1 yes	
	Board Development Program	ongoing	KD		
	Workforce Plan (10 years)	V1 - 30th Nov, V2 - 22nd Feb, Vfinal - 1st April	CH	IBP1 Partial	IBP1 updated for words and formats only.
	HR Strategy	V1 - 7th Dec, V2 - 29th Feb, Vfinal - 4th April	CH	IBP1 yes	
Governance (KD)	Appendix IBP : Membership strategy	30-Nov	JK	Draft	Final version to go to project board in January
	Membership Database	ongoing	JK	n/a	
	Recruitment of Members	ongoing	JK	n/a	
	Chapter 9 IBP - Governance Strategy	V1 - 30th Nov, V2 - 22nd Feb, Vfinal - 1st April	KD	IBP1 yes	
	Appendix IBP - Governance Rationale	30-Nov	KD	Partial	requires detailed SOs to be developed
	Appendix IBP - Draft Constitution	30-Nov	KD	IBP1 yes	
	Model election process	28-Feb	KD / JK	n/a	
	Proposals /timetable for initial elections	28-Feb	KD / JK	n/a	
	Update on implementation of membership strategy and initial elections	In monitor stage	JK	n/a	
	Review of all trust policies and approval by BoD or relevant sub committee	Jan to Jun 2008	KD	n/a	
	Board certification that applicant has organisational capacity to deliver business plan	Jun-08	KD	n/a	
	Trust Board certification on senior management	Jun-08	KD	n/a	
	Trust Board certification on Non Execs and Board subcommittees	Jun-08	KD	n/a	
			KD	n/a	
	Register of Governors Interests	Jun-08	KD	n/a	
	Register of Directors Interests	Jun-08	KD	n/a	
	Letter from Chair confirming whole Trust Board has confidence in arrangements in place for each area	Jun-08	KD	n/a	
	Copies of Trust Board minutes confirming above which record discussions in a trust board	Jun-08	KD	n/a	

FT Application - Progress Against Deliverables **Feb-07**

Workstream	Deliverables	By When	Task Owner	Completed	Notes
	Performance Management Strategy and policy documents approved by trust board	Jun-08	TA	n/a	
	Example of regular performance reports submitted to trust board	Jun-08	TA	n/a	
	Reports from Inspectorates e.g. Health commission	Jun-08	KD	n/a	
	Copy of risk management strategy and policies approved by trust board	Jun-08	KD	n/a	
	Statement of internal control	Jun-08	RW	n/a	
	Management report demonstrating how they have satisfied themselves that they have adequate controls in place to manage risk.	Jun-08	KD	n/a	
	A copy of the applicant's self assessment on the new healthcare standards;	Jun-08	KD	n/a	
	Evidence of compliance with Risk Pooling Scheme for Trusts level 1 and Clinical Negligence Scheme for Trusts (CNST) Level 1.	Jun-08	KD	n/a	
	A statement from the Trust Board that there has been no material change in the applicant's risk management policies and processes since these assessments (referred to above) were made, or details of any significant changes made and confirmation that the processes have been implemented and are effective	Jun-08	KD	n/a	

ENCLOSURE 4b

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD

6th MARCH 2008

SUBJECT:	Foundation Trust Application – Progress Report
REPORT BY	Director of Strategy
AUTHOR:	Director of Strategy

PURPOSE OF THE REPORT:

To update the board on progress on the Foundation Trust Application during February 2008.

IMPLICATIONS:

Financial:	Resources included in 2007/8 plan to support development of application
Personnel:	
Healthcare/ National Policy:	Achieving FT status is a key part of national policy and the Trust's local strategy
Other:	

RECOMMENDATION(S):

1. NOTE the progress with developing our FT application

SANDWELL AND WEST BIRMINGHAM NHS HOSPITALS TRUST
FOUNDATION TRUST APPLICATION PROGRESS REPORT
MARCH 2008

INTRODUCTION

The purpose of this paper is to provide Trust Board with an update in respect of activities related to the Trust's Foundation Trust application since the last Trust Board.

PROJECT MANAGEMENT

The project is broadly on time compared to the project plan. A detailed schedule of progress against individual tasks is included at appendix 1.

The Trust has begun the detailed development of IBP2. The chapters relating to strategy, market assessment and service plans have been produced and reviewed by the Project Board and will be presented to the whole board at the March FT seminar. The remaining chapters will be presented to the project board in March and the seminar in April.

The Trust is continuing to work with the SHA on the likely timetable for the application following April in the light of performance on the MRSA target. The project board have also reviewed a list of the "key questions" that the completed application will need to answer in order to ensure that the IBP addresses these. The project timetable up to the April special trust board remains unaltered.

WORKSTREAM REPORTS

Engagement

The consultation process is now well underway. Consultation documents have been widely distributed to patients, people who have previously expressed an interest in our FT plans and key community groups and stakeholders. The Trust has attended a wide range of local meetings to present our plans and received a number of responses to the consultation so far. It should be noted that public interest at these sessions often concentrates on progress with the Towards 2010 Programme and plans for interim reconfiguration as much as on the FT application itself.

Initial recruitment of potential members has also commenced although is proceeding more slowly at this stage. Further work to boost this part of our activity is planned for the rest of the consultation period.

The membership strategy continues to be developed following the discussion at the Project Board.

Strategy

The sections of the IBP relating to the Trust's strategy, market assessment and future service plans have been substantially revised as part of producing IBP2. These chapters have been reviewed by the Project Board and will be presented to the FT seminar in March. Meetings have been arranged for March to present these sections to Sandwell and Heart of Birmingham PCTs.

The marketing strategy continues to be developed and will be finalised by the end of March for presentation to the Project Board.

Finance

The current activity and capacity model and LFTM were presented to the board at the February FT seminar. Work continues to refine the LFTM for IBP2. The most significant issues include:

- updating the LTFM for 2007/8 forecast outturn and the 2008/9 LDP;
- linking this to the OBC financial model and the 2010 transition trajectory as set out in version four of the programme activity and capacity model;
- clarifying the assumptions about the future development of the sites currently owned by SWBH that will become future community hospitals;
- further developing our view of the financial impact of the transition between now and the new acute hospital.

An updated LTFM will be presented to the Project Board in February and the FT seminar in March.

Workforce

Staff engagement plans continue to be developed. The Trust has also begun to develop its approach to service line management in more detail. An updated workforce section of the IBP will be presented to the Project Board in March.

Governance

The governance rationale has not been completed as it requires detailed standing orders for both the Council of Governors and the Board of Directors to be developed. This is now underway.

Although this item is now behind schedule it can be caught up and should not have any consequence to the eventual finish date of the programme.

CONCLUSION AND RECOMMENDATIONS

The Trust Board is recommended to

1. NOTE the progress with developing our FT application

Richard Kirby
28th February 2008

Enclosure 4d

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD

6th MARCH 2008

SUBJECT:	Towards 2010 Programme Progress Report: March 2008
REPORT BY	Director of Strategy / New Hospital Project Director
AUTHOR:	2010 Implementation Director / 2010 Programme Director / New Hospital Project Director

PURPOSE OF THE REPORT:

To provide the Trust Board with an update on the work of the Towards 2010 Programme including the work of the New Acute Hospital Project as at the end of February 2008.

IMPLICATIONS:

Financial:	
Personnel:	
Healthcare/ National Policy:	The Towards 2010 Programme and the New Acute Hospital Project will set the future strategy for health and social care to the people of Sandwell and West Birmingham.
Other:	

RECOMMENDATION(S):

1. NOTE the progress made with the Towards 2010 Programme.
2. NOTE the progress made with the New Acute Hospital Project.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TOWARDS 2010 PROGRAMME: PROGRESS REPORT
MARCH 2008

INTRODUCTION

The Towards 2010 Programme is the partnership of S&WBH, HoB tPCT, the Sandwell PCTs 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 February 2008.

This report is in three sections:

a) overview of the work of the Programme and the New Acute Hospital Project;
b) Programme Director's report as presented to the 2010 Partnership and the Boards of Sandwell and HoB PCTs (appendix A);
c) Acute Hospital Project Director's report (appendix B).

This format is designed to strengthen the accountability of the Programme to the boards of the partners and to ensure regular progress reporting on the New Acute Hospital Project.

OVERVIEW

This section provides an overview of the work of the Programme and the New Acute Hospital Project.

2010 Programme

As set out in the Programme Director's report work has continued on the development of plans and implementation of exemplar projects, for the 2010 Programme. The most significant issues arising this month are as follows:

- The local health economies in Sutton, Merton, East Elmbridge and Mid-Surrey, based around the Epsom and St Helier University Hospitals NHS Trust, have established a wide-ranging service transformation programme - *Better Healthcare Closer to Home* – similar in scale and scope to the Towards 2010 Programme. Senior officers from this programme visited the local health economy on the 12th February to exchange experiences and lessons learned. They were impressed by the very high level of partnership working and sense of direction in the Towards 2010 Programme.

- The SHA external review team's final report from their review of the Programme has now been produced and is presented in a separate paper to the March Trust Board meeting along with an action plan that will be developed through the towards 2010 Strategy Group.

- As part of the *Investing for Health* strategic framework, the SHA asked every local health economy to prepare its draft overarching vision for the five year period up to 2012/13. The Sandwell and Heart of Birmingham Local Health Economy submitted its draft overarching vision based upon the Towards 2010 Programme in December. Formal feedback from the SHA is still awaited, although we have been told informally that the view of the submission is that:

    - it represents probably the best example in the West Midlands of the level of detailed planning concerning transformational change across a local health economy in a 5 year period,
    - the LHE has well developed plans, some of which have been implemented,
    - the quantitative analysis within the templates shows a significant shift of care from secondary to community based facilities,
    - there are no real negatives although the External Review identified some areas of improvement required and these will be addressed in the response by the local health economy to the External Reviews recommendations.

  Final versions are due to be submitted to the SHA in April 2008 upon completion of 20008/09 LDPs.

- The Information Management and Technology (IM&T) Directors from the acute trust and the two PCTs have developed options for a strategic way forward that provides effective IM&T support to the Towards 2010 Programme and to support local organisational developments. This includes two principal interim options. In order to identify the most appropriate option the following further work streams have been commissioned:

    - A Benefits Realisation Exercise – to identify the risks and benefits to patients and clinicians from an IT perspective and to assess the Value For Money characteristics of the two interim solutions;

    - Clinical Consultation – to obtain a wider clinical view concerning risks and benefits for patient care associated with the two interim solutions; to identify desired functionality to support the exemplar programme and other planned changes in the next three to four years; to express a clinical preference for one of the interim options.

- The Programme budget for 2008/09 has been presented to the Partnership Board. It has been agreed in principle to transfer the budget management of all Programme budgets from Heart of Birmingham Teaching PCT to Sandwell PCT, in accordance with the change in the Senior Responsible Officer.

- The programme has continued to work on delivering the first wave exemplar projects and detailed planning for the second wave.

New Acute Hospital Project

As set out in the Project Director's report, work has continued on the development of the plans for the New Acute Hospital as part of the Towards 2010 Programme.

With regard to the Land Business Case :

- The pre planning consultation process has been completed and the final stages of preparation for an Outline Planning Application are being undertaken. The development of the wider Grove Lane area will mean that for the planning application to be considered by the authority work needs to be undertaken that shows how the hospital will sit in the current environment and the Trust will be required to show it may sit in a regeneration scheme.

The next stages of design development continue:

- The design development for the Public Sector Comparator has been reviewed firstly by the CABE enabler appointed to the scheme and secondly by the DoH Design Review Panel for stage 01 (DRP01). A formal response is awaited from the DRP01.

- The 1:200 scale design development of key departments is proving very worthwhile in teasing out design requirements and bringing greater clarity to the design brief. The design brief forms one of the corner stones of the procurement dialogue process, thus, absolute clarity is required. In this context the Project Board has been asked to consider extending the 1:200 design development to cover some additional areas. In addition to bringing greater clarity of design requirement this will also bring increased "buy in" from clinicians.

Private Finance Unit Review:

- The 28th March has been set aside for the next Richard Glenn review. The Board will recall that the Richard Glenn reviews were established by the Private Finance Unit in response to challenge from the Treasury regarding long term affordability of schemes. A strict ratio test has been introduced as an additional test of affordability.

CONCLUSION AND RECOMMENDATIONS

This report has provided an overview of progress with the Towards 2010 Programme and the New Acute Hospital Project for the Trust Board as at the end of January 2008. The Trust Board is recommended to:

1. NOTE the progress made with the Towards 2010 Programme.

2. NOTE the progress made with the New Acute Hospital Project.

Jayne Dunn
26th February 2008

APPENDIX A: PROGRAMME DIRECTOR'S REPORT

Sandwell and the Heart of Birmingham Health and Social Care Community

TOWARDS 2010 PROGRAMME

Report to: **2010 Partnership Board**
Report of: Les Williams , Programme Director
Subject: **Programme Director's Report**
Date: Monday, 25th February 2008

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.
- Approve the recommendations in Section 4:

  4.1 Draft Action Plan for SHA External Review
  4.2 Programme Budget 2008/09
  4.3 Principles for Involvement in External Activities

2. Background

This report updates members of the Partnership Board on progress made by the Programme since the last report.

The Partnership Board agenda includes items on the work of the Implementation Group and the New Acute Hospital Update, so these issues are not covered here.

3. Items for Information

3.1 Health Reform Demonstrator Systems Programme
I attended the latest event for this Programme at Warwick on 7th February, 2008, along with Mary Bosworth and Ian Mather from Heart of Birmingham Teaching PCT. It was useful in terms of meeting people working in similar programmes and it is clear that the Towards 2010 Programme has a very good reputation for taking a comprehensive approach to redesigning services between acute and primary and community services. The Programme included useful updates on current thinking at the Centre about policy, particularly around the future of Payment by Results. In addition, there was a good discussion about performance metrics, based on outcomes and measuring quality of care, rather than the traditional approach of measuring inputs and processes. Having said that, there is no clear view at the Centre of how this might be addressed. It may be useful to become involved in further activity on this issue.

I made contact with a similar programme in East Lancashire and will explore the potential for joint working.

3.2 Epsom and St Helier – 'Better Healthcare Closer to Home'

Four colleagues from the Epsom and St Helier Trust and Sutton and Merton PCT visited the Programme on 12th February 2008, and held discussions with me, Paul Elkin, Karen Scott, the Workforce Lead, Richard Kirby, Sarb Basi and Peter Jones. I am grateful for their time in preparation and in debating issues with colleagues. The effort put in was very much appreciated by colleagues, who felt that the Programme is clearly established, effectively resourced and demonstrates a very high level of partnership working and sense of direction, by which they were impressed. Given their current difficulties, this bordered on envy by the end of the day. I have provided them with several examples of good practice and we have been invited to visit them if we wish. My judgement, however, is that while it may be of interest, they have so many fundamental issues that it would not be worthwhile currently.

3.3 Investing for Health – LHE Overarching Vision

As members will recall, the Local Health Economy was required to submit to the SHA its draft Overarching Vision for the five year period up to 2012/13 in December. This was achieved and the Partnership received this document at its January meeting.

Formal feedback from the SHA is still awaited, although we have been told informally that the view of the submission is that:

- it represents probably the best example in the West Midlands of the level of detailed planning concerning transformational change across a local health economy in a 5 year period.
- the LHE has well developed plans, some of which have been implemented
- the quantitative analysis within the templates shows a significant shift of care from secondary to community based facilities.
- There are no real negatives although the External Review identified some areas of improvement required and these will be addressed in the response by the local health economy to the External Reviews recommendations.

The assessment being undertaken at the SHA will include judgements on:

- Extent of completion of the templates and any gaps
- Internal consistency of the plans e.g. do the workforce plans reflect the planned changes in activity
- Benchmarking comparisons between PCTs and LHEs of the extent of changes being planned
- Comparison of the plans with best/good practice models such as the Teamwork model

I met with Jon Cook from the SHA who is leading this process on 18th February 2008, and the feedback will be provided by the end of February. The next submission is due at the end of April 2008.

3.4 Engagement and Communications

Members of the Partnership will recall that they approved the Engagement and Communications Strategy at its December meeting. Since then, the Engagement and Communications Group has reviewed the proposed Implementation Plan given in Section 8 and has revised this to take account of the time lag between the original plan being developed and the approval of the Strategy. This is given at Attachment A.

3.5 Transitional Financial Framework

Members of the Partnership will be aware that a draft Transitional Financial Framework has been developed by the three Finance Directors. Having discussed this briefly with two of them, it appears that they wish to undertake some more detailed work before bringing this to the Partnership Board for approval. I have therefore agreed to meet with them in March and will report on progress at the next meeting.

3.6 PCT Facilities Update

Given that the Partnership receives a monthly update on progress with the new Acute Hospital Project, it was suggested that updates on the development of facilities in each of the PCTs should be provided regularly. This has been discussed with the Director of Service Transformation in HoBtPCT and the Director of Commissioning in Sandwell PCT and it has been agreed that a joint format should be developed. This update will therefore be provided at the next meeting.

3.7 Proposals for Expenditure of Workforce Allocation from the SHA

At the last meeting, Karen Scott, the 2010 Programme Workforce Lead, presented proposals for the expenditure of the £585,000 allocated by the SHA for the next two years. At that meeting, it was agreed that the Chief Executives should meet with Karen and I to discuss these proposals in more detail and to agree a process for approval of this expenditure. This meeting took place on 18th February 2008 and the outcome is:

- The proposals in Attachment D for the Workforce Analyst, Workforce Development and the Skills Audit will proceed, taken forward through the Workforce Group.
- The proposals for the economy wide Framework for Organisational Development and the Academic Evaluation need further work, and development. This will be undertaken through the Workforce Group and more detailed proposals will be considered by the Chief Executives and then be brought to the Partnership Board.

3.8 IM and T Strategic Alignments to Support 2010

The IM and T Directors from the acute trust and the two PCTs have developed options for a strategic way forward that provides effective IM and T support to the 2010 Programme and to support local organisational developments. At the last LHE HoB/Sandwell Implementation Board on 6th February 2008, it was not

possible to reach agreement on the appropriate course to take. In recognition of the importance of achieving the correct decision to suit all healthcare settings, the Board therefore has commissioned two further workstreams:

Benefits Realisation Exercise – to identify the risks and benefits to patients and clinicians from an IT perspective of the two principal interim options; the risks and capacity issues from an eventual data migration from an interim to the final Connecting for Health solution; and to assess the VFM characteristics of the two interim solutions

Clinical Consultation – to obtain a wider clinical view concerning risks and benefits for patient care associated with the two interim solutions; to identify desired functionality to support the exemplar programme and other planned changes in the next three to four years; to express a clinical preference for one of the interim options

The findings of these workstreams will be considered at the April LHE Implementation Board.

4. Items for Decision

4.1 Draft Action Plan - SHA External Review Report

The Partnership Board received and has discussed the External Review Report at its January meeting. I was tasked at that time with developing an action plan in response. This has been developed with the support of colleagues in the acute trust and the two PCTs, for which I am grateful. This has been agreed at the Strategy Group meeting on 13th February 2008.

The draft Action Plan is given at Attachment B.

The detailed actions are intended to provide a comprehensive response to the recommendations in the External Review Team's report. In effect, they also provide a set of actions for developing the Programme structure and project methodology over the next few months and I find this particularly helpful.

When agreed by the Partnership Board, the Action Plan will be submitted to the SHA by 29th February 2008, in accordance with their deadline. The Action Plan will then be considered, alongside the External Review Team report, at the SHA Board meeting on 18th March 2008, and Rob Bacon and I are scheduled to present it to the SHA Board, if required to do so.

The Partnership Board is recommended to debate and agree the Action Plan.

4.2 Programme Budget 2008/09

It is timely to agree the Programme budget for 2008/09. This needs to take account of the following changes already agreed during 2007/08:

- Appointment of the Programme Director on a substantive basis
- Appointment of the Workforce Lead on a substantive basis

- Agreement of expenditure for Engagement and Communications of £189,000 (including a post of Communications and Engagement Facilitator - cost subject to confirmation of banding)
- Agreement to convert the post of Programme Analyst to Programme Manager (cost subject to confirmation of banding)

Given below is a draft budget for the year, taking account of these issues and showing the budget for 2007/08. As members will see, Option 1 identifies the Programme Manager post at Band 7 and Option 2 identifies the banding at 8a. Option 2 therefore represents the highest level of expenditure proposed. Please note that the costs given are at 2007/08 pay and price levels and will therefore need to be uplifted for the agreed percentage increases.

Revenue Budget - Towards 2010 Programme 2007/08 and 2008/09

Staff Costs including on costs	**07/08**	**Option 1 08/09**	**Option 2 08/09**
Chair			
Programme Director			
PA and Office Manager			
Workforce Lead			
Programme Analyst			
Programme Manager			
Communications Facilitator			
Committee Secretary			
Total Staffing	**276,000**	**321,400**	**330,200**
Non-Pay Costs			
Expenses (office, travel etc)			
Events (rooms, catering etc)			
Training & Conferences			
Internal Audit			
Legal Advice			
Workforce Planning			
Transport & Access			
Capacity & Activity			
Engagement & Comms			
	144,000	**248,800**	**248,800**
Total	**420,000**	**570,200**	**579,000**

* The £35,000 has not been rolled forward, given the funding of £585,000 available over two years provided by the SHA for workforce issues.

This budget does not yet include the expenditure of the workforce allocation from the SHA. As members of the Partnership Board will be aware, this is a non recurrent allocation over the next two years. The Chief Executives and I have agreed that this should be held within a Programme budget, hosted by

Sandwell PCT and that expenditure is subject to the agreement of business cases which have yet to be completed.

The Chief Executives have agreed this Programme budget and the basis on which this will be funded will be confirmed following detailed discussions.

In addition, it has been agreed in principle to transfer the budget management of all Programme budgets from Heart of Birmingham Teaching PCT to Sandwell PCT, in accordance with the change in the Senior Responsible Officer. This will be actioned at a time to be agreed by the Senior Responsible Officer.

The Partnership Board is recommended to approve the Programme budget for 2008/09 and to require a monthly budget statement of expenditure against budget at each meeting.

4.3 Principles for Involvement in External Activities

As mentioned above, the Towards 2010 Programme has a deservedly excellent reputation for its vision, scope and the commitment of local health economy partners to delivery. This has resulted in several requests to the Programme to receive visitors and attend external events to share good practice. This is clearly welcome and helps the local health economy to increase its profile locally and nationally. It is important however to ensure that the overwhelming majority of the Programme's time, and the time of partners in this regard, remains focussed on delivering changes to services which meet the Programme objectives and deliver improved quality of health care, in better facilities to local people in their neighbourhoods and communities. There is therefore a risk of too much time being used which is not of direct benefit to the Programme itself.

I therefore proposed the following principles to the Chief Executives and these are now recommended to the Partnership Board for amendment or agreement:

- External activity in promoting the Programme, its objectives, approach and developing successes is an important component in delivering the full Programme over the next seven to eight years
- The time allocated to this activity should be proportionate to the benefit to be derived by the Programme in pursuing its delivery objectives
- Priority will therefore be given to:
    - Promoting the programme within and to the SHA
    - Continuing to build the commitment of all wider stakeholders to the Programme
    - Engaging in activities which involve the ability to influence NHS policy makers
    - Being involved in a selected number of network events such as the Health Reform Demonstrator Systems Programme
    - Developing a consistent and mutually co-operative relationship with a small number of selected other sites where there is evidence of direct benefit to the Programme, such as

(potentially) East Lancashire NHS Foundation Trust. Benefit is defined as the ability to see alternative good practice and opportunities to learn from others' experience of implementation.

- General promotion of the programme within and beyond the NHS as a whole will be carried out by an annual or bi-annual good practice event, developed and hosted by the Programme, to which other NHS and public/private organisations, within and beyond West Midlands NHS, will be invited. It may be necessary to consider a small charge to attendees to cover costs.
- The decision on whether or not to become involved in a particular network, event or working relationship will be directed to and taken by, the Programme Director, who will seek advice from members of the Partnership, where appropriate, before committing to involvement.

The Partnership Board is recommended to debate and agree these principles.

Les Williams
Programme Director

Attachments not included but available from Richard Kirby, Director of Strategy or Jayne Dunn, 2010 Implementation Director.

APPENDIX B: NEW ACUTE HOSPITAL PROJECT DIRECTOR'S REPORT

Report to:	**Trust Board**
Subject:	**Project Director's Report**
Report by:	**Graham Seager**
Date:	**February 2008**

1.0 CABE/ Design Review Panel 01

The design development for the Public Sector Comparator has been reviewed firstly by the CABE enabler appointed to the scheme and secondly by the DH Design Review Panel for stage 01 (DRP01). The DRP01 is a follow on from the DRP0 that has been reported earlier in the design development. A formal response is awaited from the DRP01.

2.0 Design Development

The design development continues to proceed with further consultation on the 1:500 design and development of 1:200 designs and exemplar rooms. The 1:200 scale design development is proving very worthwhile in teasing out design requirements and bringing greater clarity to the design brief, this design brief forms one of the corner stones of the procurement dialogue process, thus, absolute clarity is required.

The guidance requires "key departments" to be developed, as such 1:200 are being developed for Emergency Centre, Operating Theatres, Main entrance, OPD, ward layout and Imaging. However, it has been recommended by the PFU to consider developing 1:200s for the whole facility, whilst not going to that at this stage it is recommended to the Project Board to consider extending the 1:200 design development to cover following areas: -

Pathology, Maternity, Neonates, Medical Day Case Unity, Cath Lab and Endoscopy

This will bring greater clarity of design requirement, increased "buy in" from clinicians and hence reduce risk on the project through scope creep.

3.0 Pre Planning Consultation

The pre planning consultation process has been completed and the final stages of preparation for an Outline Planning Application are being undertaken. The development of the wider Grove Lane area will mean that for the planning application to be considered by the authority work needs to be undertaken that shows how the hospital will sit in the current environment and the Trust will be required to show it may sit in a regeneration scheme.

4.0 Richard Glenn Review

The 28th March has been set aside for the next Richard Glenn review. The Board will recall that the Richard Glenn reviews were established by the Private Finance Unit in response to challenge from the Treasury regarding long term affordability of schemes. A strict ratio test has been introduced as an additional test of affordability.

5.0 Technical team appointment

Tribal Consulting have now been appointed as Trust technical advisors for the PFI procurement.

Graham Seager
Project Director

Enclosure 4d

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD

6th MARCH 2008

SUBJECT:	Towards 2010 Programme: SHA Report from the External Review of the Towards 2010 Programme and Action Plan
REPORT BY	Director of Strategy
AUTHOR:	2010 Implementation Director / 2010 Programme Director

PURPOSE OF THE REPORT:

To present to the Trust Board the SHA report from the external review of the Towards 2010 Programme and the action plan that has been developed by the 2010 Partnership in response.

IMPLICATIONS:

Financial:	
Personnel:	
Healthcare/ National Policy:	The Towards 2010 Programme set the future strategy for health and social care to the people of Sandwell and West Birmingham.
Other:	

RECOMMENDATION(S):

- NOTE the findings and recommendations from the External Review of the Towards 2010 Programme.
- NOTE the 2010 Partnership's response to this including the development of a detailed action plan against which progress will be monitored by the 2010 Partnership on a quarterly basis.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TOWARDS 2010 PROGRAMME
SHA EXTERNAL REVIEW OF THE TOWARDS 2010 PROGRAMME

INTRODUCTION

The Towards 2010 Programme is the partnership of S&WBH, HoB tPCT, the Sandwell PCTs and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. At the launch of public consultation in November 2006 the Towards 2010 Partnership agreed with the SHA that the SHA would undertake an external review of the Programme. This external review took place at the end of November 2007 and the report from the review was presented to the January 2010 Partnership Board meeting with an action plan responding to the recommendations from the review being presented to the February 2010 Partnership Board.

.

This brief paper provides for the Trust Board, an overview of the key issues arising from the external review and the actions that have subsequently been agreed. The full report can be found in Appendix 1 and the detailed action plan in Appendix 2.

PURPOSE OF THE REVIEW

The Towards 2010 Programme is seen as an ambitious programme of reform and improvement of health and social care services across the local health economy. In this context the SHA commissioned the external review in order to:

- Evaluate the degree of achievement of the stated milestones at September 2007
- Encourage rigorous programme and project management to ensure success in implementation
- Learn lessons where progress ahs not been made in line with stated expectations.

The external review team consisted of a combination of external experts in the development of ‘out of hospital’ care and ‘peer reviewers’. The external review team reviewed documentation relating to the programme and interviewed patient representatives, teams involved with the delivery of the programme and a variety of stakeholders whose work will be affected by the programme.

FINDINGS AND RECOMMENDATIONS

The external review team was impressed by the strength of the partnership, senior leadership and programme management structures. It felt the Programme’s vision is clearly articulated and well understood. In addition it felt that the approach of choosing six early implementer projects was wise. In summary the external review team assessed the Towards 2010 Programme as being well managed and already addressing most issues. The team made the following recommendations as suggestions which the Programme may find helpful to its ongoing work:

1. The 2010 Partnership Board should consider developing a strategic framework to guide individual projects in discussion on the number of different pathways which should be supported within the health economy.

2. A standard project life-cycle should form the basis of all project plans.

3. Baseline activity should be separately identified at project level.

4. Further development of the Workforce Development Plan.

5. Each project to systematically consider the capability and capacity of primary care to respond to Towards 2010 Programme initiatives.

6. Actively pursue implementation of the Communications and Engagement Strategy and in particular strengthen links with Practice Based Commissioners.

7. Confirm assumptions on proposed 'point of care' testing and the overall imaging plan with all projects and Practice Based Commissioners, including governance arrangements, critical mass and sustainability issues.

8. Review the training needs of project leads and provide additional project management and pathway redesign training.

9. Systematic checks of the consistency of Towards 2010 Programme plans with national policy for specific services (e.g. cancer, children), changes to national policy, and significant changes to clinical practice.

10. Provide more opportunities for sharing and learning between projects.

11. Further consideration of key performance indicators, other aspects of governance of the new pathways and evaluation.

12. Develop a framework for the medium and longer term evaluation of the Towards 2010 Programme.

ACTION PLAN

Since the External Review the 2010 Partnership has undertaken a number of actions that start to address the above recommendations including, additional investment in the Towards 2010 Programme Team, reviewing clinical engagement arrangements and a review of activity targets and trajectories. A more detailed action plan has been developed in response to the External Review recommendations and has now been agreed by the 2010 Partnership Board. Progress against this action plan will be reported to the appropriate group within the Toward 2010 Programme structure with a full review against each action being presented to the 2010 Partnership Board on a quarterly basis and also shared with the SHA.

CONCLUSION AND RECOMMENDATIONS

This report has provided an overview of the findings of the SHA commissioned external review of the Towards 2010 Programme and the local health economy's response to this. The Trust Board is recommended to:

1. NOTE the findings and recommendations from the External Review of the Towards 2010 Programme.

2. NOTE the 2010 Partnership's response to this including the development of a detailed action plan against which progress will be monitored by the 2010 Partnership on a quarterly basis.

Jayne Dunn
2010 Implementation Director - SWBH
27th February 2008

APPENDIX A: Report from the SHA External Review of the Towards 2010 Programme
APPENDIX B: Towards 2010 Action Plan

Sandwell and the Heart of Birmingham Health and Social Care Community

External Review of the Towards 2010 Programme: Action Plan

1. Background

This action plan is the Health and Social Care Community's response to the findings of the External Review of the Towards 2010 Programme Final Report to the West Midlands Strategic Health Authority, 9th January 2008. This action plan was agreed by the Towards 2010 Partnership Board on 25th February 2008 and will be presented to the SHA Board meeting on 18th March 2008.

Since the External Review took place, the Partnership has put a number of actions in place to meet the suggestions made. These include:

- Additional investment in the Programme Team, including an experienced Director appointed to the post of Programme Director
- Agreement to fund a Programme Manager and a Communications and Engagement Facilitator, both dedicated to the Towards 2010 Programme
- The establishment of a Transport Group as a Towards 2010 Programme Group to address issues relating to changed service provision in both acute and community settings
- All three organisations have reviewed their clinical engagement arrangements and are implementing these, to improve co-ordination and to enhance Programme working
- Revision of the membership and terms of reference of the Clinical Group, to include the development of a Programme-wide clinical Strategy, and with each PCT having two Practice Based Commissioners as members of the Clinical Group.
- A review of activity targets and trajectories over the period to 2012/13 and their achievability. This has prompted a detailed series of actions to take the existing Projects forward and to help determine the content and range of the next waves of projects.
- The Local Health Economy has secured funding from the SHA Workforce Project of £585,000 over the next two years. This is being used to develop:
    - Workforce Analysis support
    - A Skills Audit, developing a tool for local use
    - Development of workforce capacity and capability in workforce planners and Project Leads and members of Project Groups
    - Establishment of an economy-wide framework for Organisational Development, to deliver sustainability within the organisations
    - Undertaking academic evaluation of the workforce activity, involving a partnership with an academic institution

The Local Health Economy has therefore continued to invest in Towards 2010 and proposes the following action plan as a response to the External Review report and a further extension of its planned activity.

2. Recommendations and Action Plan

Recommendation 1 Section 7 pages 8 & 9	The Partnership Board should consider developing a strategic framework to guide individual projects in discussions on the number of different pathways which should be supported within the health economy		
Action	**Lead**	**Complete by:**	**Review Process**
Develop Towards 2010 Programme Framework to cover: • Purpose of Programme • Structures and project management approach, including project life-cycle • Agreed project methodology, standards and documentation (Project Brief [draft developed for discussion by HOBtPCT], Project Initiation Document, Project Plans • Care pathways format and guidance on maintenance, to include schematic by specialty/care group of overarching pathway and associated pathways (to take account of variations within speciality and by provider) • Performance management framework, including standard reporting templates to Implementation Group and Partnership Board, activity and outcome measures • Develop Public Health joint actions, to include: CVD risk, Stroke management, home care, Home safety, aids and adaptations, telecare, Alcohol, Smoking and elective surgery, Lifestyle and health • Review Regeneration impacts (planned and potential) of Programme to cover workforce, housing, transport and medical technology • Governance guidance • Evaluation Framework - standards, measures and reporting • Training of project managers, project clinical leads and project group members	Programme Director	July 2008	Individual deliverables signed off by Partnership Board

Recommendation 2	A standard project life-cycle should form the basis of all project plans. Project plans should have a full set of milestones covering all stages of the project. Activity targets should be clearly related to the milestones within the project plans. If activity remains for which projects are not yet identified then this should be shown separately		
Action		**Lead**	**Complete by:**	**Review Process**
Include Project life-cycle in Programme Framework		Programme Director	April 2008	Implementation Group and Partnership Board
Appoint Programme Manager to support implementation of Transition Plans		Programme Manager	In post by May 2008	Programme Director
Review existing projects to agree full set of milestones covering all stages		Project Managers, supported by Programme	May 2008	Implementation Group
Establish clear linkage between activity targets and project milestones, with read across from Activity and Capacity Model Version 4 and Project Plans and performance management framework		Programme Director and Project Managers	May 2008	Implementation Group
Identify activity not covered by projects separately		Programme Director, Director of Strategy, SWBH	March 2008	Activity and Capacity Group
Develop proposals for third and fourth wave projects, after sessions on 'lessons learnt and best practice' involving all project team members		Strategy Group	June 2008	Strategy Group

Recommendation 3	It may be helpful separately to identify baseline activity at project level as projects should ideally 'own' both the target and the impact on baseline activity. The position of community based activity, for example, outpatient clinics in the community, which pre-dates the start of the project should be clarified.		
Action	**Lead**	**Complete by:**	**Review Process**
Review existing projects to agree full set of milestones covering all stages, to include review of baseline activity, how targets were set and clear rules around counting of activity, pre-existing, current and future.	Project Managers, Programme Director	May 2008	Strategy Group and then Partnership Board
Identify any impact on trajectories and end point target levels.		May 2008	Implementation Group and Strategy Group
Where activity is reduced, identify any potential alternative methods or project areas to make up shortfall		June 2008	

Recommendation 4	Further development of the Workforce Development Plan is needed and specific suggestions are:		
Explicit and systematic links with commissioners of training and education programmes are needed. Given the lead times involved, some risk taking may be necessary.			
Action	**Lead**	**Complete by:**	**Review Process**
The Workforce Group Education and Training Providers' subgroup has NHS West Midlands Commissioner representation and involvement, and will develop an action plan to strengthen this area within the Programme.	Education and Training Providers' subgroup	June 2008	Workforce Group
Ensure robust links to Locality Stakeholder Boards from the Workforce Group	Workforce Group and Workforce Lead	March 2008	Workforce Group annually and Strategy Group

Explicit recruitment plans need to be developed once service models and care pathways have been agreed			
Action	**Lead**	**Complete by:**	**Review Process**
Workforce planning process being established in all organisations and scoping of the current potential of existing workforce. Ensure that service modelling and care pathway development reflect workforce requirements to enable future recruitment plans to be designed.	Workforce Lead Workforce Group Project Leads	April 2009	Workforce Group and Strategy Group

An awareness programme for staff from secondary care who are starting to work in a primary care/community setting may be helpful.			
Action	**Lead**	**Complete by:**	**Review Process**
Proposed locality wide programme to provide support to staff about the model of workforce and service modernisation within 2010 Programme, to reduce barriers between primary and secondary care and health and social care.	Workforce Group and Workforce Lead	April 2008	Workforce Group Strategy group and SHA quarterly review of workforce spend

More specialised staff working in primary care will need ongoing training and mentoring. Commissioning this as part of the secondary care service may improve and strengthen the governance of these services, including linkage with audit programmes.			
Action	**Lead**	**Complete by:**	**Review Process**
Consensus among partner organisations to be achieved and an agreed action plan	Workforce Group and Workforce Lead	April 2008	Workforce Group and Strategy Group
HR leads to agree values and principles across the Programme to include education and training	Workforce Group and workforce Lead	March 2008	Workforce Group and Strategy Group

The potential for re-profiling of the workforce to meet the public health agenda as well as service delivery should be considered.			
Action	**Lead**	**Complete by:**	**Review Process**
Workforce planning process being established in all organisations to include this issue	Workforce Group and Workforce Lead	April 2009	Workforce Group and Strategy Group

Recommendation 5	The capability and capacity of primary care to respond to Towards 2010 initiatives is variable at present. This needs to be systematically considered by all projects and linked in an overall approach.		
Action	**Lead**	**Complete by:**	**Review Process**
Sandwell PCT			
Development of Sandwell Primary Care Strategy	Head of 2010 and Strategic Service Planning	April 2008	PCT 2010 Programme Board and Strategy Group
Sandwell PCT Capital Programme in place and will deliver additional physical capacity to accommodate shifted activity and enable primary care to respond more robustly		2011	
Review of available interim facilities solutions to enable front end activity shifts pending delivery of facilities in capital programme		May 2008	PCT 2010 Programme Board and Implementation Group
Sandwell Workforce Plan being developed in context of overall Towards 2010 Programme Workforce Plan to identify training/re-training and education needs and recruitment issues	Assistant Director of HR	September 2008	PCT 2010 Programme Board and Workforce Group
Development of action plans with PBC Clusters linked to Towards 2010 Programme Projects	Director of Clinical Service Development	September 2008	PCT 2010 Programme Board and Implementation Group
Heart of Birmingham PCT			
Implementation of 'gold standard' service specification for 24 primary care centres to be delivered through Out of Hospital Programme – to be trialled for 6 to 12 months with selected practices Development of financial and contractual framework, identification of skills and competencies to support this	Director of Commissioning	Pilot April 2008 to March 2009	HoB Out of Hospital Programme Board Implementation and Strategy Group
Provision of support in modernisation to practices through use of external experts, including Sir John Oldham, Mike Decoverley and Dr Michael Taylor		April 2008	

Recommendation 6	Implementation of the Communications and Engagement Strategy should be actively pursued. As part of this work, further consideration should be given to strengthening links with Practice Based Commissioners.		
Action	**Lead**	**Complete by:**	**Review Process**
Communications and Engagement Strategy agreed by Partnership Board, with implementation plan	Communications Leads and Programme Director	December 2007	Partnership Board
Appoint Communications and Engagement Facilitator for Programme		May 2008	Engagement and Communications Group
Implementation Plan covering branding, website, literature, staff and public engagement and provision of spokespeople agreed January 2008 (plan available as separate document)		June 2008	Engagement and Communications Group and Strategy Group

Recommendation 7	The assumptions on proposed 'point of care' testing should be confirmed and, if necessary, ensure appropriate governance arrangements established. The overall imaging plan also needs to be confirmed with all projects and Practice Based Commissioners, including governance arrangements. For pathology, imaging and equipment implications, it will be important to have a clear understanding of the critical mass necessary to sustain services outside hospital.		
Action	**Lead**	**Complete by:**	**Review Process**
Clinical Group to review current assumptions for out of hospital diagnostics in light of emerging care pathways from exemplar groups and agree overall approach.	Programme Director / Chair Activity and Capacity Group	June 2008	Partnership Board
Link work on overall strategy to ongoing work with each of the exemplar projects ensuring that they have properly identified impact of diagnostics.	Project Leads	Ongoing	Implementation Group
Sandwell and West Birmingham Hospitals			
SWBH to develop provider strategy for diagnostics (pathology, imaging and more specialist diagnostics e.g. neuro-physiology) in consultation with Practice Based Commissioners and PCTs.	Director of Strategy	June 2008	Strategy Group
Sandwell PCT			
Assumption on 'steady state' for 'point of care' testing and imaging plans to be considered by Practice Based Commissioning clusters and confirmed to Project Leads	Head of Commissioning	March 2008	Sandwell 2010 Programme Board and Implementation Group
Assessment of likely equipment requirements based upon overall anticipated demand for diagnostics service are set out on a scheme by scheme basis in the SSDP		Complete	Complete
Each specialty project review of longer term requirements	Project Leads	June 2008	Implementation Group
Heart of Birmingham PCT			
Assessment of short to medium term requirements for Percy Road, Aston and Soho	Outpatient and Diagnostic Programme Lead	March 2008	Outpatient, Diagnostic and Urgent Care Board Implementation Group
Each specialty project review of longer term requirements	Project Leads	June 2008	Implementation Group

Recommendation 8	The training needs of project leads should be reviewed. In particular, additional project management training and training in pathway redesign needed to achieve shifts from secondary to primary care may also be helpful.		
Action	**Lead**	**Complete by:**	**Review Process**
Agree approach on assessing and meeting training needs at Project Leads' session scheduled for 20th March 2008	Programme Director and Project Managers	May 2008	Workforce Group
Through Workforce Group, explore potential for links to SHA Project 9 and potential funding as pilot site	Workforce Lead	June 2008	Workforce Group
Implement training for existing Project Leads	Programme Director	June 2008	Implementation Group
Develop training package for third and fourth wave Project Leads, where new leads are identified	Workforce Lead	July 2008	Workforce Group

Recommendation 9	Periodic systematic checks of consistency of Towards 2010 plans with those relating to, for example, children's maternity, mental health, cancer, cardiac and other services may also be useful. This process could also involve checking plans against any national policy changes or significant changes in clinical practice.		
Action	**Lead**	**Complete by:**	**Review Process**
Develop programme of checks for consistency of Towards 2010 Programme with significant service areas on local, regional and national basis:			
• Define organisations able to give authoritative view on consistency locally, regionally and nationally	Programme Director	March 2008	Implementation Group
• Consider options for most effective form of consistency checking: correspondence, review of documentation, arranging visits to undertake reviews, workshops on service specific basis, broader stakeholder event		April 2008	Implementation Group
• Ensure consistency with LHE Overarching Plans submission		April 2008	Strategy Group
• Agree format for consistency checks and implement		May 2008	Strategy Group
• Review effectiveness of programme of checks and amend		June 2009	Strategy Group

Recommendation 10	Several of the project managers would appreciate more opportunities for sharing and learning between projects.		
Action	**Lead**	**Complete by:**	**Review Process**
Establish opportunity for sharing experience and learning between projects	Programme Director	First event scheduled for 20th March 2008	Implementation Group
Develop programme of regular opportunities for sharing and learning from external agencies and approaches, including Health Reform Demonstrator Systems programme	Programme Director	April 2008	Implementation Group

Recommendation 11	As part of refining project plans, further consideration should be given to key performance indicators, other aspects of governance of the new pathways and evaluation.		
Action	**Lead**	**Complete by:**	**Review Process**
Include in Programme Framework and specifically: • Review relevance and effectiveness of existing performance indicators	Programme Director and Project Managers	April 2008	Strategy Group
• Identify potential performance indicators through workshop session, to include consideration of quality measures, public health measures and pathway development measures	Programme Director, Directors of Commissioning, Strategy, Quality and Public Health, Project Managers and Clinical Leads	June 2008	Clinical Group and Strategy Group
• Confirm data can be collected and reported and implement into performance management framework	Programme Director and Information Leads	July 2008	Activity and Capacity Group
• Identify potential benchmarking data sources and establish regular feeds of relevant and comparable data, and incorporate into performance management framework	Programme Director	August 2008	Implementation Group

Recommendation 12	A framework for the medium and longer term evaluation of Towards 2010 should be developed.		
Action	**Lead**	**Complete by:**	**Review Process**
Include in Programme Framework:	Programme Director	July 2008	Partnership Board
• Review methodologies for evaluation of major service change programmes in public and private sectors		April 2008	Implementation Group
• Develop proposed framework for medium and long term evaluation: standards, measures and reporting		May 2008	Strategy Group
• Validate Evaluation Framework with SHA and HRDS programme		June 2008	Report to Partnership Board
• Implement Evaluation Framework		August 2008	
• Review Framework after initial evaluation		July 2009	Sign off at Partnership Board

3. Reporting

Progress against this action plan will be reported to the appropriate Programme Group as identified above, and reviewed on an exception basis monthly at the Partnership Board. The Partnership Board will receive a full review against the action plan each quarter and this will be made available to the Strategic Health Authority.

Les Williams
Programme Director

ENCLOSURE 4e

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD

6th MARCH 2008

SUBJECT:	Shaping Hospital Services for the Future: Progress Report March 2008
REPORT BY	Director of Strategy
AUTHOR:	2010 Implementation Director

PURPOSE OF THE REPORT:

To provide the Trust Board with a progress report on the work of Shaping Hospital Services for the Future – the Trust's interim service reconfiguration project – as at March 2008.

IMPLICATIONS:

Financial:	
Personnel:	
Healthcare/ National Policy:	The reconfiguration project aims to identify and deliver clinically and financially stable service configuration between now and the opening of the planned new hospital in 2013/14.
Other:	

RECOMMENDATION(S):

1. NOTE the progress made with the Interim Reconfiguration Project.
2. NOTE the Trust is collating further equality impact assessment work for the Equality and Human Rights Commission.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

SHAPING HOSPITAL SERVICES FOR THE FUTURE
PROGRESS REPORT – MARCH 2008

INTRODUCTION

The Trust has identified four priority areas where significant change is required in terms of configuration across the two acute hospital sites before completion of the 'Towards 2010' programme and the new acute hospital. Delivering this level of change will be a challenge and will require robust project management to ensure the desired outcomes and benefits are achieved.

As part of the project management arrangements for this interim reconfiguration work the Interim Reconfiguration Board will present a monthly progress report to the Trust Board that will also be circulated to the Strategic Development Board.

This paper sets out a progress report for the March meeting of the Trust Board.

BACKGROUND

The services identified as priorities for reconfiguration in the short-term (next 12-18 months) and in advance of the changes being developed through Towards 2010 are:

- inpatient paediatric services;
- neonatal intensive care services;
- inpatient surgical services;
- pathology.

PROJECT MANAGEMENT

The project management structure for the interim reconfiguration work continues to operate as set out in previous reports.

Key Meetings Held in February:

- The steering groups and working groups have held meetings.
- The Interim Reconfiguration Capital Scheme Project Boards in Paediatrics, Neonates and Pathology have met.
- A workshop to discuss the Surgical Assessment Unit at City Hospital post interim reconfiguration of emergency surgery was held on 18th February.

PROGRESS AND KEY ISSUES

This section summarises progress that has been made in implementing the interim reconfiguration changes in each of the four areas. It also highlights a number of key outstanding issues relating to implementation that need to be resolved to successfully deliver these changes. The steering groups and working groups are working on these issues as part of developing detailed implementation plans. Each of the detailed implementation plans will be presented to the Interim Reconfiguration Board. A progress rating is given to each of the issues in the implementation plans and this is reviewed monthly by the steering groups and/or working groups. Any significant issues or delays will be reported to the Interim Reconfiguration Board and highlighted in this monthly progress report. Progress for this month and any significant issues are outlined below

Paediatrics

The service model agreed for the interim reconfiguration of inpatient paediatric services was implemented on the 5th November 2007. Paediatric inpatient beds are now consolidated at Sandwell Hospital (on Lyndon 1, Lyndon Ground) with a 24 hour PAU at City Hospital (on D19).

The Paediatric Steering Group will continue to meet until May 2008 to oversee progress with the interim reconfiguration service model and receive evaluation reports.

Ward Refurbishments
There have been delays in completing the planned refurbishment work on Priory Ground. This is now scheduled to be complete and the ward will open early March.

The refurbishment work on the Ophthalmic ward (in order to provide appropriate accommodation for children) has started and is due to be complete in early March.

Neo-natal Intensive Care

Implementation Date.
The timescale for full implementation of the interim reconfiguration changes in neonatal care is dependant upon completion of the capital schemes (expected to be July 2008 for the clinical areas and September 2008 for the support areas).

From November 2007 until the new neo-natal accommodation is available at City, Sandwell babies needing Level Two neo-natal care will be transferred to City post-natally. There will be a temporary increase in neo-natal support at Sandwell to accommodate this and the threshold at which neo-natal babies are received back into the Level One unit at Sandwell will be raised temporarily. The Division have reviewed activity data for women delivering

babies at Sandwell between 30 and 34 weeks gestation and on the basis of this are now transferring the small number of deliveries between 30 and 32 weeks gestation (15 in 2006/07) in-utero away from Sandwell and ideally to City Hospital dependant upon individual risk assessment and available capacity at the time.

Progress
In August the Neonatal Steering Group presented a detailed implementation plan to the Interim Reconfiguration Board. With regard to key issues raised in previous reports the following progress has been made:

- *Refurbishment Work*: The refurbished Level 1 Neonatal Unit at Sandwell is now operational. The work to extend and refurbish the Level 2 Neonatal Unit at City Hospital has started with a full completion date of September 2008.

- *Arrangements for transferring the delivery element of obstetric care for women with high risk pregnancies from Sandwell Hospital to City Hospital:* The Trust estimates that about 300 – 400 extra women at high risk of a delivery before 34 weeks gestation may need to transfer from Sandwell to City if Level 2 neo-natal services are concentrated at City. The obstetric working group is using a planning assumption of 400 additional deliveries to be transferred to City Hospital and is working on the impact of this on obstetric staffing and capacity at both City and Sandwell. This work needs to be linked to other ongoing work about the Trust's obstetric services but we are aiming to have a plan by July 2008 for accommodating these additional births, ahead of the refurbished clinical area of the Level 2 Neonatal Unit at City Hospital becoming operational.

Surgery

Implementation Date.
Following discussion at the Interim Reconfiguration Workshops (September & April) the Interim Reconfiguration Board supported the need to phase the implementation of the surgical proposals aiming to complete the process by December 2008 at the latest. The phasing started with elective surgical work as follows:

- Vascular Surgery: implemented July 2007.

- Breast Surgery services: it is proposed that interim reconfiguration changes are implemented on a staged basis. This will start with the transfer of 23 hour stay sentinel node biopsy breast cancer surgery to the BTC in March 2008.

- Urology: it is proposed that interim reconfiguration changes in Urology could start to be implemented from May 2008.

- Emergency General Surgery and Trauma: it was agreed that no interim reconfiguration changes would be made to these services until after the

review by the Independent Reconfiguration Panel. Following the publication of the IRP report in December (see Appendix 1 for recommendations) an implementation plan needs to be agreed and implementation dates reviewed as part of this.

- Orthopaedics: it was agreed that changes could not be made to Orthopaedics until after the IRP review as an initial assessment suggested the required theatre and bed capacity at City Hospital could only be created once the changes to Trauma had also been made.

Progress

Breast Surgery: A detailed implementation plan and proposed timescale was presented to the Interim Reconfiguration Board at its meeting in November. These were approved and a phased implementation agreed. These changes will now begin in March 2008 starting with a routine theatre list in the BTC for women currently treated at Sandwell to have access to sentinel node biopsy procedures. There has been a slight delay in the implementation date due to staffing capacity to routinely cover the theatre list.

Urology: A detailed implementation plan and proposed timescale was presented to the Interim Reconfiguration Board at its meeting in November and agreed in principle subject to a more detailed financial analysis and equality impact assessment. Phased implementation was planned to begin in February 2008 starting with consolidation at City Hospital of all Urology inpatients requiring a length of stay of 3 days or more. There has been a delay due to theatre staffing capacity and the need to review consultant job plans. It is now anticipated that phased implementation will begin in May 2008.

Arrangements for providing surgical support for patients attending the A&E department at City Hospital including a 24 hour Surgical Assessment Unit (SAU).
The Trust has developed an initial high level model for providing emergency surgical cover to City Hospital for patients attending A&E, elective inpatients and medical inpatients. The next stage of work is to develop these arrangements in more detail including surgical rotas and an operational policy for the SAU at City Hospital. A clinical workshop was held in February and a number of key issues identified. These will now be developed into more detailed patient pathways and a service plan.

Emergency Surgery & Orthopaedics
The previously identified target date, set by the Interim Reconfiguration Project Board, for full implementation of all interim reconfiguration changes was December 2008 but with a recognised need for the phasing of implementation of changes in emergency surgery. The feasibility of this date for emergency surgery and orthopaedics needs to be tested as part of developing the implementation plan. The agreed timetable for developing the implementation plan can be found in appendix 2.

Pathology

Progress:
A detailed implementation plan was presented to the October meeting of the Interim Reconfiguration Board.

Capital work required to support reconfiguration.
The approved scheme is to consolidate the main laboratories for all of the sub-specialities at City Hospital with smaller laboratories in Haematology & Biochemistry at Sandwell Hospital for the majority of routine inpatient work (where results required within 3-4 hours) and all urgent work 24 hours a day with a 24 hour presence in these laboratories. There will also be a full blood bank service at both hospitals. This will involve refurbishing the existing Pathology Department, D9 and D10 at City Hospital.

The capital scheme required to support this service model has been approved and work commenced in January 2008 with an anticipated completion date of October 2008.

Other

Options for transport arrangements for transferring patients between Hospitals sites post reconfiguration.
This continues to be highlighted as a key issue and is being considered as part of the implementation plans for each of the four services. The Trust's own Patient Transport Service is providing the transfer service for children against an agreed specification and the plan is to extend this arrangement for surgical patients.

With regard to relatives visiting patients the Trust is in discussions with West Midlands Travel about public transport access to the sites. The Trust is including questions about transport arrangements in its forthcoming patient surveys. In addition the Trust has undertaken a mapping exercise for patients in the three patient service areas in order to develop information leaflets outlining public transport routes to each hospital. The interim reconfiguration information leaflets for children and parents include information about bus routes to both hospitals.

Impact on teaching and training.
Within Paediatrics, the Universities regarding nurse training and the Deanery with regard to junior doctor training have been advised of the interim reconfiguration changes and implications for training have been considered.

Once the proposals for the future surgical service models have been developed in more detail the Trust will need to work to ensure that the impact on teaching and training of medical and nursing staff is fully addressed in the detail of our plans.

EQUALITY IMPACT ASSESSMENT

Following the Trust's response in August to the Equality and Human Rights Commission's (previously Commission of Racial Equality) request for information the Trust has recently received a further request from the Equality and Human Rights Commission for more detailed information. The information requested relating to the Trust's interim reconfiguration plans includes:

- A copy of the detailed analysis of the demographic data about patients admitted as inpatients to Paediatrics, Neonatal Care and Surgery
- The full impact assessment and the result of wider consultation
- The action plans developed by the Steering Groups
- Details on the process of ongoing review of any implemented proposals

The Trust is currently collating the information requested in order to respond by the middle of March.

The Steering Groups continue to have equality impact assessment on their agendas and to consider related issues as part of developing implementation plans.

CONCLUSION AND RECOMMENDATIONS

This paper has provided an overview for the Trust Board of progress with the development of proposals for service reconfiguration in advance of Towards 2010. The Trust Board is recommended to:

1. NOTE the progress made with the Interim Reconfiguration Project.

2. NOTE the Trust is collating further equality impact assessment work for the Equality and Human Rights Commission.

Jayne Dunn
2010 implementation Director
26th February 2008

APPENDIX 1

Recommendations From The IRP

A copy of the full IRP report has been circulated separately.

In summary the recommendations are:

1. NHS West Midlands (the SHA), Heart of Birmingham and Sandwell PCTs and Sandwell and West Birmingham Hospitals NHS Trust should ensure that plans for future healthcare provision including new buildings are delivered as rapidly as possible.

2. The Trust should develop and deliver effective ways of integrating clinical services across the two hospital sites.

3. The Trust must ensure that workforce plans are developed and agreed which support a sustainable and safe service in and out of hours and which supports increased levels of sub specialisation.

4. The IRP support the Trust's proposals and agrees that the right approach is to concentrate the majority of emergency surgery at Sandwell Hospital and inpatient elective surgery at City Hospital.

5. The Trust Board, PCTs and SHA must satisfy themselves prior to implementation that it is safe to proceed with the detailed arrangements of the interim proposal.

6. Appropriate out of hours protocols, including a clinically appropriate 'Hospital at Night' concept, must be developed for immediate emergency surgery provision at City Hospital.

7. The Surgical Assessment unit (SAU) should be regularly monitored to ensure a safe service is delivered for patients in and out of hours and as part of a wider healthcare model.

8. Patients that are transferred from City Hospital to Sandwell Hospital for emergency surgery must be taken in a safe and appropriate manner. Appropriate protocols must be developed and agreed to underpin this process.

9. Ambulance protocols must be agreed with West Midlands Ambulance Service to arrange for patients requiring or likely to require immediate emergency surgery to be taken directly to Sandwell Hospital, other than in exceptional circumstances.

10. A solution, such as an inter site shuttle bus, to take relatives of emergency surgery patients transferred to Sandwell should be introduced.

11. The Trust should adopt National Confidential Enquire into Post Operative Outcome and Death (NCEPOD) categorisation of surgery lists.

APPENDIX 2

Timetable for Developing and Implementation Plan for Interim Reconfiguration of Emergency Surgery

Date	Action
January 2008	Agree process for developing implementation plan (Surgical Steering Group & Interim Reconfiguration Board)
February 2008	Present process and timetable for developing implementation plan to Trust Board
February 2008	Set up & hold first meetings of the working groups
May 2008	Agree implementation plan at the Surgical Steering Group
May 2008	Present implementation plan to Interim Reconfiguration Board
June 2008	Present implementation plan to Trust Board, PCTs & SHA for approval
August/September 2008	Start first phase of implementation
December 2008	Complete implementation
March 2009	Initial evaluation
June 2009	Evaluation

ENCLOSURE 5a

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE PUBLIC TRUST BOARD

6th March 2008

Subject:	**Audit Committee**
Report by:	**Jonathan Michie, Non Executive Director, Chair of Audit Committee**
Author:	**Robert White, Director of Finance & Performance Management**

PURPOSE OF THE REPORT:

To present to the Trust Board, the minutes of the Audit Committee meeting held on 21st February 2008 for information.

IMPLICATIONS:

Financial:	**None**
Personnel:	**None**
Healthcare/ National Policy:	**None**
Other:	**Compliance with Standing Orders and good Governance practice**

RECOMMENDATION(S):

The Trust Board is asked to receive and note the report

Date: 25th February 2008

Sandwell & West Birmingham Hospitals NHS
NHS Trust

Minutes of the Audit Committee meeting held on Thursday 21st February 2008 at 11:00 am in the Board Room, Medical Education Centre, Sandwell Hospital

Present:	Jonathan Michie (Chair)	JM
	Gianjeet Hunjan (NED)	GH
	Sarinder Sahota (NED)	SS
	Roger Trotman (NED)	RT
In Attendance:	Robert White (Director of Finance)	RW
	Paul Dudfield (Director CWAS)	PD
	Sharon Birdi (LCFS BSIAC)	SB
	Helen Dempsey (KPMG)	HD

		ACTION
08/01	**Apologies** Apologies were noted from Bill Thomas (NED), Isobel Bartram (NED), Mike McDonagh (KPMG), Sarah-Anne Moore (KPMG). JM suggested introductions were made as there were some new attendees. He also confirmed that this would be his last meeting as Audit Committee chair owing to a move to Oxford.	
08/02	**MINUTES** The minutes of the meeting held Thursday 29th November 2007 were agreed as an accurate record subject to a correction to the initials against Paul Dudfield's recorded attendance.	
08/03	**MATTERS ARISING** A separate paper was included as enclosure 2 which summarised the actions/feedback to all matters within the minutes of the last meeting. The Audit Committee accepted the feedback document.	
08/04	**EXTERNAL AUDIT PROGRESS REPORT** HD outlined her paper on external audit progress bringing the committee's attention to the change in partner arrangements, the work programme thus far and IFRS (international financial reporting standards). Specifically her report set out the approach to the Audit of the Accounts and Auditors Local Evaluation (ALE) in addition to the items above. Early work has been completed on the accounting treatment of the land acquisition following the Trust's submission of its intended accounting position. RT enquired as to the timing of the review of fees as well as provision in the plan for work associated with the land acquisition. HD responded that preliminary work was always envisaged associated with 2010. The review of fees would occur following the interim audit and feature as part of the May Audit committee. RW commented that as the land business case matures that	

		ACTION
	more technical accounting work would be needed. **INTERNAL AUDIT MATTERS**	
08/05	**Internal Audit Progress Report** PD highlighted progress on specific audits thus far and the level of assurance assigned to each. He mentioned that the plan in 07/08 had been reduced slightly which did not affect audit coverage. There are a number of 'significant assurance' opinions from the work to date but also a 'limited assurance' opinion on certain aspects of ordering and receipting. Recommendations have been made towards improving processing of confirmation orders, requisition pads and documentation support. SS enquired as to whether the committee should see the full reports. RT suggested an executive summary and HD advised on what other Audit committees do in terms of recommendation listing, management response and tracking. PD commented on his professional responsibility to the committee to bring to its attention any material recommendation which management had not accepted. GH enquired as to the nature of concerns over control account reconciliation. PD responded that these involved minor timing differences but needed to be reported because practice deviated from the Trust's own stated timetables. GH also enquired about the presence of 'suspense' accounts and specifically 'dump codes' where un-coded expenditure needed to be cleared out on a regular basis. RW did not feel this was an issue for the Trust especially as it represents bad practice. Such practice would indicate an inordinate level of expenditure being incurred in the absence of official purchase orders. GH also asked about Internal Audit involvement in the review of controls when Oracle was implemented. PD could not comment as he was not present when the system was put in but would expect that IA involvement would have featured as part of the project and that adherence to the principles of segregation of duties made.	
08/06	**Review of Counter Fraud Progress Report** SB outlined her work on counter fraud. RT enquired as to the uptake on awareness events. SB is working to ensure greater coverage at inductions (including medical staff where possible) as this is the most effective means of reaching staff in addition to ad hoc sessions established for existing staff. She reported that the Trust's counter fraud rating is 2 with 4 (fully embedded) being the highest. SB summarised the new, ongoing and closed fraud investigations. JM thanked her for the report.	
08/07	**Recommendation Tracker** PD presented the tracking report and confirmed that the report	**PD**

		ACTION
	contains recommendations that are due in the period. RT and GH both raised concerns that the report is not as transparent as it could be in terms of understanding total recommendations and for example, how long they had been in the system. PD agreed to give some consideration to alterations to the report so that progress against total recommendations was clear. He did explain that if a recommendation was not yet due, that it would not feature as part of the report for the purposes of assessing red, amber, green progress. The committee noted that of the 25 lines reported, 23 were green providing an overall progress position of 95% on High priority recommendations and 98% on medium.	
08/09	**INTERNAL AUDIT DRAFT PLAN 08/09 & COUNTER FRAUD PLAN 08/09** This report had been circulated to members by email on Tuesday with hardcopies available for the meeting. Whilst prepared in advance of the meeting, the paper was 'pulled' to enable a more detailed meeting to occur between PD, RW and the Chief Executive. The Counter Fraud Plan need not have also been omitted from the papers. This was an oversight. At the discretion of the Chair it was agreed to table this second Plan report. PD spoke to the main plan outlining the focus for next year, i.e. Core Financial Assurance, Assurance Framework per the Trust and specific targeted audits. He drew attention to page 6 where an increased contingency arises so that in-year resources can be devoted as the AF develops or issues arise. RT reiterated the importance of timely receipt of papers and went on to query the number of days devoted to Financial Management and Financial systems in terms of whether this is proportionate. PD set out the rationale for this. RW was asked by RT for his views and he commented that although there may be an element of a historic high baseline for this work owing to a period pre and post merger of the predecessor organisations that the additional assurance/feedback would be of value. HD confirmed that the days did not reflect an external audit pressure. The committee approved the Plan. SB presented the Counter Fraud Plan for the forthcoming financial year. The plan was developed under the 7 priority workstreams for countering fraud. The committee approved the Plan. GH confirmed that she would provide further comments on the plan should any arise following a more thorough reading given that it had been tabled on the day.	
08/10	**ASSURANCE FRAMEWORK** The committee reviewed the Assurance Framework which outlines the key gaps in control/assurance for the Trust's corporate objectives, the summary of actions planned to address any gaps, the progress report and the Status report.	

		ACTION
08/11	**DRAFT CYCLE OF BUSINESS 08/09** RW presented the amended cycle of business to the committee. The revised schedule shows movements of key agenda items and has been formulated in accordance with the NHS Audit Committee Handbook 2005. GH highlighted the need for an 'X' against 'Agreement of Counter Fraud Workplan', this will fall in February. RT wished to bring to the attention of new NEDs that provision is made for private discussions with the Audit Committee members and the external and internal auditor. RT enquired about whether there should be an item on the assessment of individual expertise of members. It was felt that this would likely get picked up as part of the review of the committee's effectiveness but needs to be specifically checked. JM also asked whether the items on the schedule could be grouped into a more coherent listing. RW confirmed that it followed the ordering from the handbook itself but that this should not be a problem.	**RW** **RW**
08/12	**INTERNATIONAL FINANCIAL REPORTING STANDARDS** RW referred to his summary notes from the PWC sponsored events. The notes set out the key considerations the Trust would need to take account of, e.g. first time adoption, leases, unfinished spells, segmental reporting. HD highlighted the issues they would be working with the Trust on in terms of conversion. The key conclusion was that the PFI treatment had not yet been published and that the Trust should move quickly on the work needed following the main preparation of accounts in terms of restating opening balances.	
08/13	**REVIEW OF STANDING ORDERS, STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATION** RW presented a report building on the significant work undertaken to approve new SOs, SFIs and Scheme of Delegation and that this was now well embedded in the organisation. He did not recommend changes to the expenditure limits at this stage but did comment on the need to ensure that inflationary effects in terms of expenditure limits did not mean that a disproportionate workload was being deferred to the Board in terms of approvals. This would be kept under review. The committee accepted the report and its recommendations.	
08/14	**SCHEDULE OF MEETINGS 2008** The meeting schedule was noted.	
08/15	**MINUTES OF SUB COMMITTEES** Minutes were noted from the Finance and Performance Management Committee 29th November 2007 and 20th December 2007 the Governance and Risk Management, 26th November 2007 and the Charitable Trust Fund Committee on the 14th	

		ACTION
	November 2007.	
08/16	**ANY OTHER BUSINESS** Committee members wished to convey their thanks to Professor Michie during his time as committee chair and wished him every success in his new role.	
08/17	**DATE OF NEXT MEETING** The next meeting is due to be held 8th May 2008, 9:30am – 11:30am, Executive Meeting Room, Management Centre, City Hospital (chair to be decided). **Sign** …… **Print** …… **Date** ……	

ENCLOSURE 5b

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE PUBLIC TRUST BOARD

6th March 2008

Subject:	**Minutes of the Finance & Performance Management Sub Committee**
Report by:	**Roger Trotman, Non Executive Director, Chair of the Finance & Performance Sub Committee**
Author:	**Robert White, Director of Finance**

PURPOSE OF THE REPORT:

To present to the Trust Board, the minutes of the Finance & Performance Management Sub Committee meeting held on 31st January 2008 for information.

IMPLICATIONS:

Financial:	**None**
Personnel:	**None**
Healthcare/ National Policy:	**None**
Other:	**Compliance with Standing Orders and good Governance practice**

RECOMMENDATION(S):

The Trust Board is asked to receive and note the minutes

Date: 27th February 2008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Minutes of the Finance & Performance Management Committee Meeting held on Thursday 31st January 2008 at 1.30pm in the Executive Meeting Room, City Hospital.

Present:
Mr Roger Trotman (RT) – Non Executive Director (Chair of Meeting)
Mrs Sue Davis (SD) – Trust Chair
Miss Isobel Bartram (IB) – Non Executive Director
Dr Sarinder Singh Sahota (SS) – Non Executive Director
Mrs Gianjeet Hunjan (GH) – Non Executive Director
Mr John Adler (JA) – Chief Executive
Mr Robert White (RW) – Director of Finance and Performance Management
Mr Tim Atack (TA) – Chief Operating Officer

In Attendance:
Mr Mike Harding (MH) – Head of Planning & Performance Management – part meeting
Mr Tony Wharram (TW) – Deputy Director of Finance
Ms Jessamy Kinghorn (JK) – Head of Communications (Item 7 only)

		ACTION
1	**APOLOGIES** Apologies were received from Councillor Bill Thomas and Professor Jonathan Michie.	
2	**MINUTES OF THE MEETING HELD ON 20th DECEMBER 2007** GH asked for a correction on Page 4 where TA should read TW. TA asked for his title to be corrected to "Officer" not "Office". The minutes were then accepted and signed by the Chair.	
3	**MATTERS ARISING** TA reported back on Item 5.1 Surgery C Deficit Plan. He reported that some funding had been given to the division in respect of excess bed days but the division would also be expected to contribute to dealing with its financial position.	
4	**TRUST PERFORMANCE MANAGEMENT REPORTS – APRIL to DECEMBER 2007** **4.1 2007/08 Month 09 Financial Position & Forecast** RW reported a year to date surplus which was £1.6m ahead of plan and a monthly surplus which was £446,000 ahead of plan. On divisional performance, he reported that Surgery B had presented proposals to recover their financial position to the Financial Management Board and Anaesthetics and Critical Care had been dealt with through the quarterly review process. RT questioned Surgery B performance and RW confirmed that a surplus of £50,000 per month was required up to the	

		ACTION
	year end. TA stated that the division had a strong income position and had received additional funding from HoB for the delivery of 18 week waits. RW reported that, by the division being charged for anaesthetic support to extra theatre lists, the division was reacting by reviewing theatre lists and the need for anaesthetic input. RW reported that cash would fall significantly towards the year end through the repayment of loans, interest and PDC dividends. On prompt payment targets, GH asked about previously reported changes to processes which were now delayed until later this year and into 08/09 and the impact on prompt payments. RW described the electronic procurement process but explained that setting up electronic procurement required a significant amount of input. He stated that the Trust had failed to recruit to vacant posts in the financial systems team but was now intending to work with the Trust's current Oracle partner to progress the project. TW described the problems with current processes and the actions which were being taken, both short and longer term, to alleviate these problems and improve performance. GH asked for an explanation of "other" expenditure on statutory standards. TW explained that, whilst it was possible to identify expenditure as statutory standards, allocation to individual projects could only be done with support from the Estates Department. As the year progressed, the expenditure would be reallocated to specific projects. GH pointed out that year to date expenditure on IM&T was higher than forecast outturn. RW explained that some of this expenditure will be transferred to revenue before the year end. RW reported that the Trust was below planned levels for both wte's and paybill. JA stated that the fall in wte's was almost wholly accounted for by bank staff. IB asked why a fall in bank staff was not matched by an equivalent increase in permanent staff. JA reported that there had been issues with staffing winter capacity. TA stated that recruitment at Sandwell had been difficult. JA reported that there had been problems with bank pay since the transfer to ESR as well as delays in recruitment. He reported that the recruitment process is being reviewed in order to streamline it, the winter planning process is being made more robust and bank nursing as a whole is being reviewed by the Chief Nurse. TA reported that there was less elective activity in December and therefore a lower requirement for bank staff. He expected January bank usage to be similar to November. SS asked why there were no wte's for agency staff. RW explained that it was difficult to establish accurate wte numbers because of variations in pay rates for different types of agency staff. RT asked about final quarter pay costs apparently being very high. RW explained that it was also necessary to look at non pay because of the need to take into account additional funding. He also explained that year end accruals may impact on pay or non pay and assumptions had been made for the forecast outturn about their effect. RW stated that he did not share the extrapolation assumptions. GH asked about redundancy costs. RW explained that the forecast outturn included some redundancy costs but that these were included within the lines for individual pay groups. RW explained the need to extrapolate both pay and non pay and explained the issues around the "other costs" line which included reserves. RT asked for further explanation of the forecast outturn and both RT and GH asked why redundancy costs were not shown on the redundancy line. RW agreed to provide further explanation.	

		ACTION
		RW
	RT asked about the possibility of bringing forward the production of financial information and quoted the Audit Commission report which cited Harrogate FT reporting to budget holders on the 5th working day and the Board on the 7th. SD requested a review of the reporting timetable in advance of FT status. JA suggested that the information could be circulated even if meetings did not take place.	**RW**
	GH asked whether the £2.3m funding for additional environment improvements etc. was included in the position. RW agreed to report back on its treatment.	**RW**
	4.2 <u>Performance Monitoring Report</u> MH delivered the report and drew the attention of the committee to its main features. The overall proportion of Cancelled Operations further reduced during December to 0.8%, comprising Sandwell 0.5% and City 1.0%. During the same period Delayed Transfers of Care fell significantly at Sandwell to 1.1%, although a slight increase to 2.7% was seen at City. A/E 4-hour wait performance fell to 97.20% during December, reducing the year to date performance to 97.90%. Improved performance has been seen during the latter part of January, regularly exceeding 99.00%, ensuring an improvement to the year to date performance. TA stated reasons for recent improvement were; heightened micro-management, improved bed flow and improved capacity in other health economies. The incidence of C. Diff, expressed as rate per 1000 bed days remained less than the upper threshold of 1.54 during December. The rate in the aged over 65 category at Sandwell was 0.91 and at City 1.52. The overall year to date incidence decreased to 1.67. JA referred to recent SHA documentation which included monitoring of the Trust's performance to a numerical target, the derivation of the target is as yet unknown. 7 cases of MRSA Bacteraemia were reported during December, 6 at Sandwell and 1 at City. This takes the number for the year to date to 36, compared with the nationally set annual upper target of 33. The percentage data completeness of Ethnic Origin for Inpatient FCEs reduced significantly during October and November. Reasons for this, associated with the migration to the newly installed I.T. system, have been identified and a rectification process is underway. TA advised the committee that robust Referral to Treatment Time data is now available from the new IT system During December the percentage of admitted and non-admitted patients commencing treatment within 18 weeks of referral was 88.3% and 91.9% respectively. TA stated that he was confident that RTT milestones for March 2008 would be met. 100% of patients now have clock starts. A lower volume of Day Case activity during December reduced overall elective performance against plan for the period to date to -1.9%. The times for patients waiting for Diagnostic investigations continues to	

		ACTION
	reduce. Particular progress is evident within Audiology and Orthotics, where within the latter, patient numbers in excess of 13 weeks have halved since April. The target of no waits in excess of 13 weeks by the end of March is progressing in accordance with plan. West Midlands Ambulance Service turnaround data is included within the report. MH made reference to recent improvement in the percentage of ambulances being turned around in excess of 30 minutes. SD referred to instances where ambulances were still waiting in excess of 90 minutes on occasion. In respect of readmissions and in response to IB, TA stated that views differ amongst clinicians regarding 'acceptable' rates. As an example TA referred to a higher rate within Elderly Care Medicine reflective of discharge from hospital as early as possible, in order to avoid dependency upon the hospital by some patients. Following brief discussion on the recent report on Maternity Services by the Healthcare Commission, it was acknowledged that it is desirable, where possible, to increase the range of performance indicators within the report, which are aligned to Patient Experience. **4.3 Debtor Report** TW presented the report, stating that whilst the overall position had improved, the improvement is not as great as had been expected. Reasons for this include; a slowing down of payments of debts by organisations over the Christmas period and organisations preparing / planning for year end financial reporting. In terms of major outstanding balances, there is no real change, with two problematic areas remaining; UHBFT and HEFT. Work is on-going in terms of striving to achieve resolution, and this is referred to in the report. GH referring to Appendix 1 asked whether the replacement for Mike Burns would be addressing the outstanding BSIAC debts relating to South Birmingham PCT, to which TW responded, yes. GH asked why a debt, relating to Radiology Trainees, dated 31 October 2007, in the sum of £68,524 (UHBFT) was not included within the schedule of Outstanding Amounts at November. TW, although not entirely sure, thought this may relate to the cut off date for inclusion of debts within the schedule. TW agreed to investigate. In response to concern by GH that a 50% risk had been attributed to recently introduced invoices, RW stated that this assessment is based upon the historical response to payment from the organisation, but should not be seen as an indication that the Trust will not aggressively pursue full payment.	**TW**
	In response to SD regarding UHBFT. RW stated that UHBFT owe SWBHT more than SWBHT owes UHBFT. A proposal has been put to UHBFT based upon accepted debts, with resolution very close. GH commented that totals in Appendix 4 do not correlate with totals in Appendix 2. TW stated that this was due to two small invoices, not payroll related, being excluded from the schedule of payroll invoices.	
5	**COST IMPROVEMENT PROGRAMME – 2007/08** **5.1 CIP Delivery Report**	

		ACTION
	JA stated that there were no significant issues to report with regards to the 2007 / 2008 Cost Improvement Programme. At a meeting held earlier in the day the Financial Recovery Board had looked at Divisional CIP submissions for 2008 / 2009. Whilst at a high level the value of schemes identified was in excess of the identified target, there are some issues requiring resolution; the degree of non-recurring schemes identified by some Divisions is not permissible and one or two schemes submitted needed to be reconsidered. JA added that detail on 'Enabling Work streams' had been circulated earlier during the week for information. Any potential redundancies submitted as part of 2008 / 2009 CIP proposals are considered in total to be less than the threshold which would trigger a consultation exercise with staff.	
	5.2 Minutes of the Financial Recovery Board Meeting held on Thursday 20th December 2007 Enclosure not received for consideration.	
6	**FINANCIAL PLANNING 2008 / 2009** RW introduced the paper intended to provide an overview of the status of financial planning for 2008 / 2009 to date. The main financial areas addressed within the paper are: ● Funding context and Operating Framework ● Anticipated financial position in 2008 / 2009 ● Internal financial planning ● CIP planning for 2008 / 2009 (and targeted levels in 2009 / 2010) ● Capital Budget and borrowing requirements ● LDP negotiations RW drew the attention of the committee to the 2008 / 2009 tariff uplift table, and stated that in terms of the Local Delivery Plan the Trust has set out a number of cost pressures, which will be subject to negotiation with PCTs. The draft Capital Programme will be subject to further internal scrutiny. SIRG financial thresholds are included within the report; RW added that any proposed revisions, currently under consideration, would be consistent with Trust Standing Orders / Standing Financial Instructions. The report was otherwise noted.	
7	**MARKET & DEVELOPMENT BUSINESS STRATEGY** JK introduced this item and outlined the priorities over the next 6 months. RT raised the issue of the large number of "amber" and "red" items. JK reported that, in many cases, discussions were ongoing with GPs, PCTs etc. and the projects had been left as amber because they had not yet been formally signed off. SD stated that ongoing discussions did not necessarily mean that the projects should not be rated as green and	

		ACTION
	believed the implication of not being green was progress was not as good as hoped for. JK said that this was the case in some areas and the projects could be rated somewhere between green and amber.	
		JK
	RT suggested that, for ongoing tasks, an extra column with planned completion date would be helpful. He stated that, on cold reading, the report suggests that there are problems. Including the additional column would have generated a fairer appraisal. JA said that a lot had been going on but not everything was progressing exactly as hoped therefore it was reasonable to have a more cautious view. SD said that what people needed to know was what was expected at this point.	
	SD asked about administrative support and JK responded that no funding was available for the post. JK reported that it was not affordable from within existing budgets and she was therefore looking at other options. SD suggested that a lack of administrative support meant that higher paid staff would do administrative work. JA reported that SIRG had approved some funding but this was insufficient to cover all proposed costs. JK said that some informal and limited backfilling was currently in place but it would not be possible to continue with this into the future. She reported that a job description for the post had been resubmitted for AfC banding. SS enquired about the possibility of taking new graduates part funded by the Development Agency. JK agreed to look at this option.	
	IB also said that, on the face of it, the report was discouraging but many projects were linked together and connected with appointments to vacant posts. JK reported that the response to advertisements had been poor and she has been in contact with agencies but this option would incur additional costs. IB suggested contacting universities. JK said that appointments had been made in the past via links with universities. SS supported links with business schools.	
	JK agreed to take the observations on board for the next report which is due in May.	**JK**
8	**WORKSCHEDULE FOR 2008**	
	Noted	
9	**STRATEGIC INVESTMENT REVIEW GROUP**	
	9.1 Minutes of the Meeting Held on 18th December 2007	
	The minutes of the above meeting were noted.	
	9.2 Summary of Decisions for Meeting Held on 15th January 2008	
	Noted.	
10	**ANY OTHER BUSINESS**	
	Following discussion initiated by SD, it was agreed that the incoming Trust Secretary would be asked to give due consideration to reducing the volume of paper in reports. An example given related to 'standard' pre-	

		ACTION
	amble replicated each month.	
11	**DATE AND TIME OF NEXT MEETING** The date and time of the next meeting is Thursday 28th February 2008 at 2.30pm in the Ground Floor Committee Room, Sandwell General Hospital. **Signed**……..… **Print**…….…….. **Date**……	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Board Meeting

To be held "**In-Committee"** on Thursday, 6th March 2008

A G E N D A

1.	**Minutes of Previous Meeting** *To approve the minutes of the meeting held 7th February 2008 as a correct record*	**Enclosure 6**
2.	**Matters Arising**	
3.	**Presentation: FT Board Development Programme** ▸ Initial Feedback and Next Steps	
4.	**Red Incident Report**	**Enclosure 8** To follow
5.	**Consultant Exclusions**	**Verbal Update**
6.	**Staff Engagement: Single Tender Action**	**Enclosure 9**
7.	**NEW ACUTE HOSPITAL: OUTLINE BUSINESS CASE/PROCUREMENT PROCESS PRESENTATION**	**Enclosure 10**
8.	**Minutes for Noting** (8.1) Draft Towards 2010 Acute Project Board: 28th February	**Enclosure 11** To follow
9.	**Any Other Business**	

Sandwell & West Birmingham Hospitals NHS
NHS Trust

ENCLOSURE 6

Minutes of the In Committee Trust Board meeting held on Thursday 7th February 2008 at 4.25pm in the Churchvale/Hollyoak Room, Medical Education Centre, Sandwell Hospital.

Present:	Mrs. Sue Davis (Chair)	Cllr Bill Thomas
	Mr. John Adler	Ms. Isobel Bartram
	Dr. Hugh Bradby	Mr. Richard Kirby
	Mr. Roger Trotman	Dr. Sarinder Sahota
	Mrs. Gianjeet Hunjan	Mr. Robert White
	Prof. Jonathan Michie	Mrs. Rachel Stevens
In Attendance:		
	Miss Kam Dhami	Mr Graham Seager
	Mrs. Dot Gospel	Mrs. Jessamy Kinghorn
	Mr. Matthew Dodd on behalf of Mr. T. Atack	Mrs. Amanda Winwood
Apologies:	Mr Tim Atack	Mr. Colin Holden

		ACTION
7(08)	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meeting held on the 3RD January 2008 were accepted as a correct record.	
8(08)	**MATTERS ARISING** There were no matters arising	
9(08)	**STAFF ENGAGEMENT PROJECT** Mr Adler presented the report. The report is self explanatory. Our application for Foundation Trust highlights our engagement with staff. Our latest staff survey results show that our ratings are typical and we need to do better than this. The first phase is a number of Trust-wide events with staff, the second phase is more focussed with organisational themes e.g. ward not functioning well or departments with issues; the third phase is about spread. The overall is to change the philosophy on how we run the organisation. This is high profile and has been reported to Clare Chapman, Workforce Director at the DH and also the SHA ask that we share with other organisations our experience. We have not yet entered into a contract with the consultancy and the appropriate procurement procedures will be follows. Key staff involved in this work include Mr Adler, Communication's and HR Mr Trotman added that Mr Holden had outlined this work to those at	

		ACTION
	the Foundation Trust project board; he added it is important to get all managers on board as well and staff side. Mr Kirby added some of this can be built into the leadership conference in May. Mr Adler went on to say service improvement and LEAN type thinking needs to be included in the work. **The board received and noted the paper.**	
10(08)	**FINANCIAL PLANNING 2008/09** Mr White presented the report; the report is to present an initial analysis of the anticipated funding position of the Trust 08/09 and to confirm the planned £2.5m surplus and CIP target. Further information will be available in April. **The Board received and noted the content of the report.**	
11(08)	**RED INCIDENT REPORT** Ms Dhami presented the report. Page 3 highlights the key areas. Ms Bartram asked where TTR feedback is reported to. Ms Dhami reported that action plans are signed off by Divisions and then reviewed by the Adverse Events Committee which is chaired by Mr Adler. Ms Bartram raised another point regarding manslaughter legislation. Ms Dhami reported that a briefing session was planned on this. Mrs Hunjan observed that a number of TTRs were still outstanding and it was agreed that an explanation of any delays would be included in future reports. Dr Bradby added that the C. Diff audit is one that is required by the SHA; we have developed our own pro-forma as the standard one is difficult to use. He pointed out that for incident 12, it should read 'encased cyst to right lung', due to this lady's condition antibiotics were required and these lead to the C. Diff. **The Board received and noted the contents of the report.**	**KD**
11(08)	**CONSULTANT EXCLUSIONS** Dr Bradby advised that the trial of Mr Moore commences next month. In the meantime he remains excluded without pay. Mr Dwarakanath – Dr Bradby gave an update on this case. He has been deemed fit to return to work and a disciplinary hearing takes place tomorrow. In the meantime he has been formally excluded on full pay.	
12(08)	**MINUTES FOR NOTING** • 2010 ACUTE PROJECT BOARD: 20TH DECEMBER 2007 **The Board received and noted the minutes.**	

		ACTION
13(08)	**<u>ANY OTHER BUSINESS</u>** Meeting closed at **4.50pm** …… …… **Signed** **Print**	

ENCLOSURE 9

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE PRIVATE TRUST BOARD

6 March 2008

Subject:	**Single Tender Action – Optimise Ltd**
Report by:	**Chief Executive**
Author:	**John Adler**

PURPOSE OF THE REPORT:

To seek the Board's approval of a single tender action in respect of Optimise Ltd

IMPLICATIONS:

Financial:	**£102,813 –fully funded by NHS West Midlands**
Personnel:	**Implementation of FT workforce strategy**
Healthcare/ National Policy:	**Implementation of national staff engagement strategy**
Other:	

RECOMMENDATION(S):

To approve the single tender action in respect of Optimise Ltd as set out in the attached approval request.

Date: 26 February 2008

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

Single Tender Arrangement for the purchase of goods estimated to cost over £50,000 (including VAT).

Standing Orders stipulate a single quotation shall not be actioned by the Supplies Manager until the appropriate officer (Divisional Director, Divisional General Manager or other authorised signatory) has submitted a report on the need for such action, and the action has been approved by the Trust Board. Prior to submission to the Trust Board the report must be reviewed and signed off by an Executive Director. This proforma has been prepared as a standard report which will provide the necessary documentation and proof that the Standing Order has been complied with.

PLEASE NOTE: That it is the responsibility of the Supplies Department to identify sources of supply.

Department/Division: **Chief Executive**

Item of equipment/Services required: **Consultancy support for Staff Engagement Programme "Listening into Action"**

Supplier: **Optimise Limited**

Estimated/Actual cost: **£102,813 incl VAT plus expenses**
(including VAT, delivery, maintenance and training if applicable)

Value of previous order/contract (if applicable): **Not applicable**

Has this service or item of equipment been the subject of a competitive tender/quotation in the past?

Yes. Competitive procurements have been undertaken by the NHS Institute and Department of Health in 2007 for the national pilot staff engagement projects. Information provided by the Institute and DH indicates that the rates quoted by Optimise to the Trust compare favourably with the rates obtained through the previous competitive procurements.

Reasons why this Supplier must be used:

A full briefing on the staff engagement project was provided for the Trust Board at its February meeting. The SWBH project represents the West Midlands pilot of the national approach. For this reason, it is necessary to use the same consultancy as for the initial national projects, as the basis of the approach has been uniquely developed by Optimise in conjunction with the NHS Institute and Department of Health. In order to ensure continuing value for money, Optimise's quotation has been benchmarked against the previous competitively quoted rates.

Please note that the Optimise input being contracted for has reduced from the 86 days quoted in the February briefing to 70 days, with a proportionate reduction in total cost.

Signed …….. **Date** ……

Designation ……..……

Executive Director

Signed…….…. **Designation**……..

Date:……..

Approved : YES/NO

Board Minute Number…… **Date of meeting**……..

ENCLOSURE

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE PUBLIC TRUST BOARD

6th March 2008

Subject:	New Acute Hospital Services Development Project : Preparation for OBC Submission / Scope of PFI Procurement Contract
Report by:	Graham Seager, Project Director, 2010 New Acute Hospital Services Development Project
Author:	As above

PURPOSE OF THE REPORT:

- To propose a series of briefings / presentations to the Trust Board in preparation for submission of an Outline Business Case for a new acute hospital facility
- To present on the PFI business case approvals process
- To present on PFI contracts
- To seek approval of the scope of the PFI Procurement contract

IMPLICATIONS:

Financial:	
Personnel:	
Healthcare/National Policy:	
Other:	

RECOMMENDATION(S):

- **Approve** the proposed process to ensure robust and informed decisions can be made when considering the OBC for the new acute Hospital facility;
- **Note** the presentation on the PFI business case approvals process;
- **Consider** and **note** the information presented in relation to PFI contracts;
- **Consider** and **approve** the scope of the PFI Procurement as outlined in this paper.

REPORT TO TRUST BOARD

PREPARATION FOR OBC SUBMISSION AND APPROVAL / SCOPE OF PFI PROCUREMENT CONTRACT

1 Preparation for OBC Submission and Approval

It is important for the Trust Board to understand and support the decisions, recommendations and commitments being made within the "Towards 2010" New Acute Hospital Services Development Private Finance Initiative (PFI) Project (the “Project"), this is particularly relevant in light of the Trust’s pending FT status which brings additional and more formal governance obligations on behalf of the Trust Board.

To help support these requirements and the Board’s ability to make an informed decision when considering the acute Hospital’s OBC, it is proposed that a series of briefings and/or presentations are made to the Trust Board over the forthcoming months, to help prepare the Board for final submission of the OBC.

Each briefing / presentation will focus on a key area of the business case, providing background information to the process, highlighting issues to be taken into consideration, and outlining the basis upon which the OBC is being prepared, for challenging and approval by the Trust Board. Depending upon the nature of the subject area, the presentations may take the form of a presentation, a written briefing document, or a facilitated workshop with external advisers.

A programme of presentations starting as follows:-and necessary approvals is proposed as follows, in line with the current project plan:

Table 1. Trust Board Presentations / Approvals

	Presentation / Approval	**Trust Board Meeting**
1.	OBC Process (presentation only)	6th March 2008
2.	Scope of PFI Procurement	6th March 2008
3.	Outline Planning Application	3rd April 2008

Other topics for presentation will include:

- Review of Draft OBC
- Project Affordability
- Collaboration Agreement with SMBC re Grove Lane site
- OBC Submission Approval
- Summary of the Invitation to Participate in Dialogue ("IPID") documentation
- Explanation of the risk sharing inherent in a PFI transaction;
- Description of the evaluation process to select the preferred bidder;
- Summary of offer of the preferred bidder; and
- Reminder of commercial position prior to financial close

These will be timetabled to suit the relevant stage of the project.

It is proposed that upon submission of the final OBC in the summer, an overarching presentation will be made in relation to the business case, with updates on developments made in relation to the key areas previously covered.

As Board members will know, this will be the largest investment made within the Trust and probably for many of the individuals on the Trust Board. It is therefore important that the Trust Board is informed and updated of the work being undertaken, and the decisions requiring approval, in a sufficiently robust way.

2 PFI Approvals Process - Presentation

In preparation for the decision making process to start in earnest, an initial presentation will be made outlining the PFI business case approvals process from Strategic Outline Case (SOC) to Fully Business Case (FBC) stage. It will highlight in particular the requirements at OBC stage, and taking into account the recently introduced PFI Competitive Dialogue (CD) process.

A copy of the presentation can be found at ***Attachment A***.

3 PFI Contract – Presentation

In line with the programme of presentations and approvals outlined in the table above, the Trust Board is required to consider and approve the scope of the proposed PFI Procurement contract.

Before considering the scope, a presentation will be made (see ***Attachment B***) outlining what a PFI contract is, why a PFI contract would be used, the associated risks and benefits, and the issues to take into consideration when agreeing the scope of a PFI contract. (A supplementary written report based on the presentation is also available at ***Attachment C***, for future reference and detailed reading.)

4 Scope of SWBH PFI Contract

A paper outlining the proposed scope of the SWBH PFI contract is included for consideration and approval at ***Attachment D***.

5 Recommendations

- **Approve** the proposed process to ensure robust and informed decisions can be made when considering the OBC for the new acute Hospital facility;
- **Note** the presentation on the PFI business case approvals process;
- **Consider** and **note** the information presented in relation to PFI contracts;
- **Consider** and **approve** the scope of the PFI Procurement as outlined in attached paper.

ATTACHMENT A

PFI BUSINESS CASE APPROVALS PROCESS - PRESENTATION

TRUST BOARD PRESENTATION - BUSINESS CASE APPROVALS PROCESS

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

PFI in the NHS - Business Cases

Trust Board
6th March 2008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

APPROVAL PROCESS

- Strategic Outline Case (SOC)
- Outline Business Case (OBC)
- Appointment Business Case (ABC)
- Full Business Case (FBC)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

OBC CONTENT

- Rationale for Preferred Option
  - Statement of need
  - Identification of options available
  - Appraisal of options
- Strategic fit with local health community
  - Services
  - Capacity
  - Stakeholder support

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

OBC CONTENT

- Strategic fit with national & regional priorities
- Procurement route assessment
- Value for money and risks
- Affordability
- Benefits Realisation Plan
- Project timetable and project management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

OBC ISSUES

Historically:

- Scope of schemes not fully defined
- Large cost increases after OBC
- Timetables ambitious

NHS Changes:

- NHS financial position
- Independent providers / choice / waiting targets
- Service changes / move to primary care
- Financial regime

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

OBC CHANGES

- More detailed work on capacity requirements and sensitivity analysis
- Greater emphasis on design brief
- More development of output specifications
- Clear strategies on soft fm, equipment, interim services, and retained estate developed
- Organisation is financially viable in medium and long term

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

OBC – SCHEME AFFORDABILITY

Project is affordable and tested under a number of downside scenarios

- Revenue envelope established covering all PFI and related costs
- Project is not outside established ranges for a number of financial ratios
- Sources of funds identified for all projected revenue costs
- Long term cash flow supports the unitary charge

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

OBC – CHANGE IMPACT

- Much clearer position on scope, design and affordability when going to the market
- Clear financial parameters in taking the scheme forward
- Where outside approval parameters need OBC re-approval
- Pre-OJEU check – by PFU to ensure tender documentation is ready.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

ABC – PREFERRED BIDDER

- Main business case approval point
  - Treasury approve all schemes over £100m
  - DH Ministers approve all schemes over £50m
- Trust to confirm that project has
  - Kept within the agreed OBC criteria
  - Key focus on price certainty & affordability
  - Suitable commercial position
  - Complied with Treasury vfm guidance stage 3
  - CD requirements of firm deal consistent with approval requirements

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

ABC – PREFERRED BIDDER

- Commercial parameters
  - Standard form compliance
  - Calibration of payment mechanism
  - Funding proposals (including arrangements for funding competitions)
  - Approach to obtain funders agreement
  - Compliance with other policies, e.g. energy, concession lengths, no advance works, etc.
- DH Estates design review and forward design process
- Capacity review where significant change has occurred

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

ABC – PREFERRED BIDDER

- Fitting business case to the procurement process
  - OBCs much tighter documents
  - Business case should be live document and routinely updated, submission is Trust risk
  - Manage all stakeholders so no surprises
  - Sections can be drafted while awaiting bids
  - Align format with Board papers to minimise work
  - Work can be done in the approval period – e.g. funding competition

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI BUSINESS CASE APPROVALS PROCESS

FULL BUSINESS CASE

- Confirmation case at financial close
  - Key criteria are still met
  - Updated information (e.g. Trust's latest financial position and funding parameters etc.)
  - Final commercial parameters (e.g. final vfm of funding terms)
- Assurance to Treasury approval (> £100m) that PB conditions fully met

ATTACHMENT B

PFI CONTRACT – PRESENTATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI CONTRACT

PRIVATE FINANCE INITIATIVE CONTRACTS

Trust Board
6th March 2008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI CONTRACT

WHAT IS PFI?

- Introduced in 1992
- Aims to transform NHS from owners / operators of healthcare assets to purchasers of services as guardians of patient / end users interests

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI CONTRACT

DRIVERS FOR PFI

- Allows NHS bodies to concentrate on core functions of healthcare
- PFI Partner responsible for designing, building, financing and operating assets
- Creates a structure in which VfM is optimised
- Transfers risk to the PFI Partner

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI CONTRACT

PFI – A WHOLE LIFE SOLUTION

- PFI Partner contracted to provide services to agreed standards
- PFI Partner subject to performance-related payment mechanism
- Private sector provides capital to fund new facilities
- PFI Partner carries out design & construction, and provides services including: operation, maintenance and lifecycling for contract period of 30 years

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI CONTRACT

PFI – THE ADVANTAGES

- Integration of service delivery with design, construction and maintenance brings efficiencies of cost / money
- Risks are clearly identified and allocated
- Length of contract enables service provider to make investments in service delivery
- Clear focus on the needs of the user of the service
- Payment only made when service is operational, and in full when service / performance measures achieved

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI CONTRACT

PFI – THE DISADVANTAGES

- PFI procurement process more complex
- Cost to private sector in bidding is significant
- Perceived lack of flexibility in service provision based on length of contract
- Development of a PFI project can be lengthy

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI CONTRACT

STANDARD FORM CONTRACT – SF3

- SF3 contains mandatory schedules (eg payment mechanism, review procedure, variation procedure and Deed of Safeguard)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PFI CONTRACT

SWBH – SCOPE OF PFI CONTRACT

- PFI Partner responsible for maintaining building over contract period for all PFI schemes
- Other Hard FM services (eg window cleaning, pest control, grounds etc) – Trust can decide and if included, staff seconded to PFI Provider
- Soft FM services can be included

ATTACHMENT C

PFI CONTRACT – BRIEFING PAPER

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

"TOWARDS 2010" PFI PROJECT – TRUST BOARD BRIEFING PAPER No 1

1. Why are we having these briefings?

It is important for the Trust Board to understand and support the decisions, recommendations and commitments being made within the "Towards 2010" PFI Project (the "**Project**"). In particular, FT status brings additional and more formal governance obligations on behalf of the Trust Board. The Trust Board will be required to release its Board Minutes which states its understanding and support for the Project. Monitor will wish to see non-executives which have the knowledge and information to challenge decisions being made by the executive team.

This will be the largest investment made within the Trust and probably for many of the individuals on the Trust Board and thus important that the Trust Board receives updates such as this briefing paper.

We have used the question and answer style for this briefing paper to keep it user-friendly and for members of the Trust Board to retain it as a reference to refresh their knowledge. It is envisaged that this briefing paper will constitute the first of a series prepared by the Trust's Project team (with the Trust's external advisers) to inform the Trust Board (see Section 8 below).

For more complicated or extensive communications, we will deliver presentations or facilitate workshops.

2. What is PFI?

Introduction

The Private Finance Initiative ("**PFI**") was introduced in 1992. It is one form of public private partnership and is particularly relevant for capital-intensive services. The principal aim of PFI is in transforming the role of the procuring NHS body from being the owners and operators of healthcare assets, to the purchasers of services as guardian of the interests of their patients and end-users. A driver of the PFI is to allow procuring NHS bodies to focus on their core healthcare functions, thus leaving the private sector to perform those functions which it can do more cost-effectively and efficiently and add innovative thought to the provision of the same. In a PFI transaction, the Trust's preferred private sector partner is given responsibility for designing, building, financing and operating assets (in this case the new facilities), from which the Trust's healthcare service is delivered.

Using the PFI, procuring NHS bodies and their communities can achieve long-term benefits from private sector expertise and investment in the delivery of public healthcare facilities and services.

Objective, Risk and Process

The overriding objective of the PFI is to create a structure in which value for money is optimised, through private sector innovation and management skills, through the synergies from linking design, build and operate, through re-engineering, through the efficient allocation of risk, and through the whole life and whole service approach to service delivery.

Risk allocation is a fundamental element of the PFI. Successful risk transfer is inextricably linked to the achievement of value for money. As such, the key question is: "Who is best able to control and manage risk". It must be remembered at all times that every risk has its price. The greater the ability to control and manage risk, the lower the price will be for transferring it.

The procurement process prescribed for the PFI should now follow the competitive dialogue process (as detailed in the Public Contracts Regulations 2006) and is likely to take between 18 and 24 months from approval of the proposals (by Trust Board, and then departmental support) to contract signature. Procurement guidance for healthcare schemes has been Department of Health's Private Finance Unit (the "**PFU**") and is available on the Department of Health's website at:

http://www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/Privatefinanceinitiative/index.htm

Why PFI? A Whole-Life Solution

With PFI, many of the functions that underpin the delivery of the service become the responsibility of a single private sector partner, who is contracted to deliver the service to agreed standards and subject to a performance-related payment mechanism

The concept of PFI involves the procuring NHS body buying capital-intensive services from the private sector in return for an annual payment. The private sector provides the capital to fund the provision of the new facilities, carries out the design and construction required and then provides the service, including the operation, maintenance and life-cycling of the new facilities for the life of the contract, which for this project is 30 years. The annual payment covers all the costs of the private sector in providing the services, including the financing of the new facilities but only commences once the facilities have been completed.

The focus is on looking at the whole life of the service and making sure that during the procurement phase all the elements making up the service are taken into account. Payment is made by reference to the standard of the service received, and is only made in full if the standard set by the specification is met and after the operation of the service commences.

Specifications are based on outcomes and outputs rather than being input focused and encourage innovation and new ways of working.

Advantages of PFI

- The **integration of service** delivery with design, construction and maintenance brings about efficiencies both in cost and time of delivery. It removes the conflicts inherent in traditional procurement;

- **Risks** are clearly **identified** and **allocated** during the procurement phase and therefore are better managed throughout the whole life of the service;

- The **length of the contract** enables the service provider to make investments in service delivery knowing there will be sufficient time to make a return on that investment;

- There is a clear **focus on** the **needs** of the user of the service and a link through from the objectives of the scheme to the specification and payment mechanism;

- **Payment** is only made when the service is **operational** and is **only made** in full when the specification is achieved or **performance standard met**. There is a clear incentive for the service operator to provide the services to the appropriate standard as quickly as possible; and

- There is **stability in service** delivery brought about by the length of the contract and to the level of services inherent in the Output Specification and Payment Mechanism.

Disadvantages of the PFI

- The process of procuring a PFI scheme is **more complex** than traditional procurement;
- The **cost** to the private sector in bidding (especially now under the competitive dialogue process) is significant and needs to be recovered against the cost of schemes;
- There is a **perceived lack of flexibility** in service provision brought about by the length of the contract;
- The **development** and **justification** of a PFI project can be a **lengthy** and **complex** process. The need to justify the use of the process by comparison against traditional forms of procurement can lead to a protracted period before the private sector becomes involved in the process; and
- The process has been viewed in some quarters as a **passing of influence** over public services to the private sector.

Key Risks

The key risks to the Trust and its private sector partner arising in a scheme of the nature of the Project are summarised in the table below:

Risk	Description	Normal Market Position
Change in Law	This is the risk of the impact of changes in legislation over the life of the contract	Shared risk. The Trust's private sector partner is obliged to comply with all applicable legislation. Failure to so comply can give rise to termination of the contract by the Trust. When pricing the contract the bidders will take into account the cost of complying with current legislation and any legislation that is foreseeable at the time of the contract. Changes in Law are often broken down into the following categories: (i) *Discriminatory* – this is usually defined as non-foreseeable changes in law which expressly apply to the contract or to the contractor but not generally to similar contracts or contractors, or legislation which expressly applies to organisations such as the contractor carrying out similar contracts. The procuring NHS body usually retains the risk of non-foreseeable Discrimatory Changes in Law; (ii) *NHS Specific* – this refers to non-foreseeable changes in law which specifically apply to the provision or operation of healthcare premises. It is therefore considerably wider than a Discriminatory Change in Law. The procuring NHS body usually retains the risk of non-foreseeable NHS Specific Changes in Law;

Risk	Description	Normal Market Position
		and (iii) *General* – this usually covers any change in law that in not non-foreseeable Discriminatory or NHS Specific in nature (i.e. they affect everyone, for example, road fund licence costs, health and safety, employee rights etc.). The risk of General Changes in Law is usually shared: with the contractor taking the risk of such changes which have a revenue consequence and those which result in the contractor incurring capital expenditure are normally shared in accordance with an agreed ratio.
Change in Requirement	This is the risk that during the contract period the Trust changes its requirements for the services or the use of the new facilities	Trust risk. The Trust should carefully consider potential changes that are foreseeable at the procurement stage and include any details of any extension or variation within the original procurement process. This allows, at the competitive bidding stage, the price to be agreed for any foreseeable extensions or variations in the early years of the contract term.
Planned Exit	This risk is how the parties will exit the contract at the end of the term; this will include who assumes the residual value risk in the facilities and how any land will be transferred	In health PFI contracts the assets are usually licensed to the contractor for the life of the contract and upon expiry will return to the Trust at nil cost in an agreed "handback" condition. The Trust will need to careful consider such arrangements at the outset of the project's procurement.
Early Termination	This is who bears the financial and operational risk of early termination of the contract	Shared risk. The contract will set out the arrangements covering early termination of the contract prior to the expiry of the contract term. Examples of early termination events are: contractor default, force majeure, corrupt gifts/fraud, voluntary termination and Trust default. The level of compensation payable by the Trust to the contractor and the provisions regarding exit depend on which party is at fault for the early termination (if any).
Insurance	This is the risk of increases in insurance premium or that certain types of insurance will become uninsurable in the insurance market	Shared risk. The risk insurance premium increases is shared in accordance with mandatory PFU guidance. Similarly, the standard contract covers the apportionment of risk that has previously been included within the insured risks no longer being insurable in the insurance market.
Affordability	This is the risk of the Trust being unable to meet its requirements for payments under	Trust risk.

Risk	Description	Normal Market Position
	the contract	
Financial assumptions	This is the risk that the financial assumptions contained within the contractor's financial model are incorrect or inaccurate	Contractor risk.
Capital Costs	This is the risk that the costs of purchasing or constructing the new facilities are greater that originally assumed by the contractor	Contractor risk.
Operational Costs	This is the risk that the costs of running and operating a service will increase beyond those assumed	Contractor risk. Market Testing provisions are included within the standard contract and are the responsibility of the Contractor from both a cost and management perspective.
Design and Construction	This is the risk of there being defects in the design and construction of the new facilities	Contractor risk.
Fitness for purpose and availability	These are the risks that the new facilities constructed meet the Trust's required outputs for the project and that they are available for use by the Trust	Contractor risk.
Performance	This is the risk that the contractor will not meet the performance targets contained within the contract	Contractor risk.

Standard Form Contract, version 3 ("SF3")

The key risks set out in the table above are captured within the PFU's SF3 contract. This contract contains mandatory drafting that reflects the Department of Health's position in relation to risk allocation. The SF3 contract also contains a number of mandatory schedules (for example, payment mechanism (including energy principles), review procedure, variation procedure, compensation on termination drafting and independent testing) and a form of early works contract.

A Deed of Safeguard forms a schedule to the SF3 contract. The purpose of the Deed of Safeguard is to ensure that contractors are not left unpaid if an NHS Foundation Trust fails to perform its obligations under the contract (for example if the Trust became insolvent).

The Deed of Safeguard is given in all PFI contracts, including those where the NHS organisation is an NHS Trust. This is because of the possibility that the Trust may become an NHS Foundation Trust at some point during the contract term. The exceptions to this are small projects (currently defined as those with a capital value of £10m or less, although there are plans to increase this limit) and projects entered into by PCTs.

If the Trust has already become an NHS Foundation Trust at the time the PFI contract is signed, it is necessary to use a slightly different form of the Deed of Safeguard. This will be requested from PFU if needed.

Site Assembly and Planning

Key risks for the Trust relative to this scheme include site assembly and planning relating to the proposed site for the new facilities. Whilst it is acknowledged that the site will be controlled by the Trust (either directly owned or through a form of leasehold structure) prior to construction commencement the risk of delays to the procurement process arising from the planning (and any compulsory purchase) process are real. The PFU will not authorise the Trust to proceed with the scheme until certainty is reached on site assembly and planning issues. This will need to be borne in mind by the Trust.

These risks will need to be managed by the Trust with its advisers in order to give bidders a clear understanding to inform their bid submissions. The risk to the Trust in terms of bid cost consequences should planning and/or site assembly issues result in a fundamental problem in the procurement of the project as a whole need to be borne in mind.

Finally, should potential bidders form an opinion that the Trust does not have sufficient control over these issues it may result in them not bidding or withdrawing from the procurement. This "scheme credibility" issue is something else that the Trust will need to manage.

Scope of this Project

On all PFIs, it is the responsibility of the PFI provider to maintain the fabric of the building over the 30 years and thus hard FM maintenance and lifecycle responsibilities sit with the PFI provider. As a result dedicated estate staff would transfer to the PFI provider under TUPE arrangements.

There are other hard FM services which the Trust can decide to include such as: window cleaning, pest control, grounds and gardens. Where these services are included in the PFI, then dedicated staff will transfer to the PFI provider under TUPE arrangements.For soft FM services, the Trust must undertake a value for money assessment to conclude on their inclusion. This covers such services as: catering, cleaning and portering. If these services are included in the PFI package then staff would be covered by the Retention of Employment arrangements where they continue to be employed by the NHS but are seconded to the PFI provider.

In November 2006, HM Treasury issued “Value for Money Assessment Guidance” which aims to strengthen the test for rigorously assessing the VfM benefits of including soft services in PFI projects.

Possible benefits of including soft FM in the PFI are, for example:

- Consistency of provider and Whole lift costs (subject to market testing);
- Lower interface issues and single point of contact (addressing some of the interface responsibilities, for example where hard FM service repair a leak and cleaning addresses the residual issues);

- Design integration- where soft FM services and the service delivery methods are integrated into the design;
- Effective management of resources.

Possible disadvantages of including soft FM services include, for example:

- Lack of control in areas which are key to performance measures of the Trust (eg cleaning);
- Limiting flexibility in changes to future service delivery (costly variations).

http://www.hm-treasury.gov.uk./media/4/4/vfm_assessmentguidance061006opt.pdf

The Trust held a workshop and has undertaken a financial analysis and considered the criteria identified in the HM Treasury report and a paper is included in this Board Briefing.

3. What are we asking bidders to do / provide for us?

The bidders will be asked to return in their bid submissions details for the design, build, operation and provision of hard facilities management ("**FM**") services (for example, estate maintenance, grounds and gardens, utilities management, pest control, external window cleaning, car parking, physical security of estate) and retail catering (including hospitality and vending), insurance and funding. The bidders will also need to detail within their proposals for effectively interfacing with the Trust's provision of soft FM services (for example, catering for patients, portering, waste management, laundry and cleaning) and equipment.

The Trust is currently finalising the exact scope of the services to be provided by the private sector partner. Details relating to the responsibility for both IT and sterile services will also need to be determined.

4. Where are we in the process?

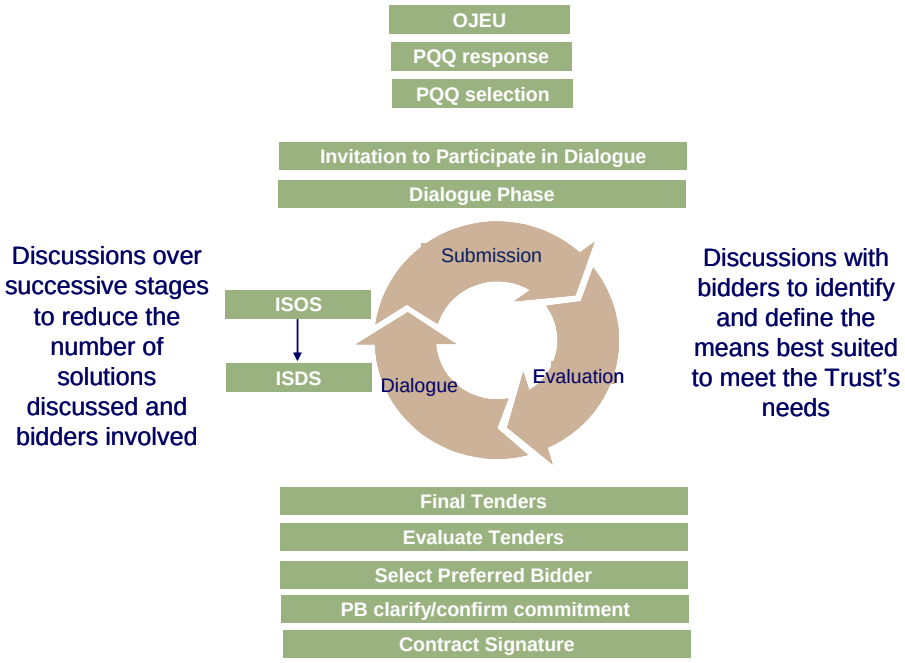
Whilst the Trust is still at a fairly early stage in the overall process for the procurement of the Project, significant work has been undertaken within the Trust and the wider health economy to provide confidence in the future direction.

In order to gain approval for the Project's Outline Business Case (the "**OBC**"), the Department of Health normally would simultaneously sign off the documentation for the procurement.

On this Project, we will be discussing with the SHA and DH if a staged approval process would be acceptable given the land purchase issue on this project. The staged approach would consist of approving elements or the entire OBC document and the land purchase business case subject to the procurement documentation being approved at a later date.

Following approvals, the Competitive Dialogue process would begin with an OJEU to attract potential bidders.

Figure 1. Competitive Dialogue Process



5. What is Competitive Dialogue and why is it important to us?

The Public Contracts Regulations 2006 introduced the competitive dialogue procedure for procuring "particularly complex projects" (this includes PFI schemes) into UK law. Like the old negotiated procedure, the competitive dialogue procedure starts with an OJEU notice and pre-qualification. The procedure then allows for the Trust to conduct a dialogue with bidders with the aim of developing one or more suitable alternatives capable of meeting its requirements. Those bidders remaining at the conclusion of the dialogue submit Final Tenders. Following an evaluation a Preferred Bidder is identified (i.e. the bidder providing the most economically advantageous tender to the Trust) and following an opportunity to "clarify aspects of the tender or confirm commitments provided" (but without allowing substantial changes to the tender that risk distortion of the competition or causes discrimination) the procurement closes.

Key messages for the Trust to bear in mind to allow for a successful competitive dialogue:

- prepare clear and complete documentation that reflect the Trust's requirements (the Trust will be required to complete all work upfront before being permitted by the PFU to go to the market and publish its OJEU notice);
- make decisions before the OJEU is published and consulting with stakeholders (including the PFU);
- plan and take ownership of its strategy and timetable, what has worked elsewhere may not work for this project;
- be realistic with its timetable and consider whether its timetable matches its resources;
- ensure it is clear about what it is getting from the bidders and that nothing is outstanding when the dialogue closes;

- the Trust must bear in mind what is said about not changing mind on scope and the potential for payment of bid costs (with the resulting loss in credibility).

The following websites (both the Department of Health and 4ps) provide helpful guidance to procuring Trusts on the competitive dialogue process:

http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_063444

http://www.4ps.gov.uk/PageContent.aspx?id=2&tp=Y&s=0&title=competitive+dialogue&searchbtn=Go&p=149

6. At what point are we committing ourselves to things?

The level of the Trust's commitment, risk and financial obligations increase as the procurement of the project progresses. This commitment can be summarised as follows:

OJEU Notice

Taking the publication of the OJEU notice as a trigger for the commencement of the Trust's procurement, following such date the Trust will assume certain risks should it seek to re-scope the project or if the project is cancelled.

The Trust will reserve a right within its procurement documents to withdraw the procurement of the project at any time following the publication of the OJEU notice. It will also state that costs of bidders in bidding for the project will be retained by the bidders.

However, the Trust needs to bear in mind the principle of the Bates' Review[1] which stated that bid costs should be refunded where a Trust abandons a viable scheme. This now forms part of the Department of Health's policy. In addition, it should also bear in mind the Department of Health's 2002 guidance paper[2] that states that additional bid costs will also be reimbursed if a Trust seeks further clarification of bids as a result of a change in the scheme's scope in a competitive situation. A properly planned scheme should reduce the risk of scope change. This should also reduce the prospects of local support for the scheme dwindling to the extent that it is cancelled.

In addition to the 2002 guidance, the Department of Health has published further guidance[3] setting out a framework for Trusts to follow should they receive claims arising from the cancellation or re-scoping of health PFI schemes. The decision to contribute to such claims in whole or in part is entirely discretionary (i.e. an *ex gratia* basis) and the base position is that Trusts do not accept any liability for any costs incurred as a result of a scheme being cancelled or re-scoped. Although cancellation is rare, it has happened. Re-scoping is a relatively common occurrence. Comments above about the robust planning of schemes are also relevant here.

Whilst the guidance framework is expressly stated not to set a precedent nor as establishing rules as to what may be reimbursable in future claims, the Trust must bear in mind that bidders may have a commercial expectation that a payment will be forthcoming on a cancellation or re-scoping. Although bidders have no right to payment from the Trust, on a case by case basis the Trust may have little or no option to make a payment because of the need to preserve the Government's wider reputation as a procurer of complex projects; to

[1] See paragraph 29(vi) of: "*Review of PFI (Public/Private Partnerships) – Summary and Conclusions)*", Sir Malcolm Bates, 1997
[2] See paragraphs 7 and 8 of: "*Improving PFI Procurement*", Department of Health PFU guidance, 21 March 2002
[3] "*Framework for the identification and validation of heads of claim arising from cancelled or re-scoped PFI schemes*", Department of Health, February 2007

ensure that bidders continue to participate in the health PFI sector; or to ensure that bidders continue to participate in the Trust's procurement.

In essence, the guidance framework states that should the project be cancelled or re-scoped during the competitive process then the direct costs (i.e. employment cost of individuals directly engaged on the project (including taxation and other on-costs), expenditure incurred with third parties (on an invoice cost paid basis) and expenditure incurred with related parties (provided that the service or product was provided at a commercial rate)) incurred from the commencement of that competitive process until the notification by the Trust that the project would not be proceeding may be considered by the Trust for reimbursement. Contingent costs may also be considered and the Trust may decide that any services were provided on an "at risk" basis and therefore such costs will not fall to be considered.

The guidance expressly excludes from consideration in any *ex gratia* payment costs relating to overheads (including management time), profit, opportunity costs, financing costs and claim costs.

As the guidance framework was drafted on a non-competitive dialogue procurement model, the Trust should liaise closely with the PFU to understand the reimbursement risks it may be exposed.

Preferred Bidder

Once a preferred bidder has been selected by the Trust the principles above will continue to apply until the contract is signed. Following that date, any changes or variations/re-scoping and/or cancellation of the scheme (i.e. voluntary termination by the Trust) will be dealt with in the relevant provisions within the Project Agreement as signed by the parties.

7. How do we get bidders to bid?

The capital cost of the Project is large and thus only the larger players in the market will be capable of delivering the scheme. The prequalification assessment, at the outset of the procurement process, will consider the technical capability and the financial capacity of the bidders.

These consortia will be bidding and delivering schemes in a number of markets and with the high cost of bidding for a PFI they choose their opportunities with care. To ensure a robust competitive process, we would like 3-4 strong contenders. The Trust and its advisers should do the following to encourage market interest:

- Speak to potential bidders about the scheme;
- Offer to meet with them if they make contact but actively pursuing them when we are clear about the timetable;
- Host an open day just prior to OJEU where Trust Board must demonstrate, commitment and consistency in messages; and
- Ensure the Trust is adequately resources and can demonstrate to the private sector its ability to deliver to timetable.

8. What will be the topics of future briefings?

Provided the Trust Board finds this approach useful, a number of potential future briefings have been identified:

- Summary of the Invitation to Participate in Dialogue ("**IPID**") documentation;
- Explanation of the risk sharing inherent in a PFI transaction;
- Description of the evaluation process to select the preferred bidder;
- Summary of offer of the preferred bidder; and
- Reminder of commercial position prior to financial close.

Graham Seager

New Hospital Project Director

Dated: 26th February 2008

ATTACHMENT D

SCOPE OF SWBH PFI CONTRACT

Scope of SWBH PFI Contract

1 Background

Initial work was undertaken to define the Scope of the PFI Project in August 2007, and the report setting out the proposed approach was considered by the 2010 Acute Hospital Services Development Project Team on 13th September 2007. A copy of this initial report is attached as ***Appendix A***. Clearly the main hospital construction would form the basis of the PFI contract. The development of a separate education, academic, research and admin building has the option of being procured separately.

2 Education, Academic, Research and Administration Building

The initial work in August 2007 concluded that the optimal approach to the project would be to separate out a non-clinical office accommodation into a separate building adjacent to the main hospital for planning and capital cost minimization reasons. It is proposed that this building to form part of the PFI Project, rather than being developed through separate arrangements. However, with the development of the wider Grove Lane development there may be benefit in changing this decision procuring the facility through the Grove Lane developer.

Development of the Outline Planning Application for the new hospital and related facilities has continued, and this has confirmed the approach to separating general office and training accommodation into an adjacent building.

Given the above, the approach to this aspect of the project will remain as proposed in the initial work, namely a separate non-clinical office and training building procured as part of the overall PFI project.

3 Hard FM Services

The general approach to Hard FM is that these services will form part of the requirements on the Trust's PFI Partner, to maintain the fabric of the buildings and estate and ensure their lifecycle replacement for the duration of the PFI Contract.

As set out in the initial report, further work has been undertaken relating to certain aspects of the Hard FM service to define the optimal approach. The conclusions following this work are as follows:

Table 1. Hard FM Services Scope

Service	Commentary	Conclusion
Routine & Ad Hoc Security Patrols / Response	The security service operates in close co-operation with the clinical functions of the Trust to deliver those elements of the service that directly relate to patient and visitor safety. Given the importance of this service and the absence of any over-riding value for money advantage from including the service within the PFI Contract, it is proposed to exclude this function from the requirements of the Trust's PFI Partner. This service is also best delivered in combination with the management of car parking. Whilst it would be possible to include the car park management within the PFI Contract, and thereby obtain a guaranteed level of car park income through the Contract, the Trust will always retain the risk related to price in order to maintain control of car parking prices. This means that the only risk transferred to the PFI Partner is in relation to the volume of car parking, and this is unlikely to achieve the best value solution.	Exclude from PFI Contract, and consequently also exclude the delivery of the Car Park Management service.
Operation of Switchboard	The switchboard service acts as the first point of contact for members of the public to the Trust's services. It also provides a range of other functions for the Trust related to the clinical operations (maintenance of telephone directory; on-call status / contacts; emergency response; etc.). Whilst it would be possible to include these services in the requirements of the Trust's PFI Partner, there are unlikely to be value for money advantages from such an approach.	Exclude from PFI Contract.
IT	The management of IT services and systems has a very different risk profile to the rest of the services considered in delivering a PFI Project. The future requirements and systems of the Trust are extremely difficult to forecast for the duration of a PFI Contract (around 30 years), and therefore extremely difficult to price on any realistic basis. Given this, the only aspect of IT services proposed to be included within the PFI Contract is the network infrastructure within the facilities and the relevant connections to the external environment.	Include Network Infrastructure. Exclude all other IT requirements.

Based on the initial work and the above further analysis, the overall approach to Hard FM is summarised below and in ***Appendix C***.

Table 2. Hard FM Services - Summary of Scope

Service	Incl. in PFI	Excl. from PFI
Building Maintenance	✓	
Building Life-cycle	✓	
Grounds / Gardens	✓	
Pest Control	✓	
External Window Cleaning	✓	
Car Parking: Physical infrastructure Car Park Management	✓	✓
Security: ■ Physical security of buildings ■ Routine Patrols ■ Ad Hoc Patrols / Response	✓	✓ ✓
Switchboard: ■ Physical switchboard ■ Operators	✓	✓
IT ■ Infrastructure ■ End-user Equipment and Systems	✓	✓
■ Utilities Management	✓	

4 Soft FM Services

Whilst the general approach to Soft FM services, in line with many current PFI Projects was agreed to be to exclude them from the PFI Project, this was subject to a review to demonstrate that this is likely to be the best value solution.

Following the appointment of FM Advisers as part of the Trust's Technical Advice Team, this work has now been completed, and a copy of this report is attached as ***Appendix B***.

The conclusions of this work supports the original proposal, and therefore Soft FM services with the exception of Retail / Hospitality / Vending Catering will be excluded from the scope of the Requirements on the Trust's PFI Partner.

5 Other Services

5.1 Equipment

The initial work suggested that the delivery of equipment was unlikely to be included given the difficulties of implementation and pricing / allocation of risk.

Further work has been undertaken by an Equipment Sub-Group, and this has confirmed that only items of fixtures and fittings normally associated with a building contract will be included within the PFI Contract. The Trust will retain responsibility for all other equipment, with any specific requirements on the PFI Partner being defined through an Equipment Responsibility Matrix. Decisions on the best method of procurement for equipment (lease / buy / managed contract) will be made as part of the development of the Equipping Plan for the new hospital.

5.2 Sterile Services

The Trust has recently concluded an agreement with an external provider to deliver Sterile Services as part of the local Collaborative agreement in conjunction with other Trusts in the local area. This contract runs for a period of 15 years, with an option for further 5 years, and there are no advantages in seeking to change this arrangement.

Consequently, Sterile Services will be excluded from the scope of the PFI Contract.

6 Summary of the PFI Procurement Contract Scope

A summary of the proposed PFI procurement scope based on the findings above, can be found as attached at ***Attachment C***.

APPENDIX A – PFI SCOPING WORKSHOP (13TH September 2007)

APPENDIX A: PFI SCOPING WORKSHOP - Tuesday 28th August 2007

1. Aim of the Workshop

To agree the scope of the PFI contract for the proposed new acute Hospital.

2. Impact of Land

The Grove Lane site will be re-developed partly by SWBH, and partly by Sandwell Metropolitan Borough Council (SMBC) with its Development Partner (called the "PxP") with a mix of residential and commercial developments. An Outline Planning Application (OPA) will be submitted by the Trust for the new Hospital, with a separate Site Masterplan being submitted by the PxP for the remainder of the site as part of the development of an overall Area Action Plan by SMBC.

Of the Trust's current requirements (totalling circa 87,000m^2), approximately 4-6,000 m^2 is required for non-clinical office accommodation (including training and research space) which is required to be adjacent to the main hospital but not as part of it. Consideration has been given to locating these functions in a separate building, outside of the main hospital building. The main reasons for this are: (a) should the new Hospital be deemed to be too big in the future, the Trust will have the flexibility to relocate the office accommodation back into the main Hospital; and (b) the capital cost per m^2 to build office accommodation in a separate building should cost less than building it as part of the main hospital building, although it is acknowledged there will be some diseconomies of scale / duplication of functional areas.

When asked to consider whether the office accommodation ought to be considered as part of the PFI scheme or to be provided by the PxP, the following points were raised:

- It will be easier to dovetail the delivery of the office block with the delivery of the new Hospital if the PFI Partner is responsible for both buildings;
- Using the PFI Partner reduces the need for an additional interface and agreement between the PFI Partner and PxP;
- If training and research space is required in the office block, it will be required to a specific standard which may not be suitable for renting to others in the event the building has to be sub-let, making it less marketable in the long term for the PxP;
- Should the PxP provide the building, a break clause will need to be negotiated which is likely to be costly and therefore reduce the perceived flexibility of being able to vacate the building;
- The PxP solution appears to give the Trust an exit strategy for vacating the building, which the PFI solution does not have. A mothballing procedure for the building could potentially be negotiated under the PFI solution but the cost of doing this is unlikely to be financially beneficial.

It was agreed that it was not possible to undertake a detailed analysis to cost and compare the 2 different options as this would require information that is currently not available, such as leases / agreements between parties etc.

Therefore, based on the discussions held at the workshop, it was agreed that for the purposes of the new Hospital development:

- The non-clinical office accommodation would be separated out and housed in a building separate to the main hospital, for planning and reduced capital costs reasons;
- The differences for having the PxP or PFI Partner provide the building were marginal, but overall, the PFI solution will provide a more practical and easier logistical route for delivering the building. Therefore the building should form part of the PFI solution for planning purposes.

3. Hard FM Services

It was accepted that Hard FM will form part of the PFI contract, and the following areas are a given:

- Maintenance of the fabric of the buildings and estate;
- Lifecyle of the buildings and estate.

The following decisions were reached about the inclusion of Hard FM services in the PFI scope:

Service	Incl in PFI	Excl. from PFI	Comments
Grounds / Gardens	✓		Included due to the potential impact and interface grounds and gardens have to the operational functioning of the Hospital
Pest Control	✓		PFI Partner better suited to manage risks and issues such as access to the building
External Window Cleaning	✓		PFI Partner better suited to manage risks and issues such as access to the building
Car Parking	✓		PFI Partner will take the risk on generating guaranteed level of income
Security: ❖ Physical security of buildings ❖ Routine Patrols ❖ Ad Hoc Patrols / Response	 ✓ ? ?	 ? ?	 It was agreed to keep these two areas linked. **Trust to investigate how other Trusts have provided these services and make recommendation**

Service	Incl in PFI	Excl. from PFI	Comments
Switchboard: ❖ Physical switchboard ❖ Operators	?	?	To be looked at as part of the IT work the Trust is undertaking. **Trust to investigate how other Trusts have provided these services and make a recommendation**
IT	?	?	Infrastructure (network cabling, etc.) to be included in PFI contract. The Trust is undertaking a separate piece of work to look at this area which will include the switchboard infrastructure
Utilities Management	✓		

4. Soft FM Services

The following Soft FM services were discussed, and decisions reached about their inclusion in the PFI scope:

Service	Incl in PFI	Excl from PFI	Comments
Catering ❖ Retail ❖ Hospitality ❖ Vending ❖ For patients	✓ ✓ ✓	(✓)	**Likely to be excluded, but Trust to outline the case / VfM arguments**
Domestics / Ward Services		✓	
Management of Residences		✓	
Portering		✓	Market increasingly accept this area as not part of PFI **Trust to show the best value approach for moving patients, and for moving goods in and out of hospital**
Transport		✓	Market increasingly accept this area as not part of PFI
Receipt & Distribution		✓	Market increasingly accept this area as not part of PFI
Linen / Laundry		✓	Market increasingly accept this area as not part of PFI
Waste Management		✓	Market increasingly accept this area as not part of PFI
Postal Services		✓	Market increasingly accept this area as not part of PFI

5. Other Services

Other services with a potential to form part of a PFI contract were discussed as follows:

Service	Incl in PFI	Excl from PFI	Comments
Equipment		(✓)	Unlikely to be included. Other schemes have increasingly excluded this area as it is difficult to implement and manage, and equipment providers are unwilling to take the risk. A Workstream has been established to do further detailed work on this area.
Sterile Services		✓	
Day Nursery	(✓)		Not in PFI but to be considered as a potential commercial opportunity for the PFI Partner
Gymnasium	(✓)		Not in PFI but to be considered as a potential commercial opportunity for the PFI Partner
Room Hire	(✓)		Not in PFI but to be considered as a potential commercial opportunity for the PFI Partner

6. Summary

Included	Excluded
Hard FM: o Lifecycle and maintenance of buildings and estate o Grounds and gardens o Pest control o Windows (external cleaning) o Car parking o Security – physical security of buildings o Utilities management	Soft FM: o Catering – patients (subject to further work) o Domestics / ward services o Management of residences o Portering o Transport o Receipt & distribution o Linen / laundry o Waste management o Postal services
Soft FM: o Catering – retail / hospitality / vending.	
Other services: o Equipment (subject to further work) o Sterile services	
Separate building for non-clinical office accommodation, and training and research functions	
Excluded from Trust Requirements from PFI Partner but Considered as Potential Commercial Opportunity	**Areas Requiring Further Work**
o Day Nursery o Gymnasium o Room Hire	o Security – routine patrols / ad hoc patrols and response (Steve Clarke to lead) o Switchboard – operators (Steve Clarke to lead) o Portering (Steve Clarke to lead) o Catering (Steve Clarke to lead) o Equipment (work in hand) o IT (work in hand)

Attendees at the PFI Scoping Workshop – Tuesday 28th August 2007

Rob Banks	SWBH	Michael Boyd	Pinsent Mason
Steve Clarke	SWBH	Martin Davies	Provex Consultancy
Andrew Harding	SWBH	Kelly Eaves	Deloittes
Colin Holden	SWBH	Daljit Sandhu	Provex Consultancy
Rachel Overfield	SWBH		
Graham Seager	SWBH		
Robert White	SWBH		

Appendix 2 – Review of Soft FM Services

TRIBAL

www.tribalgroup.co.uk

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

PFI PROJECT

SCOPE OF FACILITIES MANAGEMENT SERVICES

REPORT TO THE PROJECT BOARD – MARCH 2008

Services for life

TRIBAL

Document control sheet

Client	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
Document Title	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST PFI PROJECT SCOPE OF FACILITIES MANAGEMENT SERVICES REPORT TO THE PROJECT BOARD – MARCH 2008
Version	02
Status	Draft
Reference	18522 FM
Author	Dave Tolley
Date	20 February 2008
Further copies from	**email: documents@tribalgroup.co.uk quoting reference and author**

Quality assurance by:	Dave Tolley

Document history			
Version	Date	Author	Comments
01	14 February 2008	Roger Franklin	Draft Report for comment sent to Graham Seagar
02	20 February 2008	Roger Franklin	Updated to reflect Tribal report Format, Trust Summary of Facilities Costings and Compliance with National Standards Of Cleanliness

Contact details			
Main point of contact	Telephone number	Email address	Postal address
Dave Tolley	Mob:07753 916608	dave.tolley@tribalgroup.co.uk	Tribal Consulting Fourth Floor 154 Great Charles

			Street Queensway Birmingham B3 3HN

TRIBAL

Contents

1 Introduction

1.1.1 This report describes the initial decision making process undertaken for the Project and makes recommendations for the scope of Facilities Management (FM) services included within the proposed PFI development. A decision on the scope of services is essential prior to the publication of the OJEU notice requesting expressions of interest, currently scheduled for ..... but would be advantageous at an earlier date as prospective bidders will be taking soundings with the Trust and potential service partners to assemble an appropriately structured SPV.

Comment [RF1]: Trust to insert planned date.

1.1.2 The transfer of certain non-clinical services to the PFI Partner is traditionally an element of PFI. The decision on which services will transfer to the PFI Partner and under what employment terms for the affected staff is an important element of the planning process for the project. Should soft FM services be included, then the PFI Partner will have responsibility for services over the lifetime of the PFI concession, typically 30 years.

TRIBAL

2 DH & HM Treasury Guidance

2.1.1 In March 2006, HM Treasury published a report; “PFI: Strengthening long term partnerships” which reviewed operational schemes; identified lessons learned and made proposals for improvements on future schemes. The report looked at more than 100 projects and revealed strongly positive results on overall performance. However, it also highlighted that some areas of PFI were performing more strongly than others: -

- Hard FM services are activities that directly relate to the maintenance of the underlying asset (e.g. maintenance & refurbishment). The research showed that these services within PFI work well.

- The review of Soft FM services (e.g. domestics, catering & portering) was less positive, concluding that whilst standards are no worse than in non PFI hospitals, PFI had not led to a step change in delivery in this area.

Prior to this, the inclusion of Soft FM services within a PFI development was promoted as the preferred decision, but the findings of the report led to the introduction of a more vigorous approach to the value for money (VfM) assessment. It is this assessment that now determines the inclusion or otherwise of Soft FM services.

3 Value for money

3.1.1 The Treasury report; “PFI: Strengthening long term partnerships” established principles for examining the VfM of the inclusion of Soft FM services within PFI contracts. Public authorities would now be required to prove rigorously:

- Genuine integration benefits in terms of accurately assessing the whole life operating costs of projects.
- That private sector management of subcontractors within PFI will be more effective than direct public sector management of a separately let soft services contract.
- That there will be a greater reduction in interface issues between service providers than if soft services were let separately.
- Flexibility benefits for end users with a single point of contact that could not be replicated with a separate soft services contract.
- Improved consideration of soft service requirements in design and construction of PFI assets leading to quantifiable reduction in maintenance and operating costs of the project.
- Financial incentives to perform within a PFI structure that are significantly better than in a separately let soft services contract.

3.1.2 The VfM assessment in the provision of FM services is an integral element of the overall assessment made for the procurement route (i.e. PFI or conventional funding) to be undertaken in the Outline Business Case.

3.1.3 An outline VfM assessment has been undertaken for the Domestic, Catering and Portering services only. This approach is reasonable given that design risk for the new hospital will primarily involve these services, particularly so for Catering, and also that these three services comprise the great proportion of the cost of all soft FM services, without which the range of services offered will not be sufficient to attract widespread market interest.

4 Recent PFI schemes within the NHS

4.1.1 The key decision required is the extent to which soft FM services are included in the PFI agreement and recent schemes have adopted different approaches:

Soft FM included:	Hard FM only :
Barts & the London Hospitals	Birmingham (UHB)
St Helens & Knowsley	Newcastle
North Staffordshire	Salford
Peterborough	North Bristol
Mid Yorks	Tameside

4.1.2 Interest from potential bidders is an important consideration in the approach to FM services and the Trust has taken soundings from all of the leading consortia. It is evident that the inclusion or exclusion of services will have little bearing on their interest in the project.

5 FM Scoping

5.1 Hard FM 'Only' Service

5.1.1 The services considered within Hard FM which would usually be considered as included are as follows:

- Estates
- General Services (Management of the Contract)
- Helpdesk
- Energy & Utilities Management
- IT Infrastructure
- Grounds Maintenance
- External Window Cleaning (included in Estates service)
- Pest Control (usually sub-contracted)

5.1.2 The requirements of PFI dictate that these services are provided by the PSP as transfer of these services is essential to the viability of the PFI.

5.1.3 It is considered that the PFI Partner is better suited to manage the risks and operational issues included in the Hard FM 'Only' Service.

6 Soft FM

6.1 Services

6.1.1 The services considered within Soft FM are as follows:

- Domestics/ Ward Services
- Catering (Patient)
- Catering (Retail, Vending & Hospitality)
- Portering
- Postal Services
- Laundry (currently outsourced)
- Transport (including Patient Transport Services)
- Security
- Car Parking
- Switchboard
- Waste Management
- Receipt & Distribution
- Staff Accommodation
- Sterile Services

6.2 Commentary On Soft FM Services

6.2.1 As can be seen from Section 3, there is recent evidence of several major schemes excluding soft FM. The market is increasingly accepting that these services do not necessarily form part of a PFI scheme, as most of the above services are better suited to in-house provision.

6.2.2 However, there may be benefit in inviting bidders for proposals for the 'commercially based' services such as Retail Catering, where there is the potential for achieving a sound commercial deal for the Trust which uses the entrepreneurial skills of the private sector to optimise income and profit.

6.2.3 On that basis, it is proposed to include Retail Catering in the scope of the PFI. This should increase the attractiveness of the scheme to the market.

7 High Level VFM Analysis

7.1.1 Services provided under PFI attract a cost premium for operational risk carried under the Payment Mechanism. Profit margin expectations also tend to be higher than market testing which are by traditional rather tight.

7.1.2 The following table summarises the outcome of the high level cost analysis which has been derived from Version 6.2 Schedule of Accomodation, and reference to DoH Standard Service Level Specifications:

Service	Projected Benchmarked In House Price for New Hospital*	Anticipated market price under PFI for New Hospital**
Cleaning	£2.9m	£3.1m
Catering	£1. 7m	£2.0m
Portering	£1.0m	£1.1m
Total	**£5.6m**	**£6.2m**

* Note 1: Uses Trust current position based on ERIC benchmark data and PFI scheme beds and floor area.

** Note 2 Uses benchmark PFI prices against scheme beds and floor area and assumes compliance with National Standards for Cleanliness

7.1.3 This initial assessment shows that the exclusion of Soft services is likely to deliver the best VfM for the project.

7.1.4 It is recommended that a more detailed exercise is required to establish firm cost projections for soft FM in the new hospital.

8 Integration & Design Benefits

8.1.1 One benefit of PFI is that responsibility for designing an efficient operational facility rests with the PSP. Using their design, construction and operational experience they are able to bring best practice to hospital design and deliver the associated benefits for the Trust. This is particularly important in respect of the Catering service where the Trust will decide the functional content in the new hospital and be responsible for any future changes in service provision (e.g. conventional, cook chill, cook freeze, etc).

8.1.2 The exclusion of Soft services will require the Trust to take this responsibility and to manage any potential risks. This risk will be mitigated in part by the development of FM design Output Based Specifications (OBS).

9 Future Flexibility

9.1.1 There are a number of non financial arguments therefore to exclude Soft services from the PFI, for example, future flexibility is a major concern for the Trust (and has been a key consideration in planning the design of the new hospital).

9.1.2 The Trust has aligned cleaning services within the Nurse management structure to ensure standards of cleaning are achieved and maintained.

9.1.3 A PFI contract will run for a long time, typically 30 years and by committing to the inclusion of Soft services in the project scope, it is arguable that future flexibility is constrained. Future service changes (e.g. improved cleaning standards to meet Hospital Acquired Infection regulations) would be charged as a variation to contract. The Trust may find itself paying a premium price without the ability to test the price under market competition.

10 Recommendations

10.1.1 The Project Board is recommended:

- To note the requirement to include hard FM services within the PFI agreement.
- To approve in principle the decision to exclude all Soft FM services from the PFI agreement, with the exception of Retail Catering, pending a more detailed VFM cost modelling exercise being undertaken prior to OBC submission

Appendix 3 – Summary of SWBH PFI Procurement Contract Scope

APPENDIX C: SUMMARY OF PROPOSED PFI SCOPE

Included	Excluded
Hard FM: o Lifecycle and maintenance of buildings and estate o Grounds and gardens o Pest control o Windows (external cleaning) o Car parking infrastructure o Security – physical security of buildings o IT Network infrastructure & Telephone Switchboard o Utilities management	Hard FM: o Car Park management o Switchboard operation o End user IT equipment and Trust ICT systems
Soft FM: o Catering – retail / hospitality / vending.	Soft FM: o Catering – patients o Domestics / ward services o Management of residences o Portering o Security – routine / ad hoc patrols and response o Transport o Receipt & distribution o Linen / laundry (separate contract) o Waste management o Postal services
	Other services: o Equipment (lease / buy decisions to be made separately) o Sterile services (separate contract)
Excluded from Trust Requirements from PFI Partner but Considered as Potential Commercial Opportunity	
o Day Nursery o Gymnasium / Health Club o Room Hire	

ENCLOSURE 11

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST.

REPORT TO THE TRUST BOARD.

February 2008.

SUBJECT:	2010 New Hospital Project Board
REPORT BY:	New Hospital Project Director
AUTHOR:	Graham Seager

PURPOSE OF THE REPORT:

To inform the Trust Board of the draft minutes of the 2010 Acute Hospital Project Board meeting 28th February 2008

IMPLICATIONS:

Financial:
Personnel:
Healthcare/
National
Policy:
Other:

RECOMMENDATION(S):

To note

Sandwell & West Birmingham Hospitals NHS
NHS Trust

ACUTE HOSPITAL SERVICES DEVELOPMENT PROJECT BOARD

Minutes of a meeting held on Thursday 28th February 2008 at 10.00 am in the Board Room, Medical Education Centre, Sandwell Hospital.

Present:	Mr. J. Adler	Councillor B. Badham
	Mrs. S. Davis (Chair)	Mrs. D. Gospel
	Mr. D. O'Donoghue (in attendance)	Professor J. Parle
	Dr. S. Sahota	Mr. G. Seager
	Mr. M. Watkins	Mr. R. White
	Mr. L. Williams	
Apologies:	Councillor S. Anderson	Mr. C. Holden
	Mrs. J. Kinghorn	Mr. R. Kirby
	Ms. L. Owen	Councillor W. Thomas

ACTION

1. INTRODUCTION

Mrs. Davis introduced Mr. Donal O'Donaghue, the new Medical Director for the Trust.

2. MINUTES OF MEETING HELD ON 20TH DECEMBER 2007

The minutes of the meeting held on 20th December were agreed as an accurate record.

3. MATTERS ARISING NOT INCLUDED ON THE AGENDA

2010 Programme Update

Mr. Seager advised that he understood that Mr. Kirby had circulated the community hospitals issues paper to Board members.

4. PROJECT DIRECTOR'S REPORT

Mr Seager presented the February Project Director's report.

CABE/Design Review Panel 01

It was noted that a meeting had been held with the CABE enabler to review the design development for the Public Sector Comparator. Mr. Dave Wood from Sandwell Council had also been present at the meeting.

The Design Review Panel for Stage 1 (DRP01) had also met to consider this matter. Mrs. Davis had been present as Design Champion. The meeting had proved to be good but challenging. The report from the Panel was now awaited.

ACTION

In answer to a query from Mr. Adler regarding the role of the CABE enabler, Mrs. Davis advised that their remit was more than advisory. Councillor Badham confirmed that the views of the enabler have to be taken on board and it was important to keep them fully advised.

Design Development

The design development was continuing with further consultation on the 1:500 design and development of 1:200 designs and exemplar rooms. The process was proceeding well and was highlighting design requirements and bringing clarity to the design brief.

1:200 guidance required that "key departments" be developed. However it had been recommended that the Board consider extending the 1:200 design development to cover further areas. This would bring greater clarity to the design requirements, increased involvement from clinicians and hence reduce risk on the project. There would be a cost to achieve this of approximately £50,000.

Mrs. Davis asked if there was consistency in the involvement of clinical staff in the PP&DD process. Mr. Seager advised that at the moment there was inconsistency. However in order to improve this it had been agreed that the present Clinical & Service Capacity Workstream would be replaced with a wider peer group (including clinical leads). The remit of the group would be to review the 1:500, 1:200 designs, PPDDs and operational policies, the group would be the body developing the clinical brief and then evaluating the bids. Mrs. Davis felt it important that all levels of staff should be involved in this process, this was acknowledged.

Dr. Sahota felt it important to make the use of the rooms within new Hospital as flexible as possible. Mr. Seager confirmed that flexibility had been included in the design vision particularly with regard to generic space and standard room sizes.

Mrs. Gospel expressed the hope that communication with all levels of staff was being maintained. Mr. Seager advised that he had recently met with Mr. Nedrick, Engagement Manager, to further progress engagement with staff and the public regarding the project.

In answer to a query from Mr. Adler, Mr. Seager confirmed that there was an engagement plan but that this was being revised and improved. It was agreed that a copy of the plan should be included for discussion at the next meeting. **GS/JK**

Pre-Planning Consultation

The pre-planning consultation process has been completed and the final stages of preparation for an Outline Planning Application were being undertaken. The planning application would be considered at the April Trust Board and submitted the next day.

However in the absence of a wider master plan Board would need to consider allocating additional resources to enable the production of additional information to support the planning application. This was estimated to be in the order of £51,000.

ACTION

Richard Glenn Review

It was noted that Richard Glenn would undertake a further review on Friday 28th March 2008. These reviews were established by the Private Finance Unit in response to a challenge from the Treasury regarding long-term affordability of schemes. A strict ratio test had been introduced (Trust turnover to estate cost).

Technical Team Appointment

It was noted that Tribal Consulting have been appointed as Trust technical advisors for the PFI procurement. It was noted that there had been no challenges to this appointment.

5. LAND ACQUISITION

A paper from Mr. Seager regarding the approach to land acquisition was received and discussed.

Mr. Seager reported on the current approach to land acquisition and advised that following recent meetings with interested parties to discuss the acquisition of land through a Regeneration Compulsory Purchase Order, there may be a delay in delivering the project due to unforeseen gap funding. The issue had been followed up with SMBC, Regenco, AWM and EP, Regenco had requested a report regarding this to be submitted to their next Board meeting.

As a consequence of this consideration had been given to ascertaining the feasibility of an alternative approach, namely a "Health Powers" CPO and the Board was asked to consider and approve the recommendation set out in the paper prepared by Mr. Seager.

It was noted that approval of the Secretary of State was required in order to progress a Health Powers CPO and was a process that was rarely pursued.

Mrs. Davis felt that it was sensible to have alternative plans in place and advised that she was in the process of arranging a meeting with SMBC, AWM, RegenCo and EP to ensure that everyone was working to the same understanding. Councillor Badham confirmed the continued support of SMBC for the hospital project. He did however express concern that waiting for approval from the Secretary of State may lead to delays on the project. Mrs. Davis advised that, subject to the approval of the Board to the suggestion to pursue a Health Powers CPO, she would arrange to meet with one of the local MP's and the Secretary of State to flag up this issue as soon as possible and prior to a formal request being made. Councillor Badham felt that the work that had already done for the Regeneration CPO would help with the work that would be required.

It was noted that the Regenco report would be received within the next few days and this would be a useful indicator of likelihood of resolving this issue.

In answer to query from Professor Parle, Mrs. Davis advised that she hoped to arrange for the Regional Minister to chair the meeting with land acquisition partners to progress the matter. Dr. Sahota suggested that representatives from Urban Living and the Black Country Consortium be invited to attend. However it was felt that these groups were "vehicles" of other organisations.

ACTION

It was agreed that Regenco represented the main players and the receipt of their report would be a key milestone. Mr. Adler advised that a meeting was being arranged with Mr. Shanahan at the SHA and other relevant people to discuss the process for the land business case.

GS

Mr. Adler suggested that the wording in the Conclusion & Recommendation section of the report may be misleading and suggested that the wording be changed to make it clear that the Trust would be pursing a twin track process (ie a Regeneration CPO and a Health Powers CPO). This was agreed. The Board accepted the recommendations (following this amendment) as the way forward.

It was further agreed that the Board would be kept informed about expenditure and additional costs that may be incurred.

7. PROGRESS AGAINST PROJECT PLAN

A copy of the February report was received.

It was noted that considerable progress was being made on many aspects of the Project Plan, aimed at delivering an Outline Business Case for approval in summer 2008. However there were two significant areas where progress had been more difficult; these being securing land acquisition and finalising affordability.

Land acquisition had been discussed separately thus the affordability issue was discussed. Ensuring that the proposed solution was affordable within the likely levels of income of the Trust was taking longer than first anticipated. This had been complicated by the need to ensure consistency between the plans for the new hospital, the plans for Foundation Trust status and the way in which local commissioning plans were developed into formal contracts with the Trust for 2008/9.

This matter was discussed. It was noted that as a result of the LDP negotiations, the activity and capacity model would need to be reviewed. The budget position is better than previous base year which suggested that the Trust would be in a better position when the new hospital was opened if this base year was used.

In answer to a query from Les Williams, Mr. White explained the work that had been undertaken as part of the negotiations for the LDP. Transitional funding would need to be agreed with the PCTs.

Mr. Seager advised that there were two alternatives for resolving this issue; namely, applying local fixes to the current affordability plan or starting wirth a new base year

It was noted that the timescale for completion would take longer for the new base year option and estimated to be end of April 2008 as opposed to March 2008.

Following brief discussion, it was agreed that the second alternative should be pursued.

8. PROJECT BUDGET REPORT

ACTION

The Project Budget Report for February 2008 was received.

It was noted that the year end position was £1.035 million under forecast.

There were pressures on the budget, namely the enhanced requirement on the 1:200 design work and the additional planning information. Both these items were approved to fbe funded from the contingencies. The planning work would impact to a certain extent on the 2007/08 budget but the 1:200 design work should not have an impact this year.

In answer to a query from Mrs. Davis, Mr. White confirmed that the £1.035 million underspend would draw down the net amount for 2008/09.

The Board noted the expenditure to date and projected year end position, agreed the application of contingencies to the new items of work identified and approved the budget for 2008/09.

9. SCOPE OF PFI PROGRAMME

A copy of a report setting out the results of further work that had been undertaken to finalise the scope of the PFI project was received and considered.

It was noted that the report recommended that the non-clinical office accommodation should be separated out into a separate building adjacent to the main hospital and for this separate building to form part of the PFI project, rather than being developed through separate arrangements. However, if the development of the wider Grove Lane area could be undertaken in timescale to suit the project this could be reconsidered.

Following a query from Mrs. Davis, it was agreed that Mr. Seager would prepare a report detailing future arrangements for other services/departments not yet accommodated within the new hospital project (ie fleet services). **GS**

Discussion took place regarding the provision of patient telephones and televisions. Mr. Seager advised that a provision had been made for containment for the service infrastructure within the scheme but a final decision had not yet been made.

It was noted that although cabling, trunking etc would be included as part of the PFI, a final decision had not yet been made regarding IT equipment etc.

The process for variations under a PFI was discussed. Rates for changes to the project such as dispensers would be develop as far as foreseeable through the procurement process.

10. RISK REGISTER

A copy of the latest risk register was received.

It was noted that a Risk Management Workshop had taken place on 5th February to review the risk register. The workshop had resulted in a number of changes to the register, one of which was that “red risks” were now brought into the report. Land acquisition was showing as a 5 x 5 risk within the report.

Mrs. Davis asked if the text of the risks could be shown in colour to highlight

ACTION

those risks that had changed since the previous report. Mr. Seager agreed to arrange for this to be done. **GS**

It was noted that only the names of the risk owner were shown against the red risks. All other risks were owned by the group.

Councillor Badham pointed out that the risks shown were only the same as those faced by other companies/groups.

11. ACUTE HOSPITAL PROJECT OBJECTIVES

A copy of a paper prepared by Mr. Kirby was received. The document set out how the new acute hospital project responded to national, regional and local policy and strategy. Mrs. Davis considered that the flow chart attached to the paper was very useful.

The document was received and noted.

12. REGISTER OF INTERESTS

A paper reinforcing the processes that had been agreed for establishing a Register of Interests was received. It had originally been agreed (in July 2007) that those involved in the 2010 project should be asked to declare any interest, where indirect or direct, on a quarterly basis. However the report revised the frequency of recording interests to be in accordance with key project milestones or at identified points in the project.

Discussion took place regarding the definition of "interest". It was agreed that Mr. Watkins would ask his counter-fraud colleagues to provide a definitive statement about this. The advice of the Trust's legal advisers would also be obtained. **MW**

This item would be discussed further at a future meeting.

13. ANY OTHER BUSINESS

There was no further business.

14. DATE & TIME OF NEXT MEETING

The next meeting will take place on Thursday 27th March 2008 at 10.00 am in the Board Room, Hilda Lloyd Building, City Hospital.