MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Board – Version 0.3

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 19 June 2008; 1700h

Members

Mrs S Davis [Chair]
Mrs G Hunjan
Mr R Trotman
Ms I Bartram
Dr S Sahota
Mr R White
Mr R Kirby

In Attendance

Mr G Seager
Mr T Atack
Ms K Dhami
Mr C Holden
Mr T Wharram
Mr P Smith

Apologies

Cllr B Thomas
Prof D Alderson
Mr J Adler
Dr D O'Donoghue
Mrs R Stevens

Secretariat

Mr S Grainger-Payne [Minutes]

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
The Chair noted apologies for absence from Professor Derek Alderson, Cllr Bill Thomas, John Adler, Rachel Stevens and Donal O'Donoghue.	
2 Declaration of interests	**Verbal**
No members of the Trust Board declared an interest in connection with any agenda items.	
3 Questions from the public	**Verbal**
No members of the public attended.	
4 Opening comments	**Verbal**
The Chair expressed her thanks to Robert White and team for their hard work to ensure a successful and timely audit of the annual accounts. The team was also thanked for their contribution to the improved financial position of the Trust. In connection with the ALE scoring, the Chair encouraged the Board to pursue scores of 4 against all themes where possible and practical.	

5 2007/08 annual accounts	**SWBTB (6/08) 041** **SWBAC (6/08) 016** **SWBAC (6/08) 016 (a)**
Following scrutiny at the prior Audit Committee, the Board was recommended by the Committee to adopt the annual accounts for 2007/08. The Board voted unanimously to adopt the accounts.	
AGREEMENT: The Trust Board accepted the Audit Committee's recommendation to adopt the annual accounts 2007/08	
6 2007/08 audit memorandum	**SWBAC (6/08) 017**
It was proposed that the Board noted the 2007/08 audit memorandum, recommending in particular that the Board noted the auditor's intention to give an unqualified audit opinion. The Chair enquired whether the working relationship with the auditors was satisfactory. Tony Wharram confirmed that the relationship with KPMG was good.	
7 2007/08 Statement on Internal Control	**SWBTB (6/08) 044** **SWBAC (6/08) 018**
Following review by the Audit Committee the Trust Board was recommended to accept the statement on internal control and note in particular the internal audit opinion which suggests significant assurance in relation to the Trust's system of internal control. The Trust Board voted unanimously to accept the 2007/08 statement on internal control.	
AGREEMENT: The Trust Board accepted the Audit Committee's recommendation to accept the 2007/08 statement on internal control	
8 Letter of representation	**SWBTB (6/08) 043** **SWBAC (6/08) 019**
Following review by the Audit Committee the Trust Board was recommended to approve the signing of the letter of representation which discharged the Trust's responsibility to disclose any material related party transactions relevant to the Trust, confirm that the officers and officers of the Trust were not aware of any actual or potential non-compliance with laws and regulations that may have a material effect on the Trust's accounting statements and to acknowledge the Trust's responsibility for the fair presentation of the financial statements. The Trust Board voted unanimously to approve the signing of the letter of representation.	
AGREEMENT: The Trust Board accepted the Audit Committee's recommendation to approve the signing of the letter of representation	
9 BSIAC – Merger with CW audit	**SWBAC (6/08) 019**
Following a review of the merger plans by the Audit Committee, the Trust Board was recommended to approve the proposal for the merger of Birmingham and	

Sandwell Internal Audit Consortium (BSIAC) and Coventry and Warwick audit (CW audit). The Trust Board noted the caveats to the business case stipulated by the Audit Committee. The Trust Board voted unanimously to accept the Audit Committee's recommendation to approve the plans for the merger, although noted that the business case is to be presented for final ratification at a future meeting of the Audit Committee and the Trust Board.	
AGREEMENT: The Trust Board accepted the Audit Committee's recommendation to approve the plans for the merger of BSIAC and CW audit, subject to the caveats to the business case stipulated by the Committee	
10 Any Other Business	**Verbal**
There was none.	
11 Details of Next Meeting	**Verbal**
The next meeting of the Trust Board is planned for 3 July 2008 at 1430h in the Anne Gibson Boardroom, City Hospital.	

Signed .....

Print .....

Date .....

MINUTES

Sandwell and West Birmingham Hospitals NHS Trust

Trust Board (Public Session) – Version 0.3

Venue Anne Gibson Boardroom, City Hospital **Date** 3 July 2008 at 1430h

Present:	Mrs Sue Davis [Chair]	Mrs Gianjeet Hunjan	Dr Donal O'Donoghue
	Mr Roger Trotman	Dr Sarindar Sahota	Mr Robert White
	Ms Isobel Bartram	Mr John Adler	Mrs Rachel Stevens
In Attendance:	Mr Matthew Dodd	Miss Kam Dhami	Mr Simon Grainger-Payne
	Mr Colin Holden	Mr Graham Seager	Ms Ruby Ubhi
	Mrs Jessamy Kinghorn	Mrs Judith Whalley	
Guests:	Mr Steve Clarke [Item 7 only]		Express and Star
Apologies:	Prof Derek Alderson	Cllr Bill Thomas	Mrs Dot Gospel
	Mr Tim Atack	Mr Richard Kirby	

Minutes	**Paper Reference**
1. Apologies for absence	**Verbal**
The Chair noted apologies for absence from Professor Derek Alderson, Cllr Bill Thomas, Richard Kirby and Tim Atack and Mrs Dot Gospel. Matthew Dodd attended in place of Mr Atack.	
2. Declaration of interests	**Verbal**
There were no declarations of interests expressed.	
3. Chair's opening comments	**Verbal**
The Chair reminded the Trust Board of the Long Service dinner planned for 16 July. The majority of staff who have been invited have accepted the invitation.	
4. Minutes of the previous meeting	**SWBTB (6/08) 040**
The minutes of the meeting held on 5 June 08 were approved. Colin Holden asked the Trust Board to note an error in the performance monitoring report presented at the previous meeting. The sickness absence rate should have been reported as 4.29%; not 3.91%.	
AGREEMENT: The minutes of the previous meeting were approved	

5. Update on actions from previous meetings	**SWBTB (6/08) 040 (a)**
The outstanding actions from the previous meetings were reviewed. In relation to action SWBTBACT.032, Gianjeet Hunjan and Roger Trotman advised that they would be free to assist with the launch of the visitors' policy. All other non-executive directors were asked to advise Rachel Stevens if they would be free to support the launch. In connection to SWBTBACT.040, Rachel Stevens reported that timescales are still to be assigned to the various actions in the patient experience action plan. When these are agreed the plan will be circulated as requested.	
ACTION: All Non Executive Directors to advise Rachel Stevens of their availability to attend the launch event for the visitor policy	
6 Questions from members of the public	**Verbal**
There were no members of the public present.	
7 Catering contract	**SWBTB (7/08) 048** **SWBTB (7/08) 048 (a)** **SWBTB (7/08) 048 (b)** **SWBTB (7/08) 048 (c)**
The Chair welcomed Steve Clarke and thanked him for arranging the food before the Board meeting in support of the item. A presentation was delivered outlining plans to revise the preparation and distribution of patient food. Rachel Stevens advised that the provision of the Trust's inpatient food was currently unsatisfactory and the plans presented outline a move to improve the overall service. The plans also aim to provide value for money and improve the patient experience through an integrated approach to the service through nursing and facilities. The approach is also consistent with the service requirements for the new acute hospital. The current service provision arrangements were described. At City Hospital a cook/chill service is in place, with meals being purchased from a local NHS provider; Sandwell Hospital however provides a conventional cook serve service; Rowley Hospital uses a cook chill service provision delivered via City Hospital. The Trust Board was advised that a cook chill production unit is currently available to use at Rowley Hospital, although this has not been operational for some time. Four options for future provision of patient food have been considered: do nothing; harmonise all sites to use the same NHS provider; outsource the service to a private provider or utilise the cook chill production unit at Rowley Hospital for the provision of food to the whole Trust. The favoured option from a cost and development perspective was to use the facilities at Rowley Hospital. This option also supports the proposed new a la carte menus, which offer considerably more patient choice and flexibility. The service is also consistent with the plans to introduce ward service officers at City Hospital.	

Sarindar Sahota enquired what arrangements were in place for the transport of food between sites. He was advised that dedicated vehicles are already in place for this purpose, which can continue to be used. Gianjeet Hunjan asked if there would be an additional cost in respect of the purchase of trolleys for the service. She was informed that there would be no need to purchase any further trolleys. Roger Trotman questioned how the provision of the service from Rowley Hospital would result in the cut in costs outlined. Mr Clarke advised that the cost of current provision of the meals includes a margin added by the supplier, which would be eliminated by in house provision. The capacity of the facilities was questioned. The Trust Board was reassured that the current capacity of the Rowley set-up of 1500 meals per day was sufficient, although there was an option to expand the facilities if required. The lead time of capital purchases for the service is anticipated to be 6 weeks to 2 months, in line with the planned launch of the service when the existing contract expires in October. This also coincides with the timing for the introduction of the ward service officers. The process by which patients order food was discussed. Patients ordering a meal by 8am on their first day of the stay will receive their required choice for lunch on the same day. Colin Holden suggested that competence and quality of the staff supporting this service would be key to the success of the food provision. It was agreed that staff affected by the plans should be briefed on the proposals at the first opportunity. The plans also include a number of revisions to the retail food lines, although there are separate plans to review the existing provision of this service. The Chair asked if there were plans to address the current level of food wastage, particularly by offering different sized portions. She was advised that the current service offers this ability although greater effort will be put into adjusting the portion size to the patients' requirements when the new system is implemented. The present cultural meal arrangements will remain unchanged for the foreseeable future, although it was acknowledged that the PPI forum was very supportive of greater choice of this type of food. John Adler reported that the financial appraisal of the plans had been discussed and approved by the Strategic Investment Review Group. The Trust Board was asked for its approval to progress with the cook chill option at Rowley Hospital. Unanimous approval was given.	
AGREEMENT: The Trust Board approved the proposal to progress with the cook chill option at Rowley Hospital for Trust catering	
8 Performance management	
8.1 Monthly performance monitoring report	**SWBTB (7/08) 060**

	SWBTB (7/08) 060 (a)
Robert White provided an update on the Trust's performance for May 08. There has been a single breach of an urgent cancer referral waiting time, which occurred due to the complexity of the case. The responsibility has been shared with University Hospital Birmingham which was also involved with the case. Cancelled operations reduced during May and the situation regarding delayed transfers of care improved in month, particularly at Sandwell. The Trust Board was concerned to hear of the continued reduction in the proportion of patients offered an appointment within 48 hours of contacting the GUM service and percentage of patients seen within 48 hours of contacting the service. Performance was noted to be considerably short of the 100% target. The situation is being investigated. In the longer term the operation of the service is to be examined more widely with a view to running the service under a partnership arrangement in the community. Good performance against infection control targets was seen during May. There has been a continued reduction in incidents of infection, with no MRSA cases having been reported in May or June and a continued downward trend in *C difficile* cases. There has been a slight underperformance against contracted plans for the month for the majority of activity types. Activity levels overall still remain significantly higher than delivered during the same period prior year. The average length of stay has increased to 5.3 days, with an increase seen on both sites. Day case rates continue to improve and ambulance turnaround times have also improved in respect of the proportion of delays in excess of 30 minutes. An increase in agency spend to 2.18% was seen during May. Greater work needs to be done to reduce this to the desired 2% target. PDR returns to Learning and Development during the month were disappointing at only 115. The CEO is however taking a personal hand to ensure an improved compliance against this target: all managers have been instructed to ensure staff PDRs are completed by 31 August 08.	
8.2 Monthly finance report	**SWBTB (7/08) 058** **SWBTB (7/08) 058 (a)** **SWBTB (7/08) 058 (b)**
The Trust Board was pleased to hear that an in-month surplus of £359k was achieved against a target of £253k. At a divisional level it was noted that Medicine B has underperformed during the month. This is driven by income issues however and much work is underway to address this situation. At present this is not a major cause for concern. Robert White reported that there was currently a significant number of challenges to the activity data generated by the Trust. PCTs have recently centralised the responsibility for data challenge which has prompted the high level of enquiries.	

Pay expenditure is below plan across a number of staff groups. Non pay expenditure is showing pressure, particularly on reserves in connection with the rising cost of energy. The Chair remarked that the effect of energy cost rises should be monitored and a course of corrective action considered if a major impact on the budget was projected. Roger Trotman suggested that a regular report on these costs should be considered by the Finance and Performance Management Committee. Graham Seager agreed to work with Robert White to prepare this report. It was also suggested that a price increase for fuel to support the Heart of England FT transport service might need to be considered. Isobel Bartram questioned whether the vacancies reported were historic or new positions. John Adler responded that in proportion to the size of the workforce the level of vacancies was not a cause for concern. This was confirmed by Colin Holden. The recruitment process is, however being revised to eliminate some of the manual steps by introducing measures such as electronic vacancy approval. Roger Trotman suggested that the current way in which vacancies are reported could be misleading and that consideration should be given to adjusting the report to highlight true recruitment issues as distinct from unused WTE budget that does not present a cause for concern. Robert White agreed to consider how best to represent this picture in future reports.	
ACTION: **Graham Seager to work with Robert White to prepare a report monitoring the effect of energy price rises and a corrective action plan should a major impact on the budget be projected** **ACTION:** **Robert White to consider a more appropriate way of reporting WTE vacancies to highlight recruitment issues**	
8.3 Developing the NHS performance regime	**SWBTB (7/08) 059** **SWBTB (7/08) 059 (a)**
Robert White gave a summary of the Department for Health's recent guidance 'Developing the NHS Performance Regime'. There has been recent media attention concerning the guidelines, although the purpose overall is to introduce a regulatory framework for performance of NHS Trusts. A number of metrics to inform the assessment are currently being developed. Following assessment, the framework also provides the NHS CEO with powers to designate an organisation as challenged and to be able to act on this decision as appropriate. The developing framework is to be implemented in April 2009. John Adler highlighted that there is a synergy between the framework and the outcome of the Darzi review, although the focus is slightly different: the Darzi review focuses on quality, whereas the DoH guidelines are more performance-based.	
9 Governance Management	
9.1 Single equality scheme	**SWBTB (7/08) 057** **SWBTB (7/08) 057 (a)**
Rachel Stevens reminded the Trust Board that the draft Single Equality Scheme (SES) had been shared with the Board at the April meeting. The scheme is now presented for approval following a period of public consultation. The framework for the delivery and monitoring of the SES is to be the responsibility of	

the Equality and Diversity Steering Group, chaired by the Chief Nurse. Action plans to deliver the framework will be discharged by four sub-committees: the workforce monitoring group; independent living group; service and policy assessment group and the patient experience group. The first meeting of the Steering Group has been convened and the patient experience group has also met. The Chair noted that the SES had been presented to the Equality and Human Rights Commission, who had not responded to date. An update on the implementation of the SES is to be presented on a quarterly basis. Isobel Bartram suggested that the Terms of Reference for the various subcommittees should be circulated. The Trust Board unanimously approved the Single Equality Scheme.	
ACTION: **Rachel Stevens to circulate the terms of reference for the subgroups of the Equality and Diversity Steering Group** **AGREEMENT:** **The Trust Board unanimously approved the Single Equality Scheme**	
9.2 PEAT results	**SWBTB (7/08) 049**
Rachel Stevens presented the outcome of the PEAT inspections during March 2008, which have now been nationally validated. Results for all four sites were encouraging: environment was rated good; food was rated excellent and privacy and dignity were rated good. The Trust Board was pleased to note the definite improvement in the standards.	
9.3 Quarterly risk report	**SWBTB (7/08) 054** **SWBTB (7/08) 054 (a)**
Kam Dhami presented the key risk activity highlights for quarter 4 of 2007/08. The CNST level 2 assessment is planned for December 08 and work is underway to gather evidence to support the implementation of policies against which the Trust will be assessed. Maternity standards have been published but these will not become agreed criteria against which the Trust can be assessed until April 09. Of the 40 standards published, the Trust must meet 22 to attain a Level 1. Ten of the standards are mandatory. A summary of incidents was also presented. The Trust Board was pleased to learn that less incidents are being reported, although acknowledged that the reasons behind this situation need to be clearly understood. Red incident reports have increased in comparison to the same period prior year, largely due to the reduced PPH threshold that triggers the reporting of a red incident. Isobel Bartram suggested that the status of maternity services in totality was required, especially in view of the recent RCOG report. Ms Dhami advised that the maternity development action plan will be presented at the September meeting which should provide this picture.	
ACTION: **Kam Dhami to present the maternity development plan at the September Trust Board meeting**	

9.4 Annual complaints report	**SWBTB (7/08) 055** **SWBTB (7/08) 055 (a)**
Kam Dhami provided an overview of complaints to the Trust received during 2007/08. 695 complaints were received during the year, 81% of which were responded to within the target time of 25 working days. The Trust Board noted that in a number of areas, there was a poor performance against the target response time. Ms Dhami assured the Board that the performance issues of these divisions was being addressed. The number of complainants dissatisfied with the Trust's response and therefore referring the complaint to the HCC, has declined markedly from 20 during 2006/07 to 6 year to date. All of those referred to the HCC were returned to the Trust for local action. In terms of categorisation of complaints, the breakdown into type is similar to that of the national picture. It was suggested that the comparison between Trusts relating to the number of complaints may be better represented per 1000 patients rather than simply the total number of complaints to give a more accurate reflection of performance. Response time comparisons should continue to be presented as percentages within the target time. John Adler noted that the reduction in the number of complaints being referred to the HCC was a success, although acknowledged that there was still work to be done to address response times.	
ACTION: Kam Dhami to consider a more appropriate way of providing a comparison of the Trust's performance regarding the number of complaints received with other organisations	
9.5 Single tender agreements	
Roche modular consumables	**SWBTB (7/08) 043**
The Trust Board was asked to ratify the Chair's action to approve the purchase of modular consumables to support the operations of the pathology/clinical chemistry division at a cost of £75k. The Trust Board agreed to ratify the decision.	
AGREEMENT: The Trust Board agreed to ratify the decision to approve the purchase of modular consumables from Roche	
System C Sandwell A & E IT system upgrade	**SWBTB (7/08) 046**
The Trust Board was asked to ratify the Chair's action to approve the upgrade of the Sandwell A & E IT system at a cost of £99k + VAT and support contact of £58,500. The Board agreed to ratify the decision, although Roger Trotman remarked that proposals such as this should be presented to the Trust Board in a more timely manner. Robert White agreed to ensure that this feedback is communicated.	
AGREEMENT: The Trust Board agreed to ratify the decision to approve the upgrade	

of the Sandwell A & E IT system	
Maintenance of generator	**SWBTB (7/08) 044**
The Trust Board was asked to approve the single tender action in relation to the annual contract for the maintenance of the City Hospital combined heat and power generation plant at a cost of £122,114 + VAT. This is in line with the terms and conditions of the maintenance agreement. The Trust Board approved the tender action.	
AGREEMENT: The Trust Board approved the single tender action in relation to the annual contract for the maintenance of City Hospital's generator	
Laundry equipment	**SWBTB (7/08) 050**
The Trust Board was asked to approve the disposal of the redundant/scrap equipment from the closure of the Trust's laundry. The highest sale offer received in response to a tendering exercise was £21k. The Trust Board approved the disposal to the company offering the highest value for the equipment.	
AGREEMENT: The Trust Board approved the disposal of the laundry equipment to the company offering the highest purchase price	
9.7 Blood tracking system	**SWBTB (7/08) 052**
Robert White presented a business case in support of a Trust-wide IT solution to improve the safety and effectiveness of the transfusion of blood and blood products. The system is required to comply with the EU blood directive due to be enforced shortly and supports the reconfiguration of the pathology division. The business case had been approved by SIRG. A divisional cost pressure of £27k arising in 2009/10 is attached to Option 3, the provision of an externally sourced automated system, which the Trust Board was recommended to approve. The Chair noted that the system was designed to minimise paper handling and was therefore attractive to reduce waste and minimise the chance of human error through paper handling. Roger Trotman noted that there were no payroll costs within the business case although a project manager resource was included in the proposal. Robert White agreed to confirm that this was the services of a contractor, the cost of which was included in the business case. The Trust Board approved option 3 and the associated expenditure, subject to confirmation of the project manager position.	
ACTION: Robert White to confirm that the cost of the project manager resource is included within the blood tracking business case **AGREEMENT: The Trust Board approved option 3 of the blood tracking business case**	

9.8 Patient safety development action plan	**SWBTB (7/08) 053** **SWBTB (7/08) 053 (a)**
Kam Dhami presented the 2008/09 patient safety development plan for approval. The plan is consistent with the Trust's corporate objective around patient safety. The plan had been presented to and approved by the Governance and Risk Management Committee in May 08. The plan is structured around the National Patient Safety Agency's 7 steps for improving safety and the safety strategy framework provided by the SHA. The Board was advised that the Trust had been asked to sign up to the Patient Safety Campaign in line with many other Trusts. This shows a commitment at Board level that the Trust is addressing patient safety. A series of KPIs are being developed which will monitor the implementation of the plan. Roger Trotman asked if there were resource implications to the Campaign. He was advised that at present there is very little information, although it is understood that there are no national resources available. The Chair was asked to consider suggesting a Non Executive Director to act as the patient safety development champion. The Trust Board approved the adoption of the Safety Development Plan and the Trust signing up to the Patient Safety Campaign.	
ACTION: **The Chair to nominate a Non Executive Director to act as the patient safety development champion** **AGREEMENT:** **The Trust Board approved the adoption of the 2008/09 Safety Development Plan and the Trust signing up to the Patient Safety Campaign**	
10 Strategy and development	
10.1 Towards 2010 programme: progress report	**SWBTB (7/08) 051** **SWBTB (7/08) 051 (a)** **SWBTB (7/08) 051 (b)**
The Trust Board noted that there has been much activity to develop the new models of care underpinning the programme. Additional attention is currently being given to embedding workforce planning. As part of this workstream an organisational change framework is being developed to handle any staff transfers required.	
10.2 2010 acute hospital project: programme report	**SWBTB (7/08) 045** **SWBTB (7/08) 045 (a)**
Graham Seager presented an update on the new hospital project. There has been a consultation exercise on the proposed ward configuration, the outcome of which was that the public felt that a mixture of single-bedded and 4-bedded bays would provide the best solution. The public Smethwick Area Action Plan examination had taken place on 24	

and 25 June. There had only been one objection raised by a landowner who raised a challenge on the question of what would happen with the site if the hospital did not succeed as planned. Outline planning consent is progressing well and the affordability model and financial appraisals are underway.	
11 Update form the Board Committees	
11.1 Finance and Performance Management Committee	**SWBFC (5/08) 017**
The Trust Board approved the minutes and actions arising from the meeting held on 29 May 08.	
AGREEMENT: The Trust Board approved the minutes of the last Finance and Performance Management Committee	
11.2 Governance and Risk Management Committee	**SWBGR (5/08) 010**
The Trust Board approved the minutes and actions arising from the meeting held on 29 May 08.	
AGREEMENT: The Trust Board approved the minutes of the last Governance and Risk Management Committee	
12 Any other business	**Verbal**
There was none.	
13 Details of next meeting	**Verbal**
The next meeting is scheduled for Thursday 4 September at 2.30pm in the Anne Gibson Boardroom, City Hospital.	
14 Exclusion of the press and public	**Verbal**
The Trust Board resolved that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).	

Signed …… **Print**……

Date ……

Next Meeting: 4 September 2008, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham NHS Trust - Trust Board

3 July 2008 - City Hospital

Members: Mrs S Davis (SD) [Chair], Ms I Bartram (IB), Mr R Trotman (RT), Mrs G Hunjan (GH), Dr S Sahota (SS), Mr J Adler (JA), Dr D O'Donoghue (DO), Mr R White (RW), Mrs R Stevens (RS)

In Attendance: Ms K Dhami (KD), Mr G Seager (GS), Mr C Holden (CH), Mr M Dodd (MD), Mrs J Kinghorn (JK), Ms J Whalley (JW), Ms R Ubhi (RU)

Apologies: Prof D Alderson (DA), Cllr B Thomas (BT), Mr R Kirby (RK), Mr T Atack (TA), Mrs D Gospel (DG)

Secretariat: Mr S Grainger-Payne (SPGP)

Last Updated: 15 August 2008

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 015	Draft single equality scheme	Enclosure 4a	03-Apr-08	Arrange diversity training for Board members and regular attendees	SPGP	01-May-08	Date still to be agreed that is convenient for all Exec team members. Simon G-P now arranging date with Nora Parsons - yet to confirm. Possibly October. Arranged for 3 October.	Completed Since Last Meeting	
SWBTBACT. 022	2010 programme progress report	Enclosure 5d	03-Apr-08	Present the progress with the six first wave 2010 exemplar projects 2010 plans at a future Board meeting	RK	07-Aug-08	Scheduled for 4 September 08. Included on agenda.	Completed Since Last Meeting	
SWBTBACT. 036	Update on actions from previous meetings	SWBTB (5/08) 017 (a)	05-Jun-08	Present the progress update against the corporate objectives at the September Trust Board	RK	03-Jul-08	Included on agenda	Completed Since Last Meeting	
SWBTBACT. 043	Update on actions from previous meetings	SWBTB (6/08) 040 (a)	03-Jul-08	Advise Rachel Stevens of availability to attend the visitor policy launch	All NEDs	14-Jul-08	Advised as requested. Attended by SD, RT, IB & GH	Completed Since Last Meeting	
SWBTBACT. 044	Monthly finance report	SWBTB (7/08) 058 SWBTB (7/08) 058 (a)	03-Jul-08	Work with Robert White to prepare a report monitoring the effect of energy price rises and a corrective action plan should a major impact on budget be projected	GS	31-Jul-08	Presented at F & PMC on 31 July 08	Completed Since Last Meeting	
SWBTBACT. 045	Monthly finance report	SWBTB (7/08) 058 SWBTB (7/08) 058 (a)	03-Jul-08	Consider a more appropriate way of reporting WTE vacancies to highlight recruitment issues	RW	31-Jul-08	Now included as an annex to financial performance report, showing % staff vacancies by area	Completed Since Last Meeting	

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 049	Blood tracking system	SWBTB (7/08) 052	03-Jul-08	Confirm that the cost of the project manager resource is included within the blood tracking business case	RW	04-Sep-08	Confirmed that this is the case - e-mail on 4 July 08	Completed Since Last Meeting	
SWBTBACT. 023	2010 programme progress report	Enclosure 5d	03-Apr-08	Present the working assumptions in connection with the future ownership of community hospital sites at a future meeting	RK	03-Jul-08	Initial assessment of this work presented to one of the FT seminars and will now be undertaking further work on the detail which will come back to Trust Board later in 2008/9. **ACTION NOT YET DUE**	Future	6-Nov-08
SWBTBACT. 046	Single Equality Scheme	SWBTB (7/08) 057 SWBTB (7/08) 057 (a)	03-Jul-08	Circulate the terms of reference for the subgroups of the Equality and Diversity Steering Group	RS	15-Aug-08	A revised Single Equality Scheme, including the Terms of Reference for the various subgroups will be presented at the November Trust Board meeting.	Future	6-Nov-08
SWBTBACT. 048	Annual complaints report	SWBTB (7/08) 055 SWBTB (7/08) 055 (a)	03-Jul-08	Consider a more appropriate way of providing a comparison of the Trust's performance regarding the number of complaints received with other organisations	KD	04-Sep-08	Standardisation to be incorporated into next quarterly report due in November.	Future	6-Nov-08
SWBTBACT. 040	Patient experience report	SWBTB (6/08) 036 SWBTB (6/08) 036 (a) SWBTB (6/08) 036 (b) SWBTB (6/08) 036 (c)	05-Jun-08	Circulate the patient experience action plan when timescales have been assigned to the various actions	RS	03-Jul-08	A full revision together with dates and progress will be presented at the November Trust Board.	Future	6-Nov-08
SWBTBACT. 037	Update on actions from previous meetings	SWBTB (5/08) 017 (a)	05-Jun-08	Present the maternity workforce strategy to a future Maternity Taskforce meeting and to a subsequent Trust Board meeting	RS	03-Jul-08	Scheduled for September 08 (MT) & October 08 (TB). **ACTION NOT YET DUE.**	Review next meeting	2-Oct-08
SWBTBACT. 050	Patient safety development action plan	SWBTB (7/08) 053 SWBTB (7/08) 053 (a)	03-Jul-08	Nominate a Non Executive director to act as the patient safety development champion	Chair	04-Sep-08	Due to be discussed at NEDs meeting on 28 August 08	Review next meeting	2-Oct-08
SWBTBACT. 043	Workforce strategy	SWBTB (6/08) 039 SWBTB (6/08) 039 (a)	05-Jun-08	Advise the Trust Board when the workforce strategy is published	CH	03-Jul-08	Comments still being incorporated and publication is expected by end September 08	Review next meeting	2-Oct-08

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 008	Monthly finance report	Enclosure 3b	03-Apr-08	Work with Rachael Stevens to develop a revised reporting system concerning expenditure in respect of bank nurses	RW	01-May-08	Refers to budgets reflecting a planned level of bank rather than vacancy savings being offset by bank spend. It will be 2-3 months before precise budget changes are known. **ACTION NOT YET DUE**	Review next meeting	2-Oct-08
SWBTBACT. 009	Monthly finance report	Enclosure 3b	03-Apr-08	Ensure the revised reporting mechanism for the presentation of bank nurse expenditure is agreed with Roger Trotman	RW	01-May-08	Linked to SWBTBACT.008. **ACTION NOT YET DUE**	Review next meeting	2-Oct-08
SWBTBACT. 007	Monthly performance monitoring report	Enclosure 3a	03-Apr-08	Include further detail regarding theatre utilisation within the monthly performance report by the end of Q2	RW	04-Sep-08	**ACTION NOT YET DUE**	Review next meeting	2-Oct-08
SWBTBACT. 001	Sandwell public health report	Presentation	03-Apr-08	Consider whether there is a need for the Board to be presented with the post-operative smoking cessation policy for review	Chair	01-May-08	Due to be reviewed by the Governance Board in September and then presented to the Trust Board in October. **ACTION NOT YET DUE.**	Review next meeting	2-Oct-08
SWBTBACT. 004	Nursing workforce strategy	Presentation	03-Apr-08	Present the results of the nursing workforce strategy pilot at the October Board meeting	RS	02-Oct-08	**ACTION NOT YET DUE**	Review next meeting	2-Oct-08
SWBTBACT. 047	Quarterly risk report	SWBTB (7/08) 054 SWBTB (7/08) 054 (a)	03-Jul-08	Present the maternity development plan at the September Trust Board meeting	KD	04-Sep-08	Due to be presented at the October Trust Board, following consideration at the September Maternity Taskforce	Review next meeting	2-Oct-08

Next Meeting: 4 September 2008, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham NHS Trust - Trust Board

3 July 2008 - City Hospital

Members: Mrs S Davis (SD) [Chair], Ms I Bartram (IB), Mr R Trotman (RT), Mrs G Hunjan (GH), Dr S Sahota (SS), Mr J Adler (JA), Dr D O'Donoghue (DO), Mr R White (RW), Mrs R Stevens (RS)

In attendance: Ms K Dhami (KD), Mr G Seager (GS), Mr C Holden (CH), Mr M Dodd (MD), Mrs J Kinghorn (JK), Ms J Whalley (JW), Ms R Ubhi (RU)

Apologies: Prof D Alderson (DA), Cllr B Thomas (BT), Mr R Kirby (RK), Mr T Atack (TA), Mrs D Gospel (DG)

Minutes: Mr S Grainger-Payne (SPGP)

Last Updated: 15 August 2008

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAG.026	Minutes of the previous meeting	SWBTB (6/08) 040	03-Jul-08	The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held
SWBTBAG.027	Catering contract	SWBTB (7/08) 048 SWBTB (7/08) 048 (a) SWBTB (7/08) 048 (b) SWBTB (7/08) 048 (c)	03-Jul-08	The Trust Board approved the proposal to progress with the cook chill option at Rowley Hospital for Trust catering
SWBTBAG.028	Single equality scheme	SWBTB (7/08) 057 SWBTB (7/08) 057 (a)	03-Jul-08	The Trust Board unanimously approved the Single Equality Scheme
SWBTBAG.029	Single tender agreement - Roche consumables	SWBTB (7/08) 043	03-Jul-08	The Trust Board agreed to ratify the decision to approve the purchase of modular consumables from Roche
SWBTBAG.030	Single tender agreement - Sandwell A & E IT upgrade	SWBTB (7/08) 046	03-Jul-08	The Trust Board agreed to ratify the decision to approve the upgrade of the Sandwell A & E IT system
SWBTBAG.031	Single tender agreement - Maintenance of City Hospital generator	SWBTB (7/08) 044	03-Jul-08	The Trust Board approved the single tender action in relation to the annual contract for the maintenance of City Hospital's generator
SWBTBAG.032	Sale of laundry equipment	SWBTB (7/08) 050	03-Jul-08	The Trust Board approved the disposal of the laundry equipment to the company offering the highest purchase price
SWBTBAG.033	Blood tracking system business case	SWBTB (7/08) 052	03-Jul-08	The Trust Board approved Option 3 of the blood tracking business case

SWBTBAG.034	Patient safety development action plan	SWBTB (7/08) 053 SWBTB (7/08) 053 (a)	03-Jul-08	The Trust Board approved the adoption of the 2008/09 safety development plan
SWBTBAG.035	Finance and Performance Committee	SWBFC (5/08) 017	03-Jul-08	The Trust Board approved the minutes and actions arising from the Finance and Performance Management Committee held on 29 May 08
SWBTBAG.036	Governance and Risk Management Committee	SWBGR (5/08) 010	03-Jul-08	The Trust Board approved the minutes and actions arising from the Governance and Risk Management Committee held on 29 May 08

SWBTB (9/08) 087

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Estates Strategy 2008/09 – 2017/18
SPONSORING DIRECTOR:	Graham Seager – Director of Estates/New Hospital Project Director
AUTHOR:	Rob Banks – Head of Estates
DATE OF MEETING:	Thursday 4 September 2008

KEY POINTS:

The Estates Strategy sets out how the Clinical Services will be supported by safe, secure and appropriate environment.

Ensures that Capital investments support Service Strategies and plans.

Key objectives of the Strategy are:

- To analyse the estate condition and its performance.
- To identify costs to achieve Estatecode condition B for key facets of the Condition Survey.
- To prioritise capital investment in estate statutory compliance issues.
- To maintain/improve compliance with Annual Health Check Core standards.
- To achieve continuous improvement in Environmental Performance measured against the NHS Building Research Establishment Environmental Assessment Method (BREEAM).
- To operate all estate and facilities services at a benchmark between the lower and upper quartiles of the Estates Return Information Collection (ERIC) system measured against comparable Trusts, and demonstrate value for money.
- To achieve green status for all operational related performance indicators by March 2016.
- To maintain Patient Environment Action Team – "Good or Excellent Standards" status year on year.
- To have a formal system of control to ensure a robust Development Control Plan (DCP) in support of clinical services
- To develop and implement the acute hospital components of the "Towards 2010" programme to support the delivery of 21st century Health Care.

PURPOSE OF THE REPORT:

For consideration and approval of the Estates Strategy.

✓ **For approval**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board are asked to consider and approve this Estates Strategy.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

This Strategy aligns with the Trust strategic objectives in that it aims to:

- Make best use of its resources
- Improve the environment and contribute to the improvement of quality and standards of care
- Develop 21st Century facilities through the Towards 2010 Programme

IMPACT ASSESSMENT:

FINANCIAL	✓	10 year Capital Plan.
ALE	✓	
CLINICAL		
WORKFORCE		
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		This Strategy has been developed to support the current and future healthcare service needs of our local population. One of the long term strategic objective for the Trust is the delivery of acute healthcare principally from a new hospital on a single site by 2015. This Strategy would need to be reviewed and substantially changed if the new hospital is not delivered within the current timescale due to the risks associated with continuing to provide the services from the existing City and Sandwell hospital sites.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Estates Strategy 2008/09 - 2017/18

August 2008

ESTATES STRATEGY 2008/09 – 2017/18

LIST OF TABLES

ESTATES STRATEGY 2008/09 – 2017/18

1.0 Executive Summary

1.1 Background

An estates strategy is a plan for the current and future development/management of the estate. The recommendation from the Department of Health is for all NHS Trusts, including Foundation Trusts, to have an estates strategy.

The strategy should outline the proposals for future development/management of the estate covering up to 10 years.

The starting point for the development of the estates strategy is to identify the current and future healthcare service needs of our local population and the current condition of the existing estate. An estates strategy cannot, therefore, be developed in isolation; it is an essential and integral part of service planning.

The benefits of an estates strategy are as follows:

- The development of the estate that supports service/capacity requirements
- The provision of safe, secure and appropriate buildings
- The provision of high quality healthcare environments
- A plan for change that enables progress towards goals to be measured
- A means of targeting investments to minimise the risks associated with the built environment
- An opportunity to dispose of surplus and/or poorly used assets and reinvest released resources into the remaining estate
- An opportunity to optimise occupancy costs

1.2 Existing Estate

The Sandwell and West Birmingham Hospitals estate property portfolio consists of a variety of buildings with a very diverse range of ages and conditions. See section 6.0 Estate Performance for further details.

The total value of the Trust's building assets is as follows:

Sandwell	-	£94,669,000
City	-	£104,141,000
Rowley	-	£14,745,000
Total value of Building Assets		£213,555,000

Existing site plans and building age profiles can be seen in Appendix 1.

As part of the Trusts assessment of its current position, a high level analysis of its assets and their usage has been completed. This includes analysis of the following five facets as defined by the Department of Health:

- Physical condition
- Functionality suitability
- Space utilisation
- Compliance with health & safety, including fire
- Environmental management, including energy performance

1.3 Estate Performance

Detailed Condition Surveys were undertaken in December 2002 and recently updated as a desk top exercise in August 2007. Generally, due to its age, the estate has one of the largest backlog maintenance costs in the country, approximately £100m. However, due to robust risk management and governance structure and processes the high and significant portions of the backlog are average when compared to other Large Acute Trusts outside of London, at approximately £7 million. Further prudent investment from the 2008/09 Capital Programme to address Statutory Standards and Estates related issues of >£3m will result in an improved high risk backlog position.

Further investment in the existing estate will be required as the Trust moves towards "2010" and the development of the new acute hospital. This investment will be required in order to maintain compliance with statutory standards, impending standards and the need to achieve high levels of business continuity. The Trusts 10 year Capital Plan Forecast reflects this need for continuing investment in the existing estates. The 10 year Capital Plan Forecast is shown in Appendix 15.

1.4 Risk Management and Governance

The Estates and Capital Projects Directorate has robust systems in place for the management of estates related risks and governance. The Directorate meets on a monthly basis and formal reports are presented to the Trust Governance Board on a quarterly basis.

The Directorate has achieved compliance with all the related core standards for the Healthcare Commissions, Standards for Better Health.

The Estates Risk Register is a statutory requirement and an aid to determining the prioritisation of funding for capital investment. The Estates Risk Register is then utilised to populate the Trusts Risk Register in order that a corporate informed view is adopted to the process of pro-active risk management.

1.5 Environmental Performance

The Trust continues to improve its environmental performance, maintain statutory compliance and demonstrate social responsibility whilst ensuring value for money.

The Trust is committed to improvement in its environmental impact, energy reduction and sustainable development and has recently appointed an Energy and Environmental Manager and a Waste Minimisation manager.

Action plans for both energy and waste have been developed and are currently in the process of being implemented. Energy and Waste action plans are shown in Appendices 6 and 7.

The 1st July 2008 saw the introduction of 'Building Research Establishment Environmental Assessment Method' (BREEAM for Healthcare). BREEAM Assessment is mandatory for new buildings and voluntary for existing buildings. Although only required on a voluntary basis a BREEAM assessment for existing buildings will be undertaken. BREEAM replaces the previous NHS Environmental Assessment Tool (NEAT)

A BREEAM assessment will be undertaken for the development of the new acute hospital and an excellent rating will be required.

A range of energy saving initiatives have been identified for the existing sites following involvement with the Carbon Trust, implementation of the schemes will take place during 2008/09.

1.6 Estates Returns and Information Collection (ERIC) and Performance Indicators

Estates Returns and Information Collection were completed for 2007/08 and submitted to the Department of Health as required and within the necessary timeframe. This is a mandatory requirement.

A detailed assessment of the 2007/08 returns is being undertaken to assess the Trusts benchmark position in relation to all other large acute Trusts outside of London. A report is being produced and will be presented to Executive Team and form part of Divisional review.

The objective remains to keep the provision of all services within the benchmark upper and lower quartiles and to demonstrate value for money.

1.7 Patient Perception and Patient Environment Action Team (PEAT)

The Trust has improved its position significantly over the period 2007/08. The externally verified ratings across the four Trust sites were as follows:

Environment - Good
Food - Excellent
Privacy/Dignity - Good

The poor 'built environment' of the Trust, high levels of backlog associated with physical condition and poor functional suitability provides a very challenging task to maintain a good/excellent status. However, this remains an objective for the Trust.

The Trust has invested heavily in improving cleaning standards and has introduced an Executive PEAT Audit process.

Recurrent revenue and Capital investment will be required to meet these challenging standards.

1.8 Summary Disposal and Proceeds of Sale

The Trust currently provides its services from three main sites that cover approximately 80 acres of land and 160,000m² of buildings. There are a number of buildings currently vacant following various initiatives including

- Outsourcing laundry contract, which has lead to the closure of on site facility at City Hospital
- Outsourcing decontamination of surgical instruments has resulted in the closure of on site sterile supplies department at City and a reduction in the space used for decontamination at Sandwell.
- Vacated old Sisters and Nurses Homes
- Vacated Central Food Reduction Unit, City Hospital site

Serious consideration has been given to estate rationalisation. However, until such time as the Outline Planning Application (OPA) and the Outline Business Case (OBC) for the new acute hospital have been approved together with increased certainty about the future of the remaining estate, site rationalisation has been put on hold. Options 2 and 3 of the new hospital business case consider the new hospital being built on either City or Sandwell sites. Any site rationalisation could jeopardise these options.

1.9 Development Control Plans

There are essentially three timescales being planned for by the trust:-

- Short term planning- dealing with immediate issues of service delivery
- Interim planning- Getting Ready for 2010 – Interim reconfiguration of services
- Long term-strategic direction Towards 2010

Development Control Plans (DCP's) shown in Appendices 13 and 14 cover the short term planning timescales. The primary focus on these DCP's is the support and implementation of interim reconfiguration. The main schemes being delivered during 2008/09 and funded from the Capital Programme include:

- Neonatal reconfiguration on City site;
- Pathology reconfiguration on City site;
- Surgical reconfiguration
- Urgent Care Centre on City site.

The long term strategic direction Towards 2010 is detailed in section 13 – Strategic Options for Estate Change and a summary provided in Section 1.10 below.

1.10 Strategic Options for Estate Change

The Towards 2010 Programme remains the strategic objective of the Trust. The plan is for the Trust to provide acute services principally from a single site.

The preferred single site option for the new hospital is Grove Lane Smethwick, which is situated in an ideal location between City Hospital and Sandwell Hospital sites.

The development of the new acute hospital is making good progress. The design brief, trust requirements and Public Sector Comparator are nearing completion. The Outline Planning Application was completed on programme and submitted to Sandwell MBC in April 2008. The Trust is working with Sandwell MBC officers and statutory consultees to enable the determination of the planning application to be achieved by October 2008.

Key programme dates are as shown in Table 1 below.

Table 1 - Key Programme Dates for New Acute Hospital Development

PROJECT PHASE	DESCRIPTION	COMPLETION DATE
Phase One:	The Solution Phase	March 2009
Phase Two:	The Procurement Phase	May 2012
Phase Three:	The Construction and Commissioning Phase	July 2015
Phase Four:	The Evaluation Phase	July 2018

2.0 INTRODUCTION

The NHS estate has a current use value of about £24bn and a significantly greater replacement value. The overall aim of the Department of Health is for at least 40% of the total value of the NHS property portfolio to be less than 15 years old by 2010.

Patients' first impressions of healthcare services are formed by the appearance of healthcare buildings and facilities. Services should be delivered in well designed environments. Patients and staff need to feel safe, secure and comfortable. Healthcare buildings should ensure good functionality, meet expectations in terms of privacy and dignity, provide good access to all, reduce infection and minimise accidents.

This strategy has been developed on a framework asking three fundamental questions across a range of criteria, as follows:

- Where are we now?
- Where do we want to be?
- How do we get there?

3.0 AIMS OF ESTATE STRATEGY

- This estate strategy reviews the current key estate issues of the Trust.
- Sets out how the clinical services will be supported by a safe, secure and appropriate environment.
- Ensures that capital investments support service strategies and plans.

4.0 OBJECTIVES OF ESTATE STRATEGY

- To analyse the estate condition and its performance.
- To identify costs to achieve Estatecode condition B for key facets of Condition Survey.
- To prioritise capital investment in estate statutory compliance issues.
- To maintain/improve compliance with Annual Health Check Core standards.
- To achieve improvement year on year in NHS Environmental Assessment Tool (NEAT) assessment.

  NB NEAT will shortly be replaced by the 'Building Research Establishment Environmental Assessment Method' for Healthcare, (BREEAM).

- To operate all estate and facilities services at a benchmark between the lower and upper quartiles of the Estates Return Information Collection (ERIC) returns of comparable Trusts and demonstrate value for money.
- To achieve green status for all operational related performance indicators by March 2016.
- Maintain Patient Environment Action Team – "Good or Excellent Standards" status year on year.

- To have a formal system of control to ensure a robust Development Control Plan (DCP) to support clinical services.

- To develop and implement the acute hospital components of the Towards 2010"programme to support the delivery of 21st century Health Care.

5.0 TIMESCALE

This strategy considers the period from 2008/09 to 2017/18. It will be reviewed on an annual basis as part of the Trusts business planning process.

6.0 ESTATE PERFORMANCE

6.1 Where are we now?

As can be seen from Table 2 below (Building Age and Asset Profile) much of the existing Estate is of a significant age and does not comply with Department of Health guidelines or aspirations for 40% of the NHS Estate to be less than 15 years old by 2010. Currently more than 50% of City site is over 30 years old and over 60% of Sandwell site is over 20 years old.

Compliance with Department of Health requirements is dependant upon the implementation of the Trust's long term strategic plan for the construction of the new acute hospital as part of the Towards 2010 Programme.

Table 2 – Building Age and Asset Profile

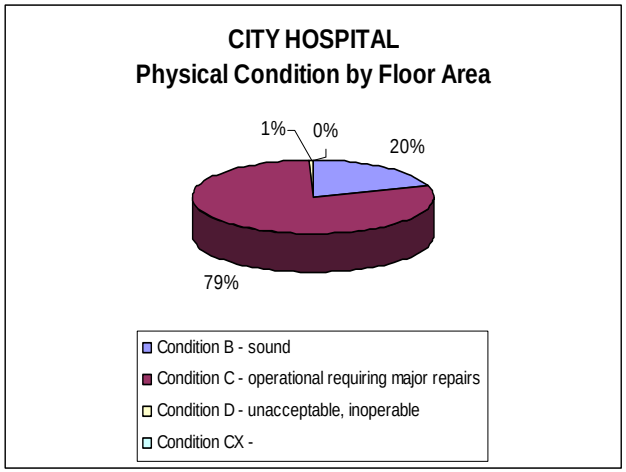
Age & Asset Profile	Unit	Sandwell	City	Rowley	Trust %
Age Profile - 2005 to present	%	27.73	28.75	0	26.5
Age Profile - 1995 to 2004	%	0	1.43	0	0.7
Age Profile - 1985 to 1994	%	0.02	8.95	100	10.9
Age Profile - 1975 to 1984	%	47.95	7.16	0	23.6
Age Profile - 1965 to 1974	%	15.06	16.47	0	14.85
Age Profile - 1955 to 1964	%	0.07	7.16	0	3.77
Age Profile - 1948 to 1954	%	0	4.30	0	2.2
Age Profile - pre 1948	%	9.16	25.78	0	17.27
Age Profile - Total (must equal 100)	%	100	100	100	100
Building Asset Value by Age - 2005 to present	£	26,250,387	29,937,933.36	0	
Building Asset Value by Age - 1995 to 2004	£	0	1,491,518.86	0	
Building Asset Value by Age - 1985 to 1994	£	20,607.70	9,321,993.63	14,745,000	
Building Asset Value by Age - 1975 to 1984	£	45,392,590.78	7,457,594.32	0	
Building Asset Value by Age - 1965 to 1974	£	14,260,746.41	17,152,467.42	0	
Building Asset Value by Age - 1955 to 1964	£	68,693.08	7,457,594.32	0	
Building Asset Value by Age - 1948 to 1954	£	0	4,474,556.59	0	
Building Asset Value by Age - pre 1948	£	8,675,974.74	26,847,341.50	0	
Total Building Asset Value	£	94,669,000	104,141,000	14,745,000	213,555,000

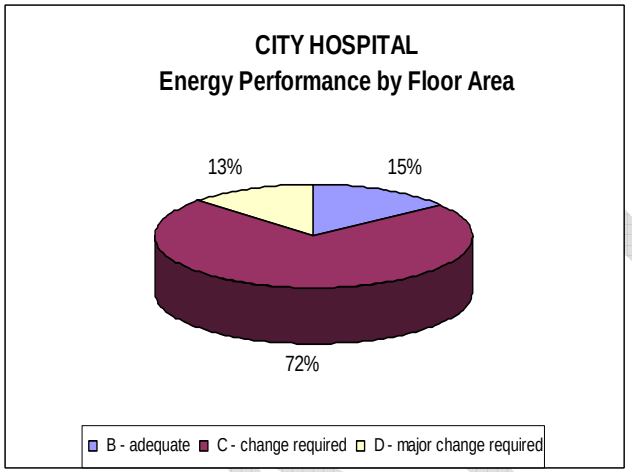
Condition surveys of the two principle sites were undertaken in December 2002 by French Thorpe Consultancy supported by Malcolm Lamb Associates. The criteria that were used to assess the estate were those defined by Estatecode:

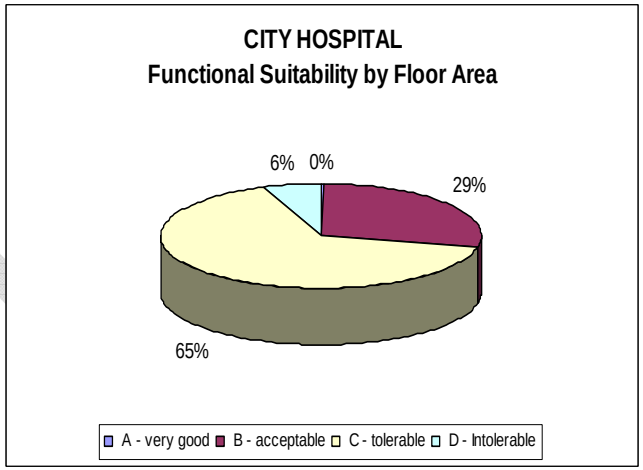
- Physical Condition
- Space Utilisation
- Statutory standards
- Energy performance
- Functional suitability.

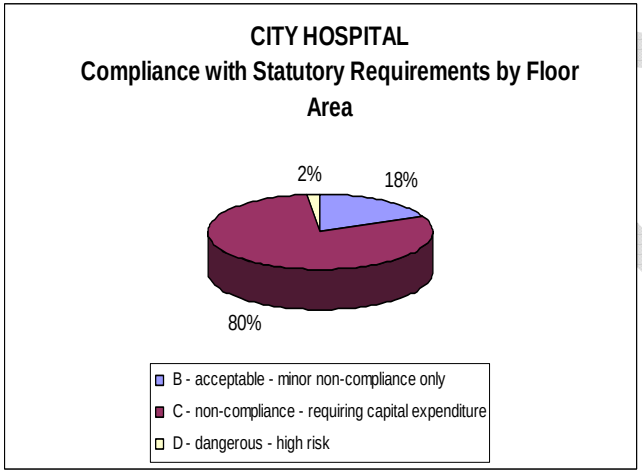
A desktop update of these surveys was undertaken in August 2007 to identify areas where condition has deteriorated or improved via capital investment. The following pie charts summarise the performance for the categories. Note the 'Part Dangerous and Inoperable' areas are generally disused areas of the estate with the exception of the upper floors of Arden House where the lack of passenger lifts limits operational use of the building for staff.

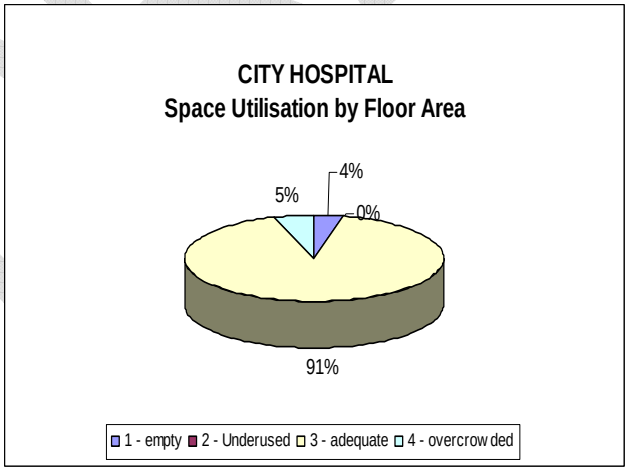
6.1.1 City Hospital Condition Survey Graphs



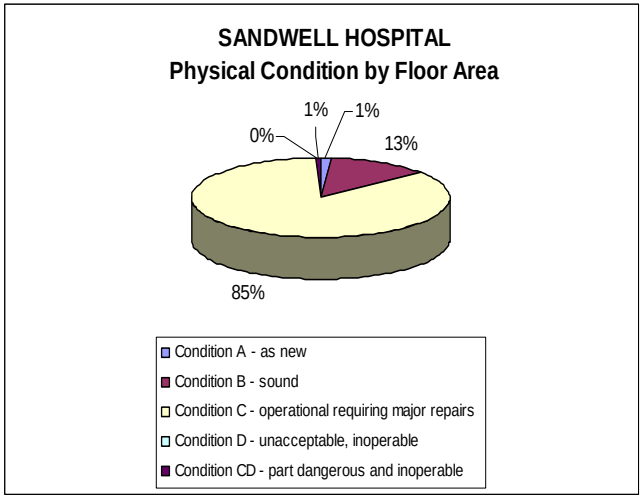


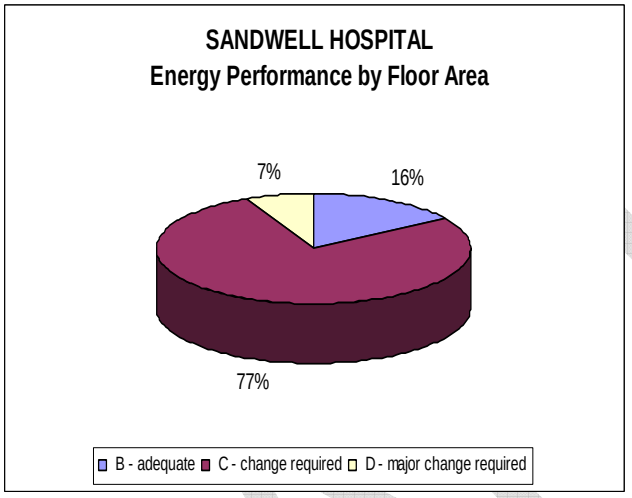


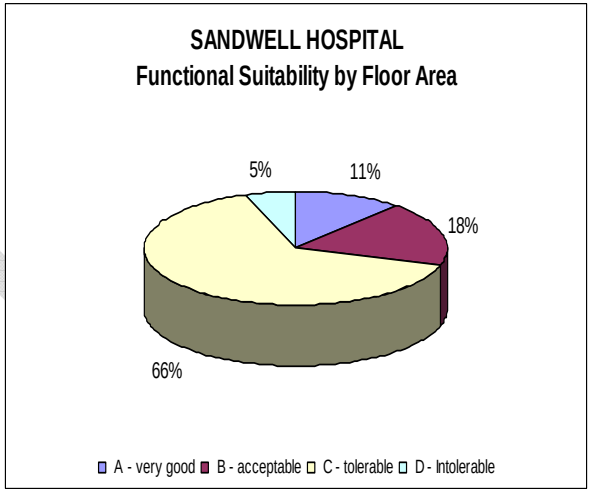


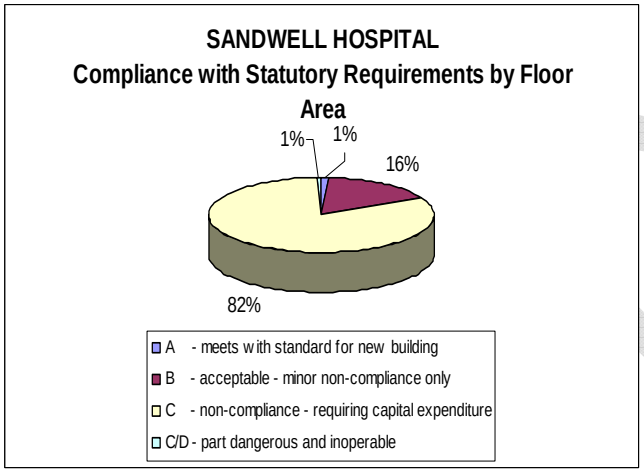


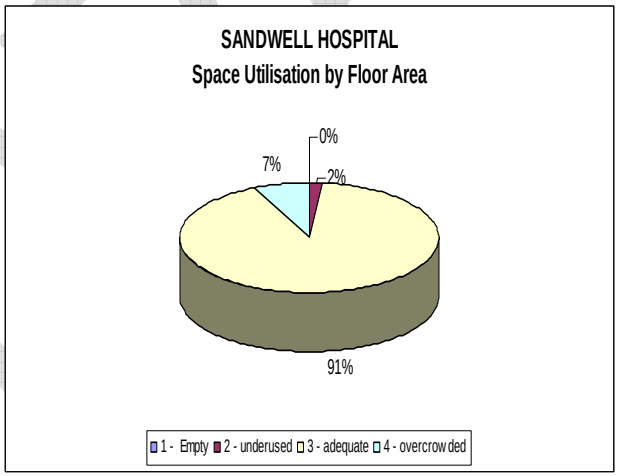
6.1.2 Sandwell Hospital Condition Survey Graphs



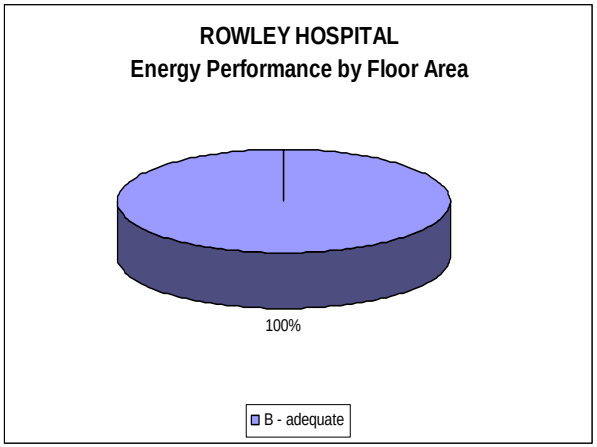


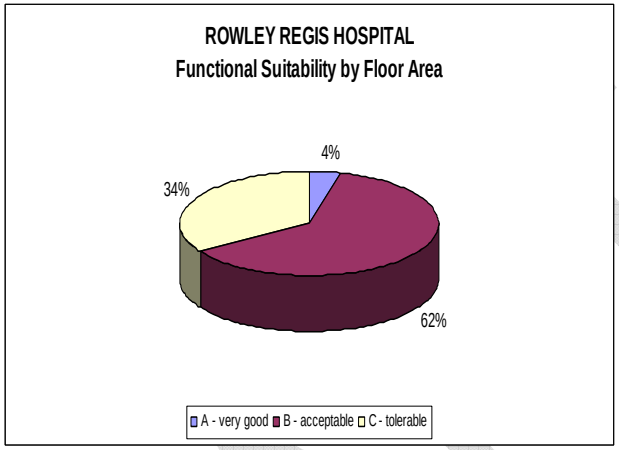


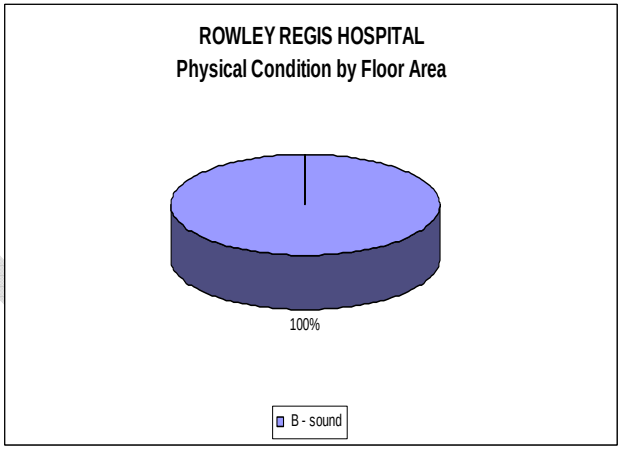


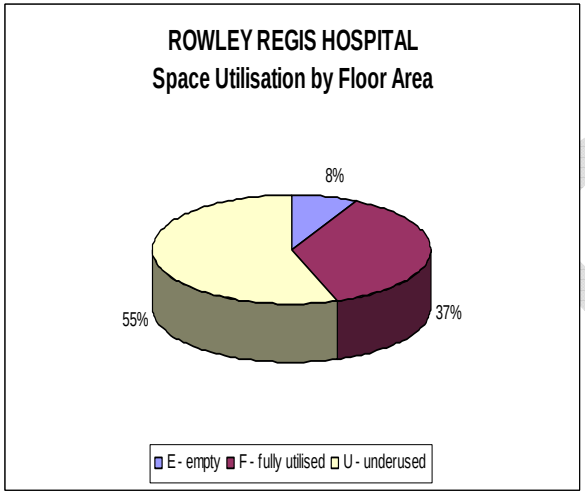


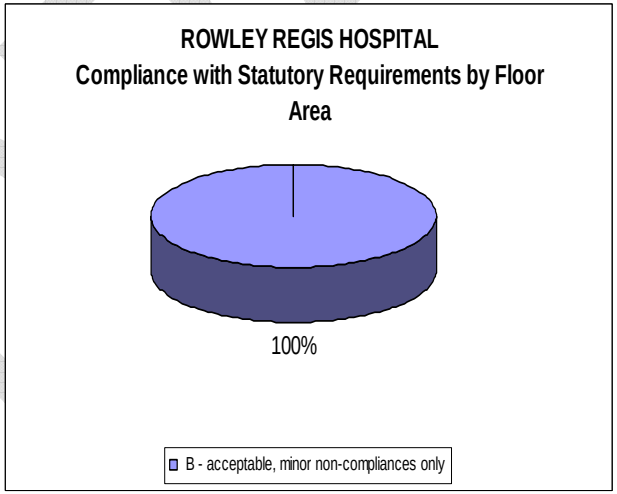
6.1.3 Rowley Regis Hospital Condition Survey Graphs











A definition of Condition 'B' taken from 'A risk-based methodology for establishing and managing backlog' is shown below:

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

The costs to achieve Condition 'B' have also been updated to take account of inflation. The cost to achieve condition B is estimated as shown in table 3 below:

Table 3 – Cost to Achieve Condition 'B'

High Risk	**£500,000**
Significant Risk:	**£3,335,000**
Moderate Risk:	**£86,860,100**
Low Risk:	**£9,123,900**
Total backlog:	**£99,819,000**
Risk Adjusted:	**£7,144,793**

Risk adjusted backlog is a relatively new concept in the NHS which was introduced in 2004 as a way of separating the highest risk and most significant risk cost elements of backlog from the moderate and low risk elements. The cost of the moderate and low risk elements of backlog can be apportioned across the remaining life of the asset, be it a building or an element of engineering plant or equipment. As can be seen in Table 3 above the Trust total backlog is circa £100million whereas the risk adjusted figure is circa £7million due to the high levels of moderate and low risk items.

The current Trust backlog maintenance position when benchmarked against other Large Acute Trusts outside of London using Estates Return Information Collection, (ERIC) is as follows:

- Total Backlog Cost – Second highest cost to achieve condition 'B' and well above the upper quartile (see Table 4 below).

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

LOWER QUARTILE	MEDIAN	UPPER QUARTILE	SWBH POSITION
£47.57	£136.00	£254.87	£603.92

- Risk Adjusted Backlog – marginally above median position (see Table 5 below).

Table 5 – Total Risk Adjusted Cost per Occupied Floor Area (£/m^2)

LOWER QUARTILE	MEDIAN	SWBH POSITION	UPPER QUARTILE
£9.04	£42.97	£43.23	£103.24

6.2 Where do we want to be?

Backlog of this magnitude has potential safety implications and may influence patient perception, this could also affect business with greater patient choice within the 'Choose and Book' arrangements.

The issues of poor physical condition need to be addressed to maintain the building fabric and to ensure patient's expectations are met. This is assessed through the Patient Environment Action Teams (PEAT) initiative and estates surveys. The objectives for the Trust are to achieve condition B for all facets of the survey through strategic capital investment and to achieve good or excellent standards for PEAT Assessments. Detailed risk assessments are also undertaken in line with the Trust's formal risk assessment process and reported through the governance/risk management structure.

6.3 How do we get there?

Issues associated with statutory compliance have to be managed through the Trusts risk management arrangements. These arrangements consist of the Facilities Governance Group, which meets on a monthly basis and reports to the Trusts Governance Board. The risk management process identifies a number of estates and facilities issues as red risks; these are reported with their control measures to the Trust's risk management committee. All risks are updated annually and implications identified through the business planning process. Continued investment into the Estate is required in order to improve the backlog position, maintain compliance with statutory standards and minimise risk. The investment required is identified within the Trusts 10 year Capital Plan Forecast (See section 6.5 for details of 2008/09 Capital Investment commitment).

6.4 2007/2008 Review

The 2007/08 capital programme concluded with a spend on statutory standards and estates related issues of approximately £2.6m as planned. Key areas upgraded/improved through capital investment were:-

- Fire Precautions
- Control of Legionella
- Disability Discrimination Act (DDA) access works
- Asbestos management works
- Site infrastructure services, electrics, water, steam, medical gases, etc.

The Trusts discretionary capital was also used to improve the physical condition of the estate. With notable schemes being as follows:-

- Sandwell Neo-Natal Unit
- City Paediatric Assessment Unit
- Sandwell Paediatric Wards
- Pathology Reconfiguration
- City Neonatal Unit
- Theatre 'A' BTC
- Hearing Services Centre

6.5 2008/2009 Capital Programme

The capital programme for the 2008/09 financial year includes £3.9m allocated to statutory standards and estates related improvement schemes. Of the £3.9m, £2.15k is allocated to statutory standards; £1.2k has been allocated to improving the physical condition of the estate related schemes such as passenger lifts upgrade, £250,000 to security and £300,000 to Hygiene Code related items.

The Capital schemes to enable the Trust's reconfiguration plans will also include an element of environmental improvement and statutory compliance works as well as facilitating the functional change required to support clinical services.

However, to achieve Condition B for all facets requires strategic investment through the Towards 2010 programme which includes the objective to improve the Trust's estate.
The 2008/09 Capital Programme is shown in Appendix 3.

Notable schemes for investment during 2008/09 are as follows:

- Neonatal reconfiguration on City site;
- Pathology reconfiguration on City site;
- Surgical reconfiguration
- Urgent Care Centre on City site.

7.0 RISK MANAGEMENT and GOVERNANCE

7.1 Where are we now?

The Estates and Capital Projects Directorate has a robust system of risk management managed through the directorate's governance group, chaired by either the Director of Estates or Head of Estates, this group meets monthly and reports to the Trust Governance Board.

The standing agenda items are:

- Privacy and Dignity
- Disability Discrimination Act
- PEAT/Better Hospital food
- Compliance with HTMs, HBNs, best practice guides
- Complaints and litigation
- Statutory enforcement bodies
- Risk management
- Consultation and patient involvement
- Staff management
- Education and training
- Governance development
- External publications
- HEFMA
- Divisional H&S mtgs

All significant Estates related Risk Assessments are managed through the Trusts Risk Management processes.

The Trust is required to comply with The Healthcare Commissions Standards for Better Health Annual Health Check core standards.

Annual Health Check Core Standards relating to estates and facilities issues are as shown in Table 6 below. The Directorate has achieved compliance with these core standards.

Table 6 – Annual Health Check Core Standards relating to Estates and Facilities

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

7.2 Where do we want to be?

The Trust needs to maintain progress on all of the above issues and provide its services in a safe and secure environment. This needs to be achieved in a transparent way and responsive to patient's perception and views through surveys and complaints. The objective is to maintain compliance with all Annual Health Check Core Standards and maintain the robust approach to Risk Management and Governance.

7.3 How do we get there?

The risk management and governance arrangements of the Trust provide a framework to meet the objective of maintaining a safe and secure environment. Over the next 12 months the directorate will develop plans of how to maintain compliance with the Annual Health Check Estates and Facilities related standards.

The risk register is a statutory requirement and an aid in determining the prioritisation of funding for capital investment and informs on going service provision. The directorate will maintain its risk register and ensure the directorate "red risks" and associated control measures are notified to the Trust Risk Management committee.

All of these risk and Governance objectives were met and procedures remain in place. The change in managerial arrangements at Director level will not impact on the Estates and Facilities governance arrangements.

However, many issues require the investment that can only come from a programme of strategic capital investment.

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

8.0 ENVIRONMENTAL PERFORMANCE

8.1 Where are we now?

The Trust has continued to improve its environmental performance, maintain statutory compliance and demonstrate social responsibility, whilst ensuring value for money.

The NHS Environmental Assessment Tool (NEAT), utilised to demonstrate the Trust's continuous improvement in environmental issues, has recently been replaced with a new assessment system; BREEAM (Building Research Establishment Environmental Assessment Method).

As from 1st July 2008, all new buildings must achieve an 'excellent' rating, and all refurbishments must achieve a 'very good' rating, under BREEAM Healthcare. See Appendix 5 for full NEAT Assessments.

The Trust is not yet required to undertake an environmental assessment using BREEAM for Healthcare for the existing hospitals. However, the development of environmental initiatives relating to 'energy and waste management' indicate that the Trust could achieve a favourable outcome when this BREEAM assessment is carried out.

8.2 Where do we want to be?

The Trust is committed to ongoing improvement in its environmental impact, energy reduction programme and sustainable development, whilst providing a cost-efficient service to the public. The Trust will undertake a voluntary BREEAM Assessment for its existing sites and aspire to a 'Good' rating.

The Trust will undertake a mandatory BREEAM Assessment on the new acute hospital development and attain an 'Excellent' rating.

8.3 How do we get there?

Last year, the Department of Health made available £100 million Energy and Sustainability Fund for use on energy reduction schemes. The Trust subsequently submitted bids totalling £605,000 for the following projects:

- Expansion of Building Management System;
- Energy saving controls on refrigeration units;
- Installation of high-efficiency lighting;
- Enhanced thermal insulation of engineering services and buildings;
- Replacement of steam condensate pumps.

Although the initial bids were not approved during the first phase of funding allocation, the bids are expected to be met in the second phase funding process, to be finalised shortly. A further £50 Million additional funding is anticipated very shortly.

In the meantime, the Trust is pro-actively reducing energy consumption with the following initiatives:

- Thermal insulation improvements to buildings and heating pipework;
- Improved heating controls;
- Improvements to steam distribution systems;
- Installation of energy saving refrigeration controls;
- Installation of energy efficient lighting and controls.

Further details of additional energy and environmental initiatives can be found in the Energy and Environmental Action Plan 2008/09. (See Appendix 6)

The Trust is a member of the recently established NHS Good Corporate Citizen Group and is represented at the Quarterly Environmental Networking meetings, established to share and promote good practice relating to environmental issues. The Group has established a voluntary self-assessment model to help facilitate discussion, generate ideas, promote learning and motivate NHS Trusts to further improve sustainable development. The model is organised around the following six areas of activity, designed to assist in prioritising future focus:

- Transport
- Procurement
- Facilities Management
- Employment and Skills
- Community Engagement
- New Buildings.

In addition, the Trust continues to address the many areas of environmental management, identified in the latest environmental audit, including;

- Full compliance with the Waste Electrical and Electronic Equipment Regulations(WEEE Regulations);
- Full compliance with the Hazardous Waste Regulations, achieving full segregation of all Healthcare waste;
- Implementation of the Trust's Waste Management Policy;
- Appointment of Energy and Environment Manager to monitor, target and reduce energy usage and carbon emissions;
- Waste minimisation measures further developed, and a Waste Minimisation Manager appointed.
- Waste Minimisation Action Plan has now been produced and its implementation commenced (see Appendix 7).

As from 1st October 2008, all public buildings over 1000m^2 will need to indicate their energy efficiency and CO_2 emissions on a scale of A to G, by the use of Display Energy Certificates (DEC's). These are based on energy consumption and indicate how well each building is managed and operated. From 1st October 2008 NHS Trusts will use existing ERIC benchmarking data to produce DEC's and have a further 12 months to produce building specific DEC's.

All new building projects continue to embrace the requirements of energy performance, sustainability and environmental responsibility. Together with the ongoing energy reduction and environmental improvement initiatives, the Trust demonstrates a continued commitment to environmental management. All new buildings, <1000m^2 will require an Energy Performance Certificate (EPC).

The long term strategic aim will be to achieve Full Compliance with Environmental Standards, through the development of the new acute hospital. This will encompass all environmental and sustainability issues.

9.0 ERIC RETURNS and PERFORMANCE INDICATORS

9.1 Where are we now?

9.1.1 ERIC Returns

The Trust has a mandatory requirement to submit information annually to the Department of Health on a whole range of hard and soft FM services. This information is provided in line with the Estates Return Information Collection requirements (ERIC). Trusts are categorised according to their size and type. Sandwell and West Birmingham Hospitals NHS Trust is in the category of 'Large Acute Trusts Outside Of London". Obviously the benchmarking information is more meaningful when provided in this way.

The returns are summarised for each service into quartiles, lower, median and upper. Any service that fall outside the upper and lower quartiles will be identified and further detailed analysis undertaken to understand the reasons why.

The overall position for 07/08 identified a number of operational service areas that required investigation:

I. Building and Engineering maintenance cost per occupied floor area – lower quartile

II. Total backlog cost – upper quartile

III. Total waste volume produced per occupied floor area – upper quartile
IV. Total cost of cleaning per occupied floor area – lower quartile

V. Gross cost of catering per occupied floor area – lower quartile

VI. Gross cost of patient food services per occupied floor area – lower quartile

Full details of ERIC returns for 2007/08 are shown in Appendix 8
Trust High Level Performance Indicators (PI's) for 2006/07 are shown in Appendix 9
(NB 2007/08 High level PI's are unavailable from Department of Health until Dec 08)

9.2 Where do we want to be?

For each element of service delivery the objective remains to keep the cost of provision of those services within the benchmark between lower and upper quartiles and demonstrate value for money.

9.3 How do we get there?

To inform the business planning process the directorate will utilise the 2007/08 ERIC returns, factor in the current CIP plans and forecast its benchmark position. Areas outside of the benchmark are being reviewed. These are shown below.

Where appropriate proposals will be developed to make changes to operational services to comply with objective.

I. Building and Engineering maintenance cost per occupied floor area – lower quartile

A detailed analysis of engineering maintenance costs has been undertaken with a review of staffing levels. Additional resources for 2008/09 have been agreed to meet new standards and maintain compliance with hygiene codes. Building and Engineering Maintenance costs for 2009/10 will move towards the Median position.

II. Total backlog cost – upper quartile

Significant investment has been agreed from 2008/09 Capital Programme to address high and significant backlog and minimise risk to the organisation. It is accepted that the Trust will continue to have a very high backlog maintenance until such time as the new acute hospital is opened. The emphasis must continue to be to keep high and significant backlog to a minimum.

III. Total waste volume produced per occupied floor area – upper quartile

A Waste Minimisation Manager has been appointed and an action plan developed to reduce waste.

IV. Total cost of cleaning per occupied floor area – lower quartile

Significant investment has been agreed for 2008/09 to improve cleaning standards. This has already made an impact on improving Cleaning/Environmental Standards; the benchmark position for 2008/09 is likely to move towards the mid quartile.

V. Gross cost of catering per occupied floor area – lower quartile

A detailed review of both patient and retail catering is being undertaken during 08/09 to establish high quality value for money services.

VI. Gross cost of patient food services per occupied floor area – lower quartile

A detailed review of patient catering is being undertaken during 08/09 to establish high quality value for money services.

10.0 PATIENT PERCEPTION & PEAT

10.1 Where are we now?

The Trust has improved significantly over the period 2007/08 in relation to the Patient Environment Action Teams (PEAT), and Better Hospital Food initiatives to Self Assessment Green/Good status.

The main PEAT inspections for the Trust were undertaken during March 2008. The Trust is classified as having four sites, Sandwell Hospital, Rowley Regis Hospital, City Hospital and the Birmingham and Midland Eye Hospital.

The outcome from all categories of the PEAT inspections were Good and there were noted improvements in grounds and gardens, cleanliness of both the general public and patient areas, cleanliness in wards and departments and the overall environment.
See Appendix 10 for Summary of 2007/08 PEAT inspections
See Appendix 11 for summary of 2007/08 National Standards of Cleanliness Quarterly Audits

All of the PEAT inspection teams were accompanied by members of the Public & Patient Involvement group (PPI), as well as meeting the requirements of the PEAT process it also provides an opportunity for members of the local community to be involved and this generates confidence in the process.

The self assessment scores were sent to the National Patient Safety Agency (NPSA) where they have been weighted against the Trust scores from the National Standards of Cleanliness audits. There are three classifications and the results for all four sites are as shown in Table 7 below:

Table 7 – 2008 Externally Verified PEAT Ratings

Site Name	Environment	Food	Privacy and Dignity
Birmingham and Midland Eye	Good	Excellent	Good
City Hospital	Good	Excellent	Good
Rowley Regis Hospital	Good	Excellent	Good
Sandwell Hospital	Good	Excellent	Good

See Appendix 12 for National Patient Safety Agency Confirmation of PEAT results for 2008.

10.2 Where do we want to be?

The poor built environment of the Trust, high levels of backlog associated with physical condition and poor functional suitability makes maintaining Good/Excellent status very challenging, however, this remains an objective for the Trust.

10.3 How do we get there?

Following the 2008 assessment the high priority issues for maintaining this status were summarised thus:

- Enhance the cleaning programme by introducing discharge cleaning teams, rapid response teams and equipment cleaning teams.
- Maintain the weekly Executive Management PEAT audits.
- Complete the programme for replacement floors in the Birmingham and Midland Eye and Rowley.
- Refurbish the main entrance of City Hospital in conjunction with the redevelopment of Arches Café and Urgent Care Centre.
- Maintain the major ward refurbishment programme.

The long term strategic objective is to achieve Excellent ratings across all factors, environment, food and privacy and dignity. This can only be achieved with the development of the new acute hospital.

11.0 SUMMARY DISPOSAL AND PROCEEDS OF SALE

The Trust currently provides it services from an estate that covers over 80 acres and 160,000m2 of buildings. There are currently a number of building areas that have been vacated and plans are developing to vacate further areas as the Trust improves its performance and implements the interim reconfiguration. The Estates directorate are developing plans to "right size" its estate by closing peripheral buildings and reducing its estate. However, until such time as the Outline Planning Application and Outline Business Case for the new acute hospital have been approved and there is much more certainty about the future of the remaining estate, site rationalisation will be put on hold. Options 2 and 3 of the New Acute Hospital Business Case consider the new hospital being constructed on either City or Sandwell hospital sites.

An Estates Terrier summary of the three existing sites is shown in Table 8:

Table 8 - Estate Terrier Information

General Information	City Hospital[1]	Sandwell Hospital[2]	Rowley Regis Hospital[3]
Gross internal site floor area	103,326m^2	65,806m^2	8,735m^2
Occupied floor area	94,394m^2	62,156m^2	8,735m^2
NHS Estate occupied floor area	100%	100%	100%
Site heated volume	248,092m^3	192,062m^3	22,760m^3
Site building footprint	63,888m^2	27,790m^2	4,868m^2
Site land area	19.47 hectares	9.97 hectares	2.76
Leased in land area[2] All Saints Way Car Park Hallam Street Car Park (2.66h) Unit 3, Church Lane, West Bromwich, (no details of land or buildings)	Nil	2.97 hectares	Nil
Patient occupied floor area	54,356m^2	32,487m^2	5,158m^2
Non-patient occupied floor area	32,738m^2	21,657m^2	2,745m^2
Un-occupied floor area	8,932m^2	3,650m^2	Nil
Main circulation area	7,300m^2	8,012m^2	832m^2
Leased in floor area	Nil	Nil	Nil
Leased out floor area[1]	884m^2		
Artificial Eye BHBN Hairdressing Salon			
Leased out floor area[2]		60m^2	
WRVS MRI 24 and 25 Hallam Close GP Deputising?			
Leased out floor area[3]			Nil
Temporary buildings and portacabins	540m^2	176m^2	Nil

In line with the 2010 programme the most significant land and property change in the medium term will be that of the transfer of Rowley Regis Hospital to Sandwell PCT. The planned date for this transfer is 2013/14.

Details of the proposals for the future of Sandwell and City Hospital sites post 2010 programme implementation can be seen in Section 13, Strategic Options for Estate Change.

12.0 DEVELOPMENT CONTROL PLANS

There are essentially three timescales being planned for by the Trust:-

- Short term planning 1 to 2 years

  Dealing with immediate issues of service delivery – Sections 12.1 and 12.2

- Interim planning 2 to 5 years - Getting Ready for 2010

  Interim configuration of services – Section 12.3

- Long term-strategic direction –

  Towards 2010 – Section 13

Management of the Development Control Plan DCP is the responsibility of the Director of Estates working with the Hospital Directors. The plans are managed through the Strategic Investment Review Group (SIRG) which is a sub committee of the Strategic Development Board. This ensures the DCP suitably supports the clinical services and takes into account the key estate and facilities issues outlined in this strategy.

The interim planning is led by the Director of Strategy, plans have been developed with a wider multidisciplinary team (ref: Getting Ready for 2010 – Interim Configuration Project). The Estates planning to achieve these service changes was led by the Director of Estates this has ensured that the interim planning correctly supports the planned changes to clinical services whilst taking into account the estates and facilities issues outlined above.

The development control plans shown in Appendices 13 & 14 cover the Short term planning. The key planning principle being pursued in the DCPs is to ensure new capital developments have appropriate service adjacencies and suitable access. This is facilitated through the use of vacant space or extension of existing environment.

12.1 DCP for City Hospital 2008/09

The Development Control Plan (appendix 13) shows the SIRG approved schemes being developed. These principally fall into five categories:-

- Capital developments occupying vacated space
  - Neurophysiology
- Upgrading existing accommodation / estate
  - Imaging
- 2010 Programme Enablers
  - Urgent Care Centre
- Statutory Improvements
  - Fire
  - DDA
- Getting Ready For 2010 – Interim configuration
  - Neonatal Unit
  - Surgical Reconfiguration
  - Pathology reconfiguration

12.2 DCP for Sandwell Hospital 2008/09

The Development Control Plan shows the SIRG approved schemes being developed. These principally fall into four categories:-

- Capital developments occupying vacated space
  - Orthotics
  - Ophthalmology

- Upgrading existing accommodation/ estate
  - Flooring improvements
  - Additional Single/Isolation rooms

- Statutory Improvements
  - Fire
  - DDA

- Getting Ready For 2010 – Interim configuration
  - Paediatric Services
  - Neonatal Unit

12.3 Interim Planning

Interim planning 2 to 5 years will be centred primarily around the transition towards the 2010 Model of Care with the devolution of Services to the community PCT's, Sandwell and Heart of Birmingham, and the downsizing of the acute Trust. Various projects are currently being developed which will require Estates changes to enable this to be delivered. There will also be the development of a Hearing Services Centre on the City Hospital site to replace and improve upon the existing facility. Currently planned for 2011/12, Capital value £5 million.

Further development of the interim planning proposals needs to be undertaken and discussion with PCT's is currently in progress.

13.0 STRATEGIC OPTIONS FOR ESTATE CHANGE

13.1 Where are we now?

Sandwell and the west of Birmingham have some of the highest levels of deprivation in the country. This is a major factor in determining the poor health of the diverse and disadvantaged communities. Local health and social care services face very challenging health needs that are a major cause for concern. For example:

- Men and women live three to four years less than the national average
- Infant mortality rates are high, in some parts they are twice the national average
- One in five people have a long-term illness that affects their daily life
- There is significant variation in health status within the area, and in general Black and Minority Ethnic groups have poorer health than others.

The need for major investment to develop and improve health and social care services to address these needs was formally recognised by the development of a Strategic Outline Case (SOC) during 2003 and 2004. The SOC set out a clear direction of travel to deliver a vision of improved physical, mental and social well being for the population of Sandwell and the West of Birmingham, and described the need to redesign the whole health and social care system by creating a major step change in service provision.

The SOC indicated a required re-balancing of capacity to reflect a substantial transfer of care into a primary care setting alongside a demanding performance improvement in acute hospital services. Substantial reductions in hospital lengths of stay are anticipated, with much of the consequent reduction in acute hospital capacity being re-provided in new services and facilities closer to people's homes. Investment in community health and social care services, as well as investment in acute hospital facilities, is seen as key to making the vision a success. This investment will also enable new models of care to be put in place in advance of any changes to acute hospital facilities.

The SOC was approved by the Department of Health in July 2004.

The development of an Outline Business Case for all of the investment needed across the local health and social care system commenced under the auspices of the Towards 2010 Programme Agency Board.

The Towards 2010 Programme is governed by the Partnership Board, which was formally established in March 2005, and comprises the following partner organisations:

- Heart of Birmingham Teaching Primary Care Trust (HOBtPCT);
- Sandwell PCT (SPCT);
- Sandwell and West Birmingham Hospitals NHS Trust (SWBH);
- Birmingham City Council (BCC);
- Sandwell Metropolitan Borough Council (SMBC)

The Towards 2010 programme Strategic Outline Case for Sandwell and West Birmingham remains the long term strategic plan for the Trust. The plan is for the Trust to provide acute services principally from a single site. The preferred option for this site is Grove Lane, Smethwick, which is located between City Hospital and Sandwell Hospital sites.

Appraisal of Options

Four options were short-listed for consideration as part of options for the future of acute services within the health communities:

- Option 1 – Do Minimum; Refurbish City and Sandwell Hospital sites
- Option 2 – New Build / Refurbish on City Hospital Site;
- Option 3 – New Build / Refurbish on Sandwell General Hospital Site; and
- Option 4 – New Build on Grove Lane.

Summary of the Financial appraisal of the four options is shown in Table 9 below.

Full details of the Option Appraisals are contained in the OBC.

The planning of the new acute hospital is making good progress. The design brief, Trust requirements and Public Sector Comparator are nearing completion. The Outline Planning Application was completed on programme and submitted to Sandwell MBC in April 2008. The Trust is working with Sandwell MBC officers and statutory consultees to enable the determination of the planning application, to be achieved by October 2008.

Table 9 – Combined Option Appraisal for New Acute Hospital

	Option 1	Option 2	Option 3	Option 4
Non-Financial Benefit Score	460	700	665	760
EAC of Options before Risk	245,306	242,131	247,211	241,168
EAC of Options including Risk	245,596	242,694	248,408	241,477
Benefit Score per £m EAC before Risk	**1.88**	**2.89**	**2.69**	**3.15**
Rank	**4**	**2**	**3**	**1**
Benefit Score per £m EAC including Risk	**1.87**	**2.88**	**2.68**	**3.15**
Rank	**4**	**2**	**3**	**1**

Equipment

A detailed equipment inventory has been developed to determine the full extent of equipment requirements to support the new hospital development.

The inventory identifies total equipment requirements for both medical and non-medical equipment and also considers investment required to ensure equipment is suitable for use in the new hospital. The costs associated with equipment purchase have been included in the Trust's 10 year Capital Planning Forecast, a summary of which is shown in Appendix 15. An Equipment Procurement Strategy has been developed and approved by the 2010 Project Board.

13.2 Where do we want to be?

Within the timescale of this strategy the Trust's objective relating to its estate is the provision of a new hospital on the Grove Lane site. The current planned date for the new facility to be operational is July 2015. Following successful commissioning of the new hospital the majority of both City and Sandwell Hospital sites will become available for sale and subsequent redevelopment, the extent of the lands sales is subject to agreement with PCT's on their requirements for community facilities in these locations. Planned date for land sales is 2016/17.

Indicative plans for surplus land sales of both City Hospital and Sandwell Hospital sites are shown in Appendices 16 and 17 respectively.

Estimated Land Sales for each site are as follows:

- City – 15.35 hectares (37.92 acres)
- Sandwell – 4.07 hectares (10.05 acres)

13.3 How do we get there?

Table 10 - Key Programme Dates for New Acute Hospital Development

PROJECT PHASE	DESCRIPTION	COMPLETION DATE
Phase One:	The Solution Phase	March 2009
Phase Two:	The Procurement Phase	May 2012
Phase Three:	The Construction and Commissioning Phase	July 2015
Phase Four:	The Evaluation Phase	July 2018

The Outline Business Case (OBC) for the new Acute Hospital is due for completion and submission to Strategic Health Authority and Department of Health in December 2008. In addition to the main OBC a Business Case to seek approval for land acquisition for the Grove Lane Site has been produced and submitted in advance of the main OBC in order to complete the overall project in the minimum timescale. Approval of a Land Business Case in advance of the main OBC enables the Trust to commence site acquisition sooner than waiting for approval of the main OBC.

The main OBC covers all aspects of the project development including the evaluation of all options in both financial and non-financial terms. The OBC and all supporting supplementary information such as the Estates Annexe will be available on the Trusts intranet site.

Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

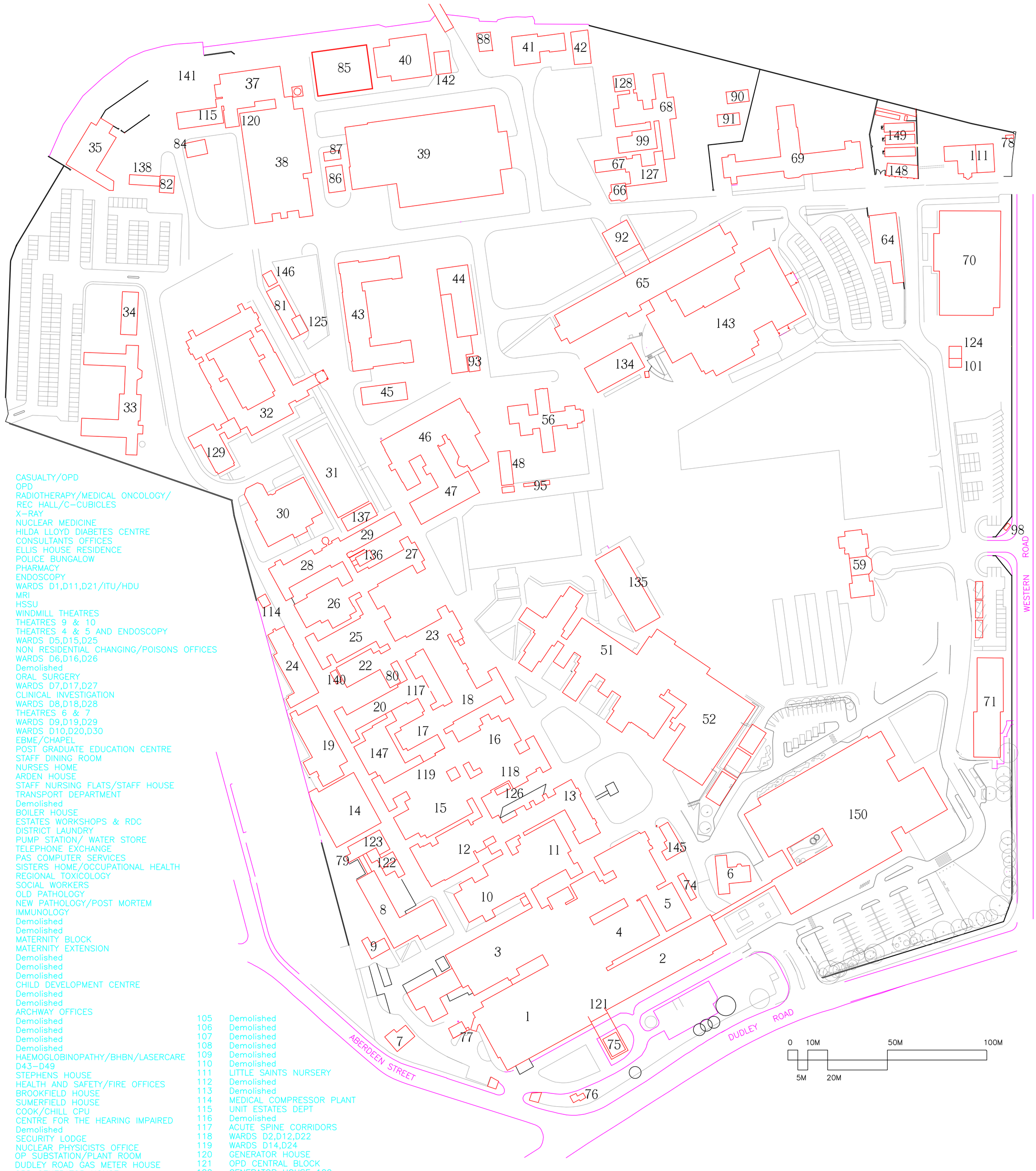
ESTATES STRATEGY 2008/2017

Appendix 1

Existing Site Plans and Building Age Profile Plans

Appendix 1a	City Site Plan
Appendix 1b	Sandwell Site Plan
Appendix 1c	Rowley Site Plan
Appendix 1d	City Block Age Profile
Appendix 1e	Sandwell Block Age Profile

Appendix 1a



001 CASUALTY/OPD
002 OPD
003 RADIOTHERAPY/MEDICAL ONCOLOGY/ REC HALL/C-CUBICLES
004 X-RAY
005 NUCLEAR MEDICINE
006 HILDA LLOYD DIABETES CENTRE
007 CONSULTANTS OFFICES
008 ELLIS HOUSE RESIDENCE
009 POLICE BUNGALOW
010 PHARMACY
011 ENDOSCOPY
012 WARDS D1,D11,D21/ITU/HDU
013 MRI
014 HSSU
015 WINDMILL THEATRES
016 THEATRES 9 & 10
017 THEATRES 4 & 5 AND ENDOSCOPY
018 WARDS D5,D15,D25
019 NON RESIDENTIAL CHANGING/POISONS OFFICES
020 WARDS D6,D16,D26
021 Demolished
022 ORAL SURGERY
023 WARDS D7,D17,D27
024 CLINICAL INVESTIGATION
025 WARDS D8,D18,D28
026 THEATRES 6 & 7
027 WARDS D9,D19,D29
028 WARDS D10,D20,D30
029 EBME/CHAPEL
030 POST GRADUATE EDUCATION CENTRE
031 STAFF DINING ROOM
032 NURSES HOME
033 ARDEN HOUSE
034 STAFF NURSING FLATS/STAFF HOUSE
035 TRANSPORT DEPARTMENT
036 Demolished
037 BOILER HOUSE
038 ESTATES WORKSHOPS & RDC
039 DISTRICT LAUNDRY
040 PUMP STATION/ WATER STORE
041 TELEPHONE EXCHANGE
042 PAS COMPUTER SERVICES
043 SISTERS HOME/OCCUPATIONAL HEALTH
044 REGIONAL TOXICOLOGY
045 SOCIAL WORKERS
046 OLD PATHOLOGY
047 NEW PATHOLOGY/POST MORTEM
048 IMMUNOLOGY
049 Demolished
050 Demolished
051 MATERNITY BLOCK
052 MATERNITY EXTENSION
053 Demolished
054 Demolished
055 Demolished
056 CHILD DEVELOPMENT CENTRE
057 Demolished
058 Demolished
059 ARCHWAY OFFICES
060 Demolished
061 Demolished
062 Demolished
063 Demolished
064 HAEMOGLOBINOPATHY/BHBN/LASERCARE
065 D43-D49
066 STEPHENS HOUSE
067 HEALTH AND SAFETY/FIRE OFFICES
068 BROOKFIELD HOUSE
069 SUMERFIELD HOUSE
070 COOK/CHILL CPU
071 CENTRE FOR THE HEARING IMPAIRED
072 Demolished
073 SECURITY LODGE
074 NUCLEAR PHYSICISTS OFFICE
075 OP SUBSTATION/PLANT ROOM
076 DUDLEY ROAD GAS METER HOUSE
077 OPD GENERATOR HOUSE
078 GAS METER HOUSE
079 SQUASH COURT
080 HAIRDRESSING SALON
081 CALORIFIER HOUSE
082 WMAS PTS OFFICE
083 Demolished
084 OIL TANKS (DIESEL)
085 OIL STORAGE (FUEL OIL)
086 LAUNDRY SOFT WATER TANKS
087 LAUNDRY COMPRESSOR
088 GENERATOR
089 Demolished
090 AIR RAID SHELTER
091 AIR RAID SHELTER
092 PLANT ROOM
093 BOTTLE STORE TOXICOLOGY
094 Demolished
095 PATHOLOGY SPIRIT STORES
096 Demoliished
097 Demolished
098 GAS AND WATER METERING
099 FACILITIES CAPITAL PROJECT OFFICE
100 Demolished
101 GENERATOR ROOM 3
102/A Demolished
103 Demolished
104 Demolished
105 Demolished
106 Demolished
107 Demolished
108 Demolished
109 Demolished
110 Demolished
111 LITTLE SAINTS NURSERY
112 Demolished
113 Demolished
114 MEDICAL COMPRESSOR PLANT
115 UNIT ESTATES DEPT
116 Demolished
117 ACUTE SPINE CORRIDORS
118 WARDS D2,D12,D22
119 WARDS D14,D24
120 GENERATOR HOUSE
121 OPD CENTRAL BLOCK
122 GENERATOR HOUSE 122
123 ELECTRIC SUB STATION 123
124 WESTERN ROAD SUB STATION
125 N/H SUBSTATION
126 CARDIOLOGY SECRETARIES
127 FACILITIES DIRECTORATE
128 BROOKFIELD HOUSE EXTENSION
129 DOCTORS ANNEXE
130 Demolished
131 Demolished
132 Demolished
133 MEDICAL GAS BOTTLE STORE
134 GERIATRIC OFFICE BLOCK
135 NON RESIDENTIAL CHANGING BLOCK
136 CATERING STORAGE
137 MEDICAL ENGINEERING WORKSHOPS
138 TRANSPORT PORTACABIN
139 OFFICES/STORES FOR HEARING IMPAIRED
140 ORAL SURGERY PORTACABIN
141 BRITISH GAS COMPOUND
142 VIE COMPOUND
143 BIRMINGHAM AND MIDLAND EYE CENTRE
144 SECURITY DEPARTMENT STORAGE
145 BREAST SERVICES UNIT
146 GENERATOR No 7 HOUSE
147 NEW TWIN THEATRES
148 GARDENERS
149 GREENHOUSES
150 BIRMINGHAM TREATMENT CENTRE

CITY HOSPITAL
SITE PLAN

Sandwell and West Birmingham Hospitals NHS Trust NHS

A0

Appendix 1b

Sandwell and West Birmingham Hospitals NHS Trust

DESCRIPTION: MASTER DRAWING

LOCATION: SANDWELL GENERAL HOSPITAL LYNDON, WEST BROMWICH

PROJECT: SITE PLAN

DRAWN	I Clark		
CHECKED			
SCALE	1:500	DATE	SEPT/07
DRG. No.	.	REVISION	-

Appendix 1c

MOOR LANE

03

04

02

01

FIRE PATH

MOOR LANE

NORTH

Mark	Date	Details	By	Chkd

REVISIONS

Employer:

Sandwell & West Birmingham Hospitals NHS Trust

NHS

ROWLEY REGIS HOSPITAL.

Project Title:

Key Plan:

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TI

Scales: for the Original Drawing Size of:

Drn By:	Chkd By:	Passed By:	Date:
RS	RK	RS/RK	

Drawing Status:

Drawing Originator:

Capital Projects Departmen

Drawing Title:

ROWLEY REGIS HOSPITAL.
SITE PLAN

Job No:	Drawing No:	Revision:

Appendix 1d

Note: This site plan is currently shown at one level and therefore does not show floor levels.

001 ACCIDENT & EMERGENCY / OPD
002 OPD
003 MEDICAL ASSESSMENT UNIT / MEDICAL RECORDS (REC HALL)
WARD D41 / 2nd FLOOR OFFICES
004 X-RAY / WARD D42 / 2nd FLOOR OFFICES
005 NUCLEAR MEDICINE
006 HILDA LLOYD DIABETES CENTRE
007 SECURITY BUNGALOW
008 ELLIS HOUSE RESIDENCE
009 ELLIS HOUSE ANNEX
010 PHARMACY
011 ENDOSCOPY
012 WARDS D1,D11,D21/ITU/HDU
013 MRI SCANNER & CT SCANNER'S 1 & 2
014 HSSU
015 WINDMILL THEATRES
016 THEATRES 9 & 10
017 THEATRE 4 / HOSPITAL LOUNGE / INFECTION CONTROL OFFICES
018 WARDS D5,D15,D25
019 NON RESIDENTIAL CHANGING/POISONS OFFICES
020 WARDS D6,D16,D26
021 Demolished
022 ORAL SURGERY
023 WARDS D7,D17,D27
024 CLINICAL INVESTIGATION
025 WARDS D8,D18,D28
026 SERVAL SUPPLIES SERVICES / CLEAN LINEN SERVICES
027 WARDS D9,D19,D29
028 WARDS D10,D20,D30
029 EBME/CHAPEL
030 POST GRADUATE EDUCATION CENTRE
031 STAFF DINING ROOM
032 NURSES HOME
033 ARDEN HOUSE
034 STAFF NURSING FLATS/STAFF HOUSE
035 TRANSPORT DEPARTMENT
036 Demolished
037 BOILER HOUSE
038 ESTATES WORKSHOPS & RDC
039 DISTRICT LAUNDRY
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144 SECURITY DEPARTMENT STORAGE
145 BREAST SERVICES UNIT
146 GENERATOR No 7 HOUSE
147 NEW TWIN THEATRES
148 GARDENERS
149 GREENHOUSES
150 BIRMINGHAM TREATMENT CENTRE

0 50 100m

N

KEY

- 2005 – Present
- 1995 – 2004
- 1985 – 1994
- 1975 – 1984
- 1965 – 1974
- 1955 – 1964
- 1948 – 1954
- PRE 1948

Mark	Date	Details	By	Chkd

REVISIONS

Employer:

Sandwell & West Birmingham Hospitals NHS Trust

Project Title:

City Hospital, Dudley Road Birmingham, B18 7QH

Scales: NTS for the Original Drawing Size of: A2

Drn By: RS | Chkd By: RK | Passed By: RS/RK | Date: 12/06/2008

Drawing Status:

Drawing Originator:

Capital Projects Department

Drawing Title:

CITY HOSPITAL
Site Plan Block Age Profile

Job No:	Drawing No:	Revision:
City Hospital	CITY/2008/SPBAP	12/06/2008

Appendix 1e

AQ

KEY

- 2005 – Present
- 1995 – 2004
- 1985 – 1994
- 1975 – 1984
- 1965 – 1974
- 1955 – 1964
- 1948 – 1954
- PRE 1948

Sandwell and West Birmingham Hospitals NHS Trust

DESCRIPTION: MASTER DRAWING

LOCATION: SANDWELL GENERAL HOSPITAL LYNDON, WEST BROMWICH

PROJECT: SANDWELL - SITE PLAN BLOCK AGE PROFILE 2008

DRAWN	I Clark		
CHECKED			
SCALE	1:500	DATE	JUNE 2008
DRG. No.	SGH/SPAP	REVISION	.

Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 2

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Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 3

2008/09 Capital Programme

Appendix 3

Sandwell & West Birmingham Hospitals NHS Trust

CAPITAL PROGRAMME 2008/2009

	Capital Programme 2007/08 £000
Capital Resources	
Internally Generated Cash (depreciation)	15,743
Contingent Resources	
Transfer of PCT's PDC allocation	1,100
Transfer of National energy via PDC s/b £600	
Total Resources	**16,843**
Capital Expenditure	
Retentions from Prior Year Programmes	400
Capitalisation of Salaries	300
Capitalisation of BTC Unitary Charge	500
Medical Equipment	800
IT Programmes	675
High Cost Diagnostics (including enabling)	500
Statutory Standards/Fire/DDA Compliance	2,150
Reconfiguration - City Neonatal	2,882
- Pathology	2,388
- Surgery	500
High Cost Diagnostics #2	100
D22	0
Estates - Plant and Building Replacement and Upgrade	1,200
IR brought forward commitments	375
Digital Hearing Aids - capitalisation requirement	0
Breast Screening investment	266
18 Week related capital £400k bid, rationalise to £250k	250
CIP related schemes (to include catering)	200
BTC Endoscopy	200
Balance of CRL undershoot representing commitments	400
Hearing Services Centre	30
Assumed slippage in 08/09	-850
Contingency	791
Security	250
Hygiene	300
Enhancement of Retail Catering	256
Rowley Cook Chill	80
Contingent Expenditure	
UCC (makes prudent provision for unfunded balance)	1,300
Energy Schemes	600
Total Expenditure	**16,843**

Under/(Over) Commitment Against CRL	**0**

Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 4

Intentionally Blank

Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 5

NEAT Assessments

Appendix 5a	Rowley
Appendix 5b	City and Sandwell

Appendix 5a

Sandwell and West Birmingham
Health and Social Care System
Towards 2010 Programme

Rowley Regis Hospital: 6th Facet and NHS Environmental Assessment

Reference: CS/003807-01-02
Date: 01st February 2006

CAPITA SYMONDS

CAPITA SYMONDS

DOCUMENT VERIFICATION/REVISION SHEET

Revision: 1		
Date: 30th January 2006		
Prepared by I. Spanos	Checked by S. Hunter	Approved By S.Hunter
Revision:		
Date		
Prepared by	Checked by	Approved By
Revision		
Date		
Prepared by	Checked by	Approved By
Revision:		

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Part of The Capita Group Plc, 71 Victoria Street, Westminster, London SW1H 0XA • www.capita.co.uk

Contents

1. ASSESSMENT METHOD

The environmental performance of the existing estate has been assessed using the NEAT (NHS Environmental Assessment Tool) which allows designers to review and improve the environmental performance of a building in the National Health Service Estate. The NEAT programme was launched in April 2002 in line with the OGC 'Sustainable Construction Action Plan' requirements as endorsed by the Government Construction Client Panel. NEAT brings with it a requirement for the NHS, and those who work with and for the NHS, to build in a sustainable manner.

NEAT is based on the construction and environmental research carried out at BRE together with the input and experience of the NHS Estates Departments, Government and building regulators.

The NEAT Assessment has been undertaken using the spreadsheet tool developed by BRE and supplied by NHS Estates. The tool has been specifically designed for the purposes of assessing the environmental sustainability of the NHS Estate. The intention is to provide NHS buildings with an environmental label, which can then be used to provide comparison with one another. This tool can be used to evaluate current operational estate or for new build/refurbishment capital programmes. In this instance the tool for existing estate has been used. This places more emphasis on operations policy and procedure than that of new build as there is little opportunity to influence issues associated with building design, plant and equipment.

In conducting a NEAT assessment a wide range of potential impacts are assessed against pre-set criteria. For each criterion there are identifiable standards of performance that must be met in order to score "credits".

A weighting system is then applied to calculate a percentage score. The criteria and weightings are as follows:

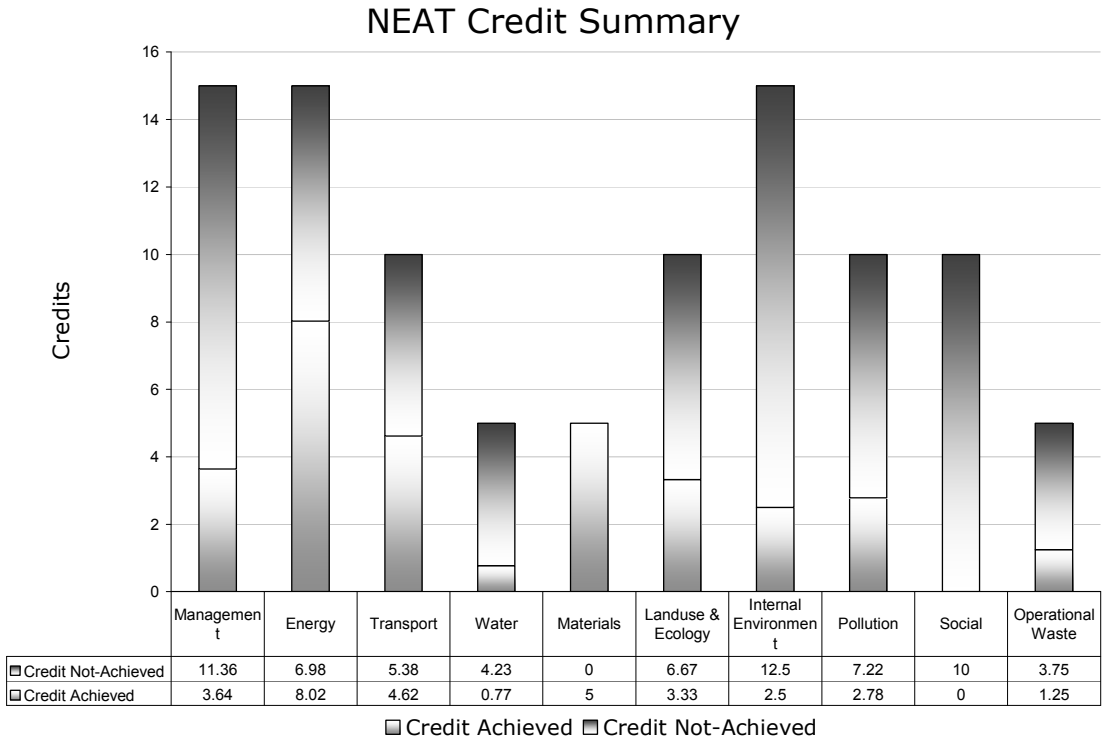
Management	15%
Energy	15%
Transport	10%
Water	5%
Materials	5%
Landuse/ecology	10%
Internal Environment	15%
Pollution	10%
Social	10%
Operational Waste	5%

This final percentage scored is then interpreted as a rating as follows:

Excellent	≥70%
Very Good	≥55%
Good	≥40%
Pass	≥25%
Fail	<25%

1.1 Assessment

Having entered the data for the building into the NEAT software tool the assessment results are summarised as follows:



	Management	Energy	Transport	Water	Materials	Landuse & Ecology	Internal Environment	Pollution	Social	Operational Waste
Credit Not-Achieved	11.36	6.98	5.38	4.23	0	6.67	12.5	7.22	10	3.75
Credit Achieved	3.64	8.02	4.62	0.77	5	3.33	2.5	2.78	0	1.25

Overall the existing estate has obtained a “Pass” rating with a score of 31.91%. It is evident that there is the opportunity for improvement in a number of areas with the greatest opportunity concerning “Management”, “Energy (Policy)” and “Social”.

A significant number of the questions which require answering in a NEAT assessment for the existing estate are determined by Trust policy and procedure. In addition there are a number of questions for which the answer relates to site-wide facilities – for example staff car parking. It is therefore the case that the actual performance of the estate with respect to quantifiable key performance indicators has a limited effect on the overall performance of the building within the context of the NEAT assessment.

There is however, an opportunity to significantly improve the NEAT rating if commitment is made to use Key Performance Indicators of environmental management at all levels in a Hospital document, Green Tariff was to be used for electricity supply, Social KPIs were improvement and waste management

/minimisation and recycling programme were to be implemented the NEAT score could be improved to 40.01% with a rating of “Good”.

This would require little or no change to the physical Estate and therefore a “Good“rating may be achievable regardless of the content of a future DCP. Furthermore improving the rating in this manner may prove substantially more cost effective than measures requiring significant capital investment.

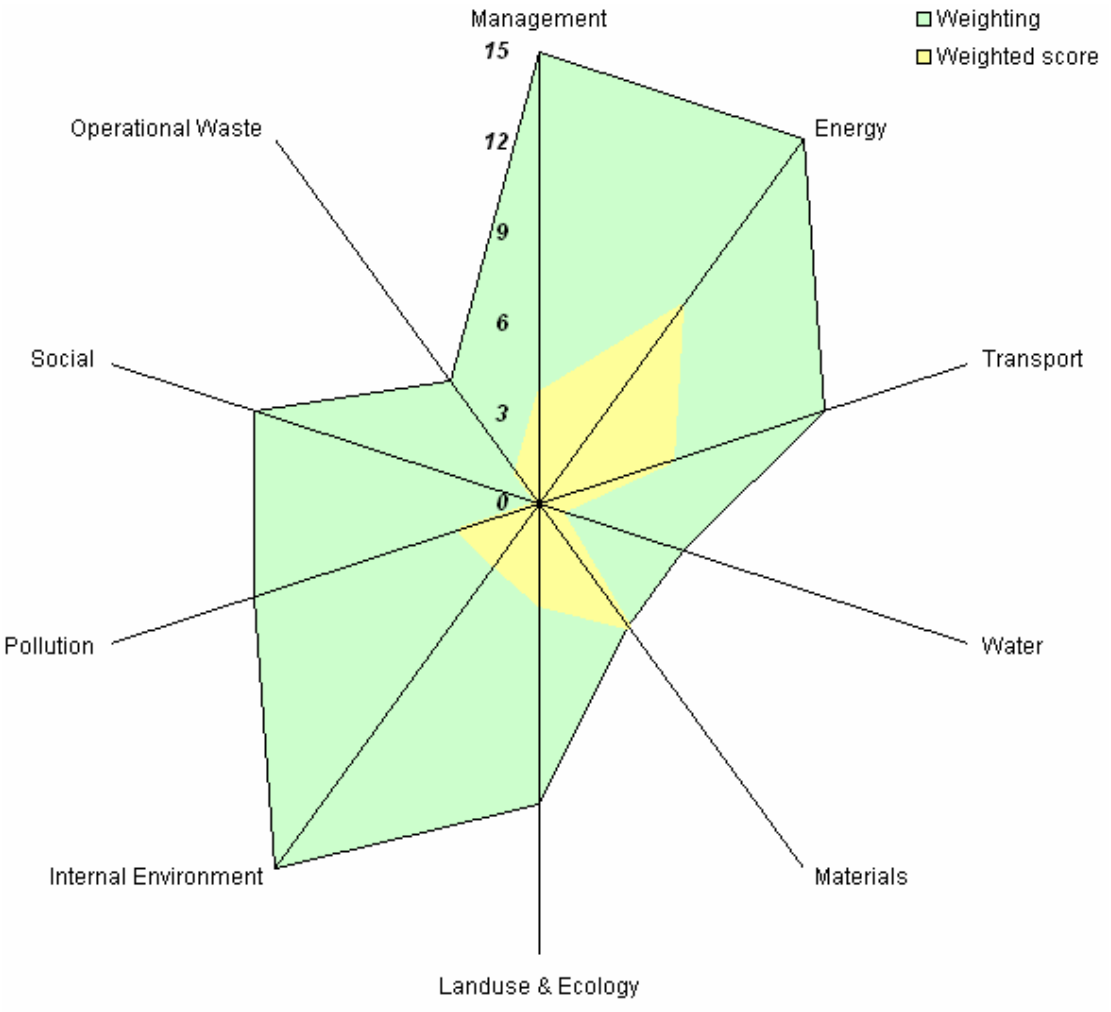


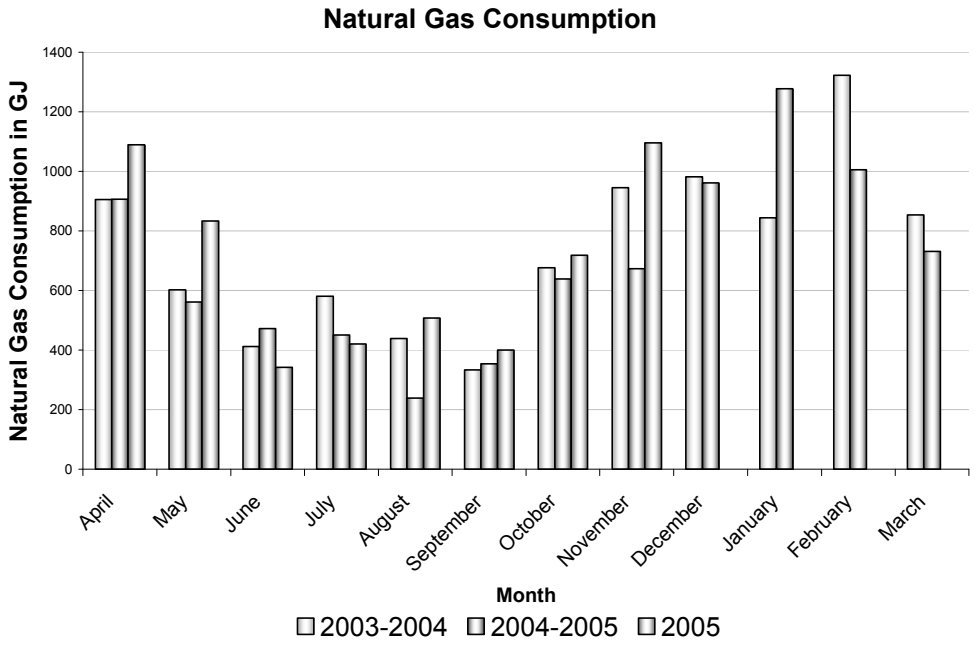
Figure 1 - Summary of the NEAT assessment for Rowley Hospital; existing NHS site

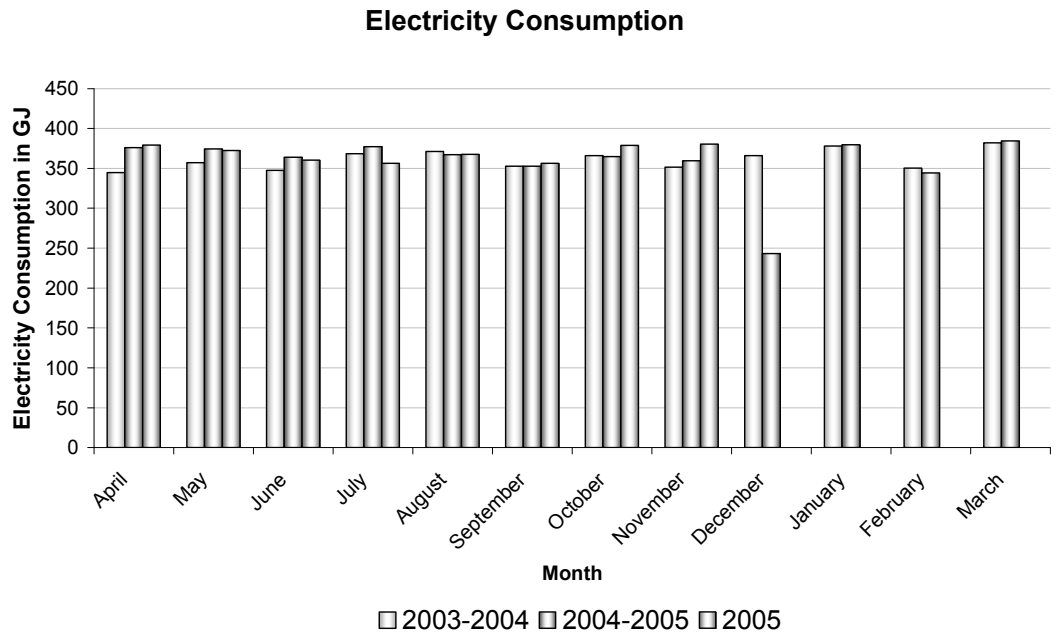
2. ENERGY CONSUMPTION

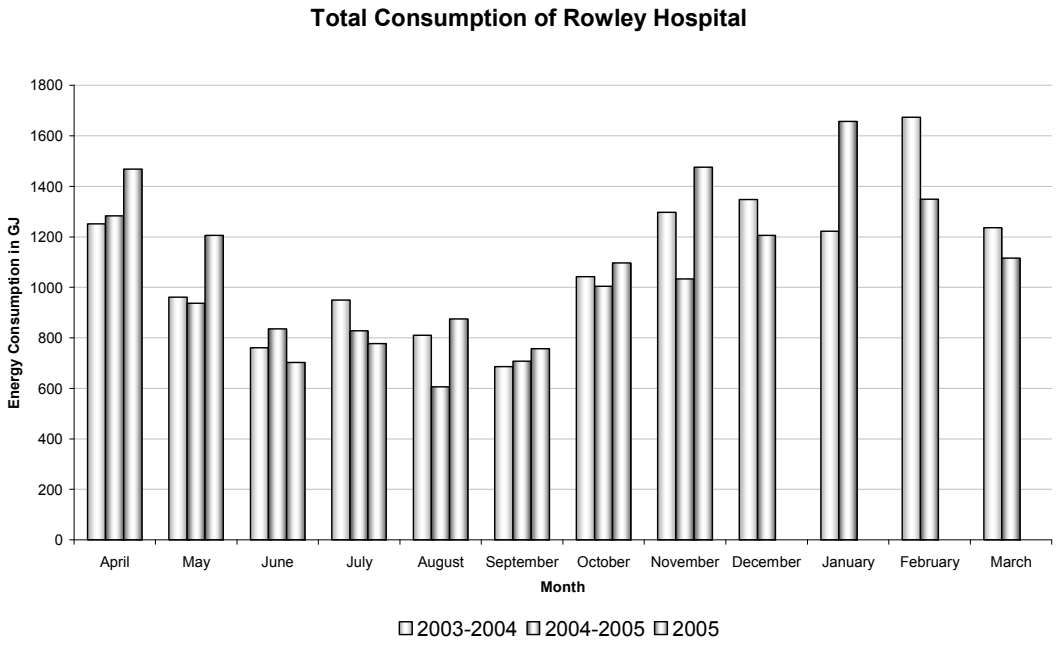
A general overview of the energy performance of the estate can be gained from an analysis of the relevant performance indicator. The appraisal in this category differs from others in that it is taken from actual energy consumption in Giga Joules and converted into a ration with the volume of the associated properties: that is, energy usage per unit volume – GJ/100 cubic metres. For strategic planning purposes the site can be ranked based on the following energy usage per unit volume figures (without needing to carry out further surveys):

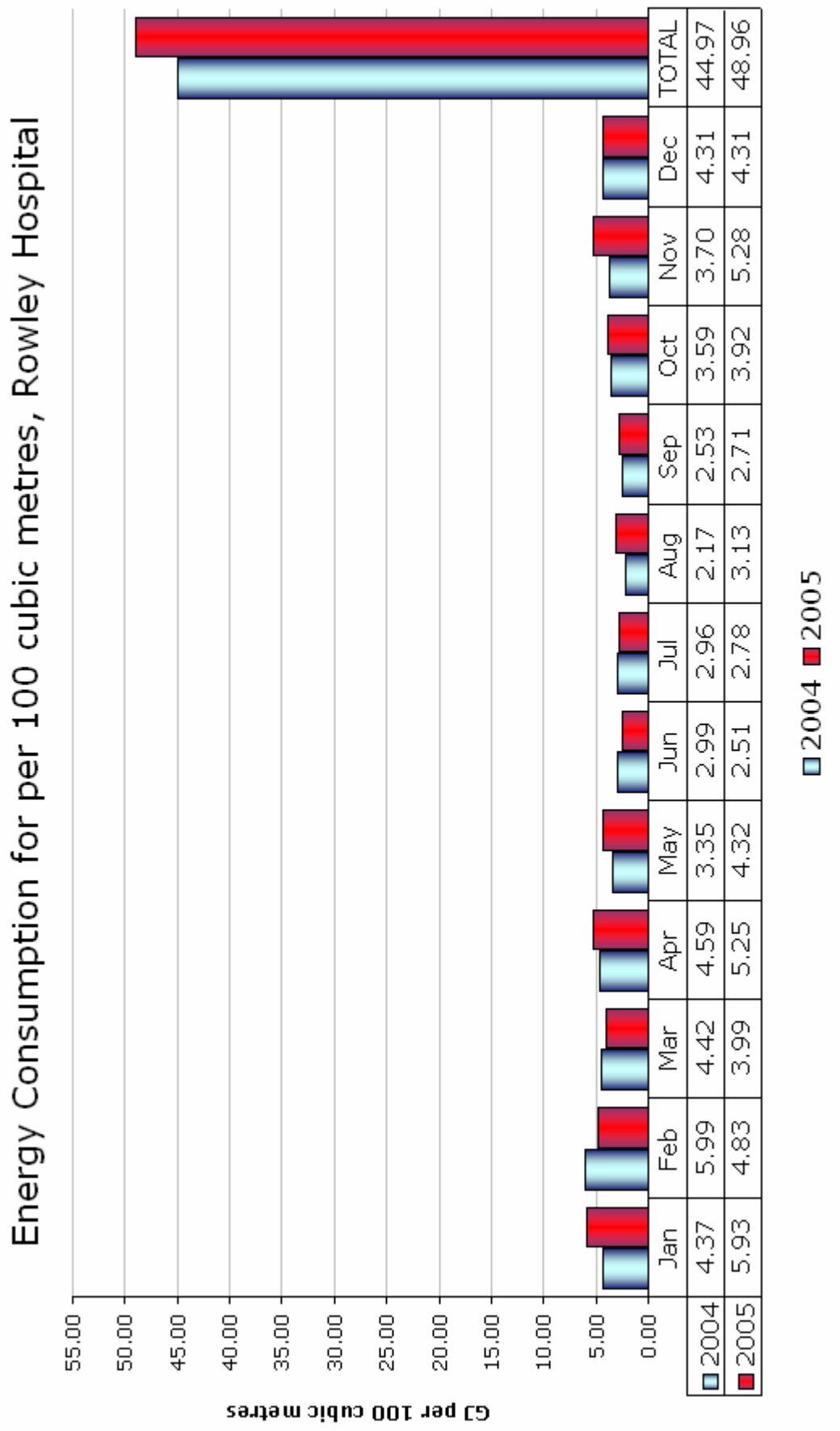
	GJ per 100 cubic metres
A	35 - 55
B	56 – 65
C	66 – 75
D	76 – 100
X	>100

Baseline data has been obtained from the Trust with regard to annual and month by month consumption of gas and electricity by the site. This data is presented as follows:




Electricity Consumption
Electricity Consumption in GJ
450
400
350
300
250
200
150
100
50
0
April
May
June
July
August
September
October
November
December
January
February
March
Month
2003-2004
2004-2005
2005


Total Consumption of Rowley Hospital
Energy Consumption in GJ
1800
1600
1400
1200
1000
800
600
400
200
0
April
May
June
July
August
September
October
November
December
January
February
March
Month
2003-2004
2004-2005
2005


Energy Consumption for per 100 cubic metres, Rowley Hospital
GJ per 100 cubic metres
55.00
50.00
45.00
40.00
35.00
30.00
25.00
20.00
15.00
10.00
5.00
0.00
2004
2005
Jan 4.37 5.93
Feb 5.99 4.83
Mar 4.42 3.99
Apr 4.59 5.25
May 3.35 4.32
Jun 2.99 2.51
Jul 2.96 2.78
Aug 2.17 3.13
Sep 2.53 2.71
Oct 3.59 3.92
Nov 3.70 5.28
Dec 4.31 4.31
TOTAL 44.97 48.96

Annual energy consumption used can be summarised as follows (this information has also been used to complete the NEAT Assessment:

For 2004

Energy	kWh per annum	GJ per annum	GJ per 100 cubic metres per annum
Natural Gas	2,299,722	8,279	
Electricity	1,191,666	4,290	
Total	3,491,388	12,569	**44.97**

Note:

Total Floor Area of Buildings =	8735 square metres	Total Volume of Buildings =	27,952 cubic metres

For 2005

Energy	kWh per annum	GJ per annum	GJ per 100 cubic metres per annum
Natural Gas	2,606,389	9,383	
Electricity	1,195,277	4,303	
Total	3,801,666	13,686	**48.96**

Note:

Total Floor Area of Buildings =	8735 square metres	Total Volume of Buildings =	27,952 cubic metres

For both years examined, the Rowley Hospital is **A-rated** hospital with respect to the actual annual energy consumption benchmarks as they are stated in the Estatecode (NHS, Estates) document.

3. CONCLUSIONS

The Trust is committed to the provision of an environment that ensures the health and well being of the community it serves.

With respect of the Energy Performance of the site, the NHS target for the healthcare estate is 35-55GJ/100 cubic metres. The energy consumption of the site is **A-rated** according to NHS estate code. The energy condition profile examined the building structure and fabric together with mechanical and electrical engineering service installations for energy efficiency and the actual energy consumption of the building, i.e. 44.97-48.96 GJ/100 cu m., indicate that the fabric of the building and building services are well maintained.

However, the building according to the NHS Environmental Assessment Tool gained a PASS Environmental rating, considering the overall environmental aspects of the site. Rowley Hospital can achieve GOOD Environmental rating if the Trust was aiming managerial targets of the credits criteria listed in the N.E.A.Tool. The Hospital Trust should provide a well documented framework for setting and achieving objectives on an ongoing basis.

In particular, the Trust should seek to:

- Measure and reduce, where practicable, pollution to air, land and water;
- Have regard for both environmental issues and value for money in all centrally purchased goods and services and promote the use of products and services of suppliers, who have environmentally friendly policy;
- Provide environmental education and training to appropriate staff and ensure all staff are aware of the environmental policy and how they can contribute to the Trust's overall environmental performance;
- Ensure that all relevant staff have access to up to date information on environmental legislation and guidance, i.e. all the energy efficient and environmental policies should be documented and widely distributed in the hospital;
- Continue to promote the efficient use of energy in an economical and environmentally sound manner by energy conservation measures and, where economically viable, investing in energy saving technology and management in both existing and new buildings and equipment;
- Promote waste minimisation and reduce the environmental impact of waste through beneficial use, where practicable, or safe disposal where not enhance the

natural beauty of the hospital site and protect natural habitats by maintaining the grounds in an environmentally sound manner and promoting visual amenity through the design, location and finishes of buildings and structures; and,

- Communicate openly the organisation's environmental performance to staff, patients, government authorities and other interested parties on request.

NEAT NHS Environmental Assessment Tool

NHS Estates An Executive Agency of the Department of Health

dti Department of Trade and Industry

BRE

Version 27/05/03

For existing sites

This is an assessment of *Rowley Regis Hospital*
This is a site within *Sandwell and West Birmingham NHS tru*

NEAT aims: Raise awareness of environmental issues within NHS facilities and services;

Estimate the environmental impact of NHS facilities and services.

Seek to establish an environmental improvement programme.

	%	Rating
	0	Fail
more than	25	Pass
more than	40	Good
more than	55	Very Good
more than	70	Excellent

Total Score 31.91

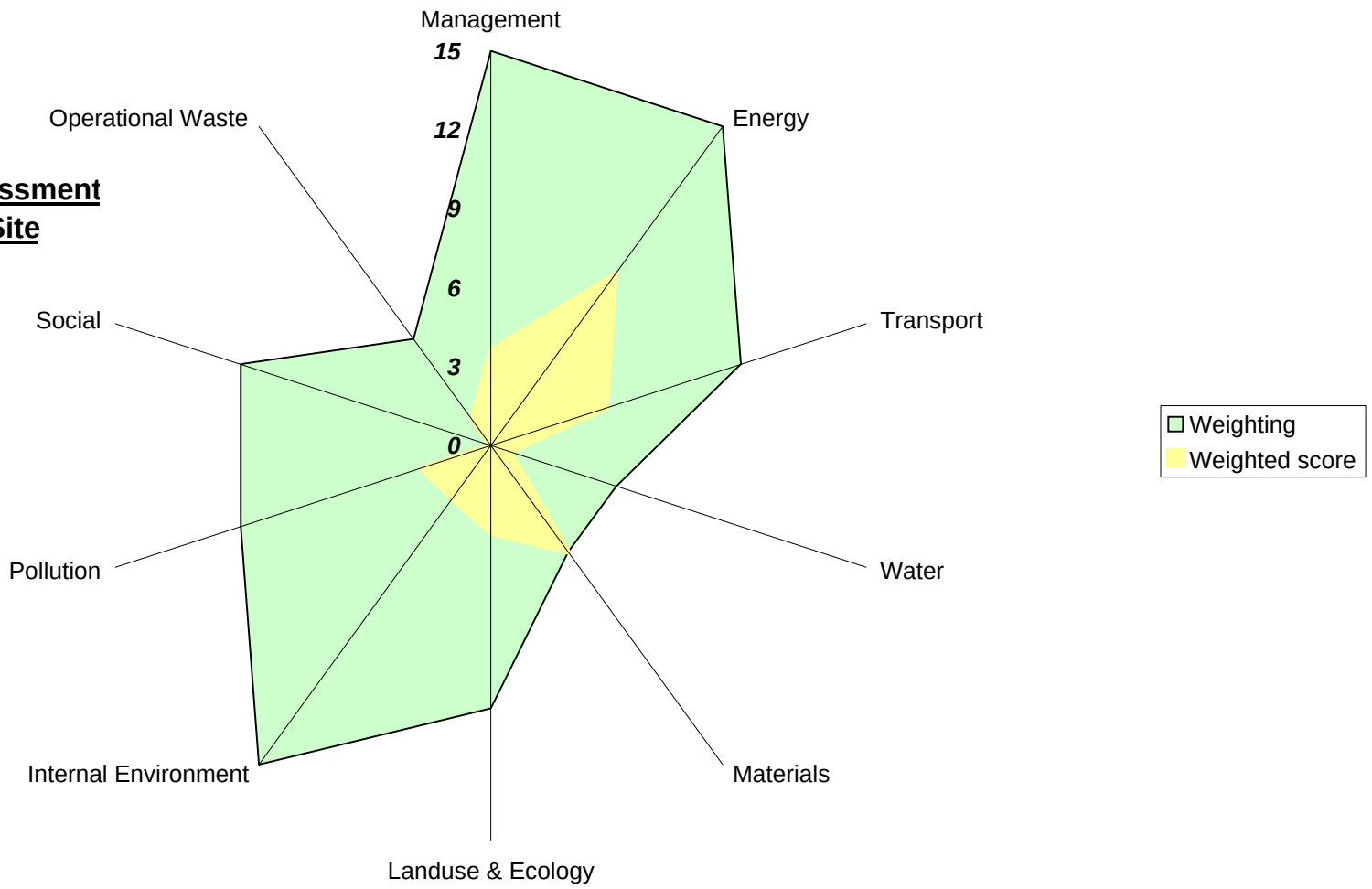
Rating Pass

	Score	Weighting	Weighted score
Management	24%	15	3.64
Energy	53%	15	8.02
Transport	46%	10	4.62
Water	15%	5	0.77
Materials	100%	5	5.00
Landuse/Ecology	33%	10	3.33
Internal Environment	17%	15	2.50
Pollution	28%	10	2.78
Social	0%	10	0.00
Operational Waste	25%	5	1.25
		Total	31.91

You have entered **1** **Unit Name**

The development of this spreadsheet was funded by DTI and NHS Estates

Environmental Assessment of an Existing NHS Site



Appendix 5b

Sandwell and West Birmingham
Health and Social Care System
Towards 2010 Programme

Sandwell General Hospital and City Hospital: 6th Facet and NHS Environmental Assessment

Reference: CS/003807-01-03
Date: 13th February 2006

CAPITA SYMONDS

CAPITA SYMONDS

DOCUMENT VERIFICATION/REVISION SHEET

Revision: 1		
Date: 13th February 2006		
Prepared by I. Spanos	Checked by S. Hunter	Approved By S.Hunter
Revision:		
Date		
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Contents

1. ASSESSMENT METHOD

The environmental performance of the existing estate has been assessed using the NEAT (NHS Environmental Assessment Tool) which allows designers to review and improve the environmental performance of a building in the National Health Service Estate. The NEAT programme was launched in April 2002 in line with the OGC 'Sustainable Construction Action Plan' requirements as endorsed by the Government Construction Client Panel. NEAT brings with it a requirement for the NHS, and those who work with and for the NHS, to build in a sustainable manner.

NEAT is based on the construction and environmental research carried out at BRE together with the input and experience of the NHS Estates Departments, Government and building regulators.

The NEAT Assessment has been undertaken using the spreadsheet tool developed by BRE and supplied by NHS Estates. The tool has been specifically designed for the purposes of assessing the environmental sustainability of the NHS Estate. The intention is to provide NHS buildings with an environmental label, which can then be used to provide comparison with one another. This tool can be used to evaluate current operational estate or for new build/refurbishment capital programmes. In this instance the tool for existing estate has been used. This places more emphasis on operations policy and procedure than that of new build as there is little opportunity to influence issues associated with building design, plant and equipment.

In conducting a NEAT assessment a wide range of potential impacts are assessed against pre-set criteria. For each criterion there are identifiable standards of performance that must be met in order to score "credits".

A weighting system is then applied to calculate a percentage score. The criteria and weightings are as follows:

Management	15%
Energy	15%
Transport	10%
Water	5%
Materials	5%
Landuse/ecology	10%
Internal Environment	15%
Pollution	10%
Social	10%
Operational Waste	5%

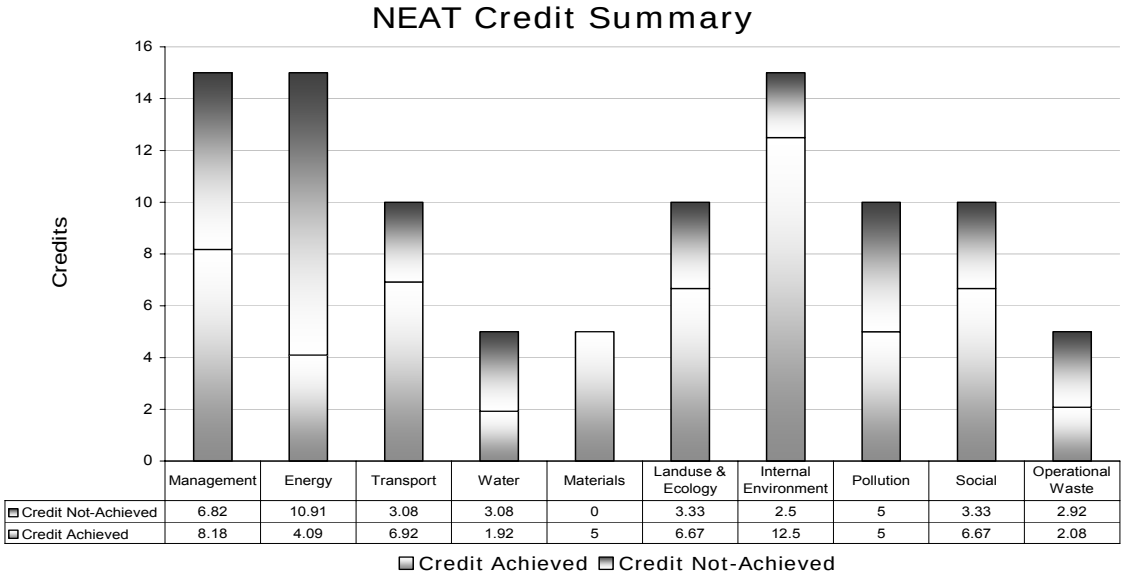
This final percentage scored is then interpreted as a rating as follows:

Excellent	≥70%
Very Good	≥55%
Good	≥40%
Pass	≥25%
Fail	<25%

A significant number of the questions which require answering in a NEAT assessment for the existing estate are determined by Trust policy and procedure. In addition there are a number of questions for which the answer relates to site-wide facilities – for example staff car parking. It is therefore the case that the actual performance of the estate with respect to quantifiable key performance indicators has a limited effect on the overall performance of the building within the context of the NEAT assessment.

1.1 Assessment: Sandwell General Hospital

Having entered the data for the buildings into the NEAT software tool the assessment results are summarised as follows:



	Management	Energy	Transport	Water	Materials	Landuse & Ecology	Internal Environment	Pollution	Social	Operational Waste
Credit Not-Achieved	6.82	10.91	3.08	3.08	0	3.33	2.5	5	3.33	2.92
Credit Achieved	8.18	4.09	6.92	1.92	5	6.67	12.5	5	6.67	2.08

Overall the existing estate has obtained a “Very Good” rating with a score of 59.04%. It is evident that there is the opportunity for improvement in a number of areas with the greatest opportunity concerning “Management”, “Energy (Policy)”, “Water”, “Pollution” and “Operational Waste”.

There is however, an opportunity to significantly improve the NEAT rating to 70.01% if commitment is made to: -

- Initiate an Environmental Management System (EMS) in place that will be independently audited and certified;
- Initiate a programme for educating and training on energy, water, waste & recycling related issues
- Produce an openly available, published energy and environmental policy with clear, agreed, targets and objectives, with KPI of environmental management used at all levels;
- Initiate an award scheme for individuals who have made an improvement to environmental performance;
- Use Green Electricity Tariff
- Initiate Contract for a planned, regular cleaning of external windows;
- Establish an energy efficiency incentive scheme;
- Develop a waste reduction strategy and demonstrate movement towards targets

- Comply with Controls Assurance Standard best practice with regard to waste
- Sought and accept upon advice on ecological enhancement of the site from a fully qualified ecological advisor; and
- Monitor all emissions to water, land and air.

This would require little or no change to the physical Estate. Furthermore improving the rating in this manner may prove substantially more cost effective than measures requiring significant capital investment.

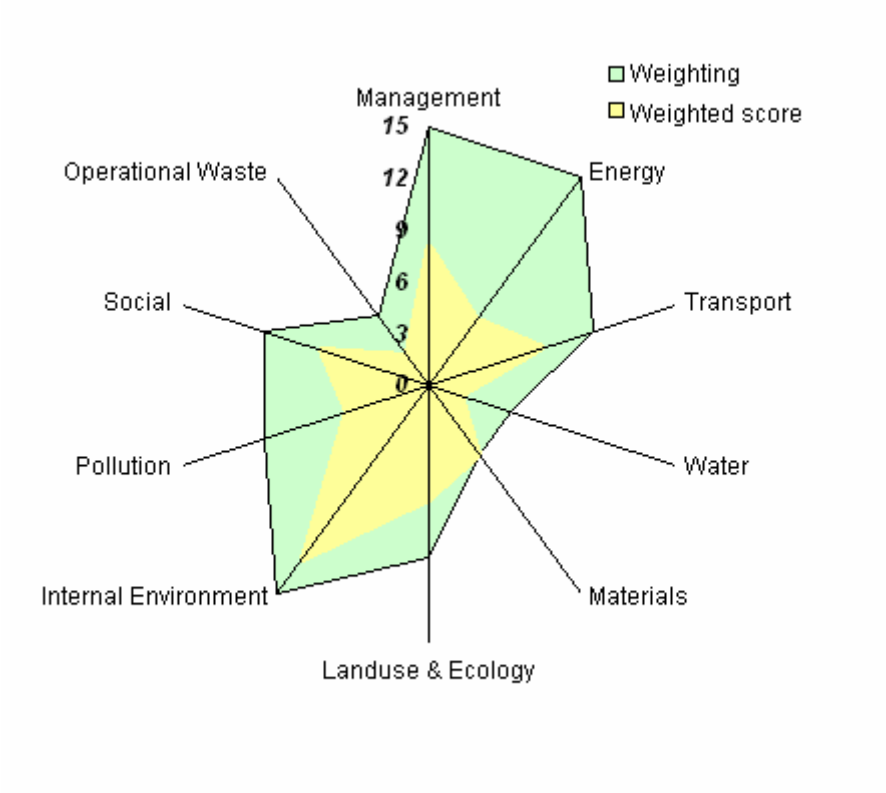
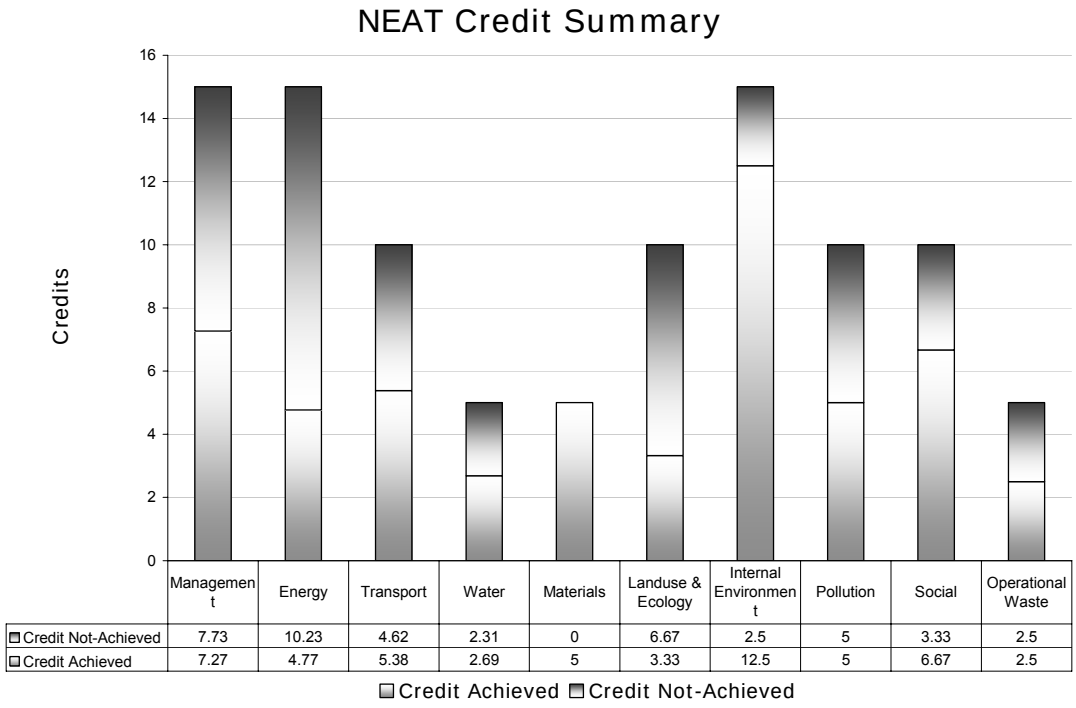


Figure 1 - Summary of the NEAT assessment for Sandwell G.H.; existing NHS site

1.2 Assessment: City Hospital

Having entered the data for the buildings into the NEAT software tool the assessment results are summarised as follows:



	Management	Energy	Transport	Water	Materials	Landuse & Ecology	Internal Environment	Pollution	Social	Operational Waste
Credit Not-Achieved	7.73	10.23	4.62	2.31	0	6.67	2.5	5	3.33	2.5
Credit Achieved	7.27	4.77	5.38	2.69	5	3.33	12.5	5	6.67	2.5

Overall the existing estate has obtained a “Very Good” rating with a score of 55.12%. It is evident that there is the opportunity for improvement in a number of areas with the greatest opportunity concerning “Management”, “Energy (Policy)”, “Landuse & Ecology” and “Pollution”.

There is however, an opportunity to significantly improve the NEAT rating to 67.75% if commitment is made to: -

- Initiate an Environmental Management System (EMS) in place that will be independently audited and certified;
- Initiate a programme for educating and training on energy, water, waste & recycling related issues
- Produce an openly available, published energy and environmental policy with clear, agreed, targets and objectives, with KPI of environmental management used at all levels;
- Initiate an award scheme for individuals who have made an improvement to environmental performance;
- Have a nominated Energy Manager or Energy Specialist

- Sought and accept upon advice on ecological enhancement of the site from a fully qualified ecological advisor; and
- Monitor all emissions to water, land and air.

This would require little or no change to the physical Estate. Furthermore improving the rating in this manner may prove substantially more cost effective than measures requiring significant capital investment.

The NEAT score could be improved to 70.01% with a rating of “Excellent” if capital investment was available for improving the energy consumptions and management on site.

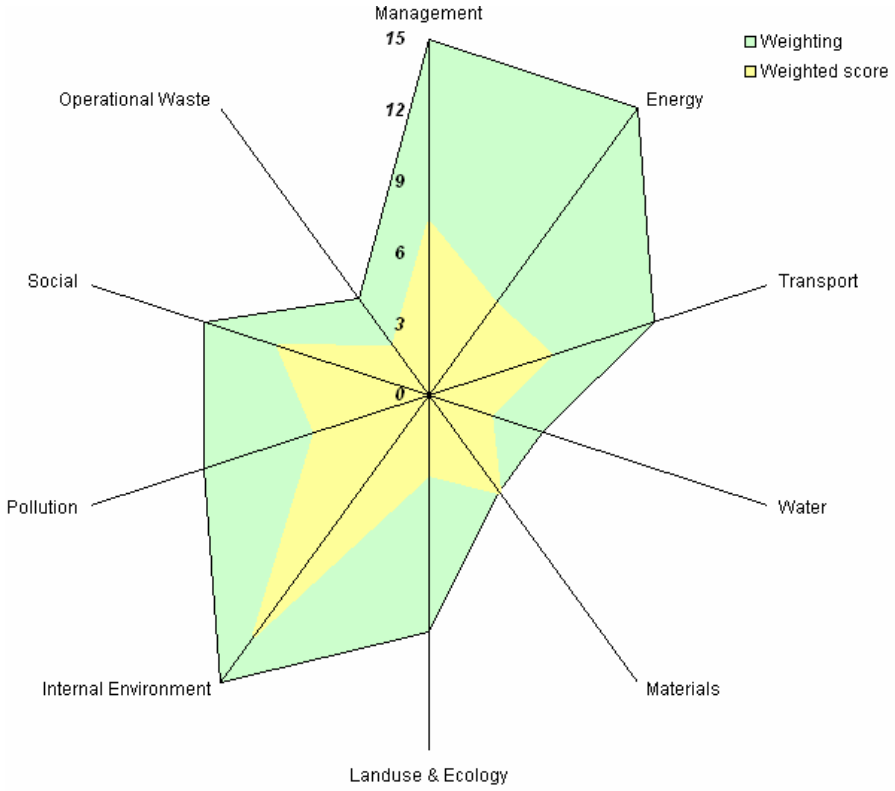


Figure 2 - Summary of the NEAT assessment for City Hospital; existing NHS site

2. ENERGY CONSUMPTION

A general overview of the energy performance of the estate can be gained from an analysis of the relevant performance indicator. The appraisal in this category differs from others in that it is taken from actual energy consumption in Giga Joules and converted into a ratio with the volume of the associated properties: that is, energy usage per unit volume – GJ/100m^3. For strategic planning purposes the site can be ranked based on the following energy usage per unit volume figures (without needing to carry out further surveys):

	GJ per 100 m^3
A	35 - 55
B	56 – 65
C	66 – 75
D	>76

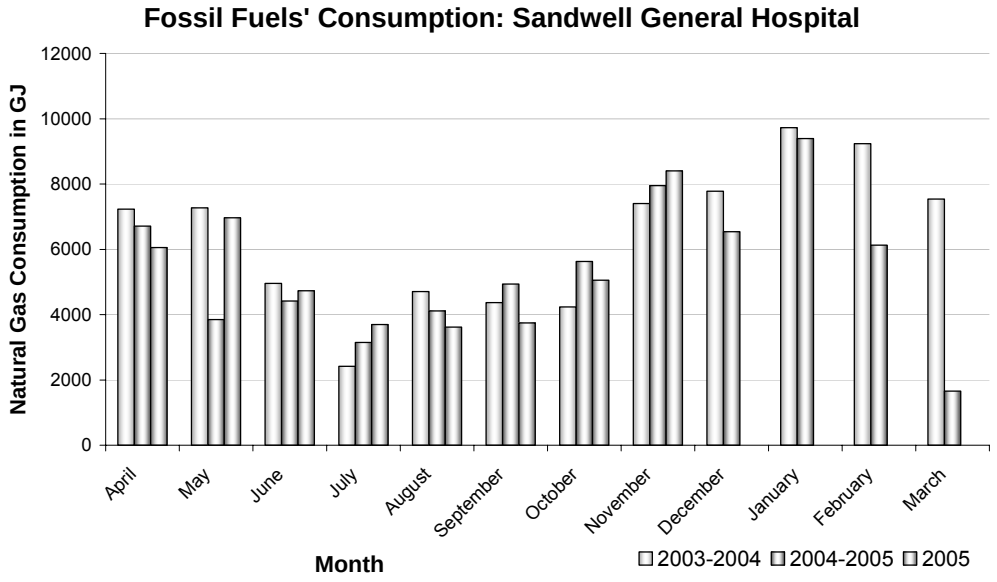
One variable quantifiable KPI that is variable between buildings is energy consumption. However the site wide energy consumption must be entered into the NEAT spreadsheet tool and there is no scope for consideration of specific blocks unless a completely separate assessment is completed for each building. It has to be stated that there is no separate metering of energy to each of the buildings. Therefore in order to present a separate indication of the relative performance of individual buildings and blocks the comparative energy consumption of the buildings has been modelled. This model is based upon:

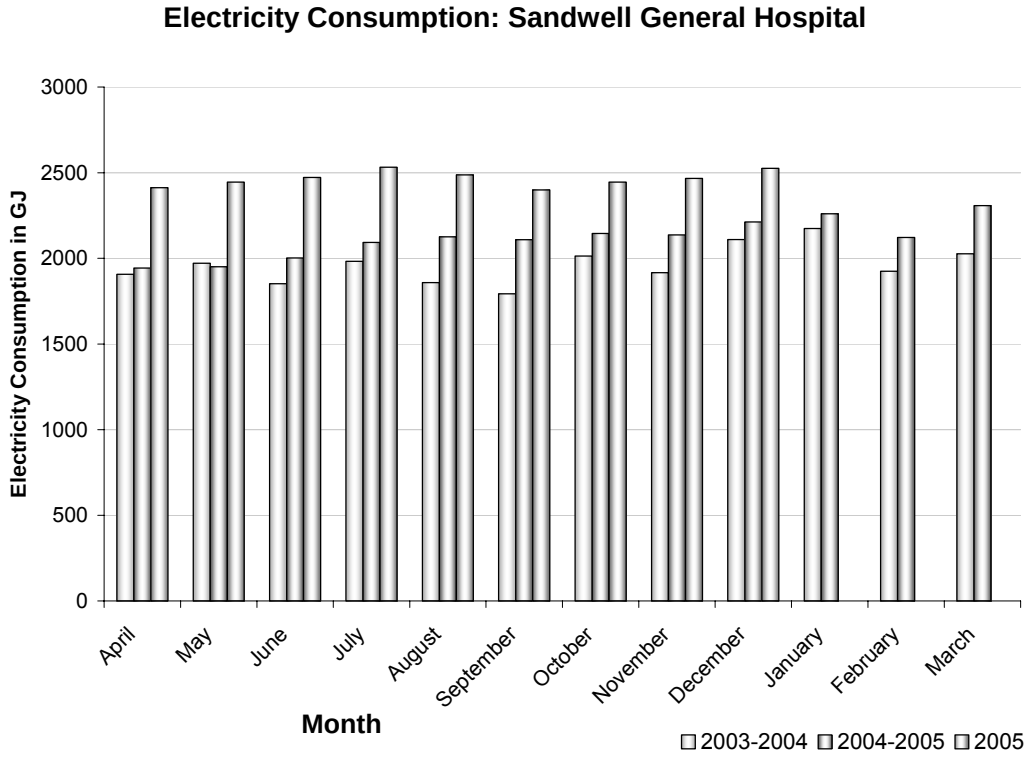
- the age of the building;
- the thermal properties of the methods of construction used;
- the estimated number of air changes in the building as a result of controlled ventilation and infiltration;
- Occupancy;
- Internal temperature set points;
- Electricity and hot water consumption based upon the available performance indicators.

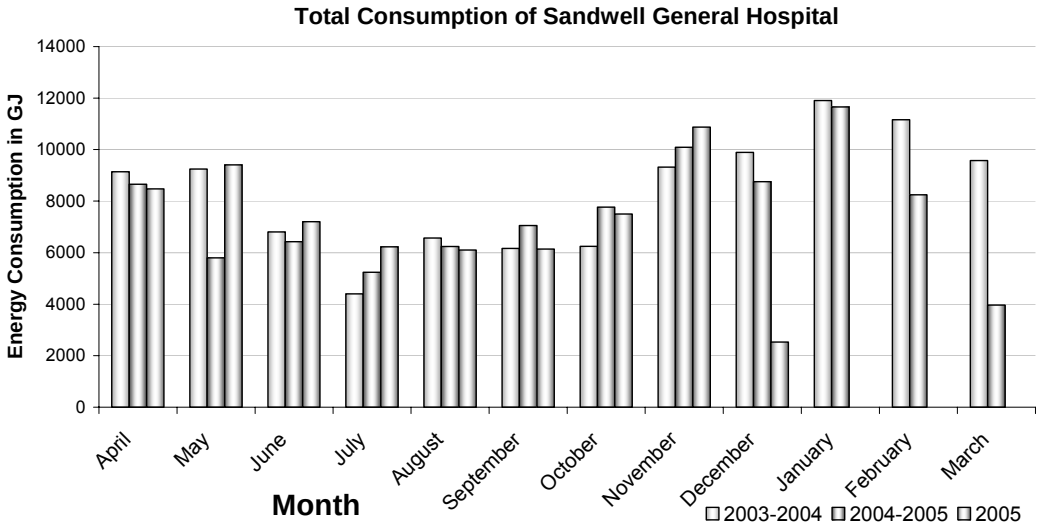
Baseline data has been obtained from the Trust with regard to annual and month by month consumption of gas and electricity by the site.

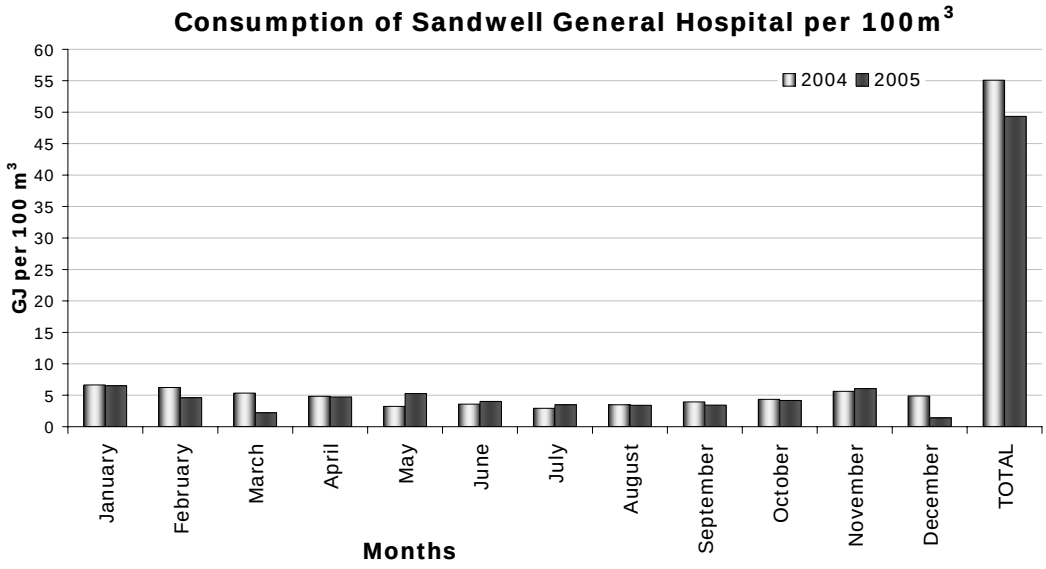
2.1 Energy Assessment: Sandwell General Hospital

Baseline data has been obtained from the Trust with regard to annual and month by month consumption of gas and electricity by the site. This data is presented as follows:









Annual energy consumption used can be summarised as follows (this information has also been used to complete the NEAT Assessment:

For 2004

Energy	kWh per annum	GJ per annum	GJ per 100 m^3 per annum
Natural Gas	20,201,944	73,807	
Electricity	6,901,667	24,846	
Total	27,103,611	98,653	**48.3**

Note:

Total Volume of Buildings = 203,863 m^3

For 2005

Energy	kWh per annum	GJ per annum	GJ per 100 m^3 per annum
Natural Gas	16,512,778	59,445	
Electricity	8,020,833	28,875	
Total	24,533,611	88,320	**43.3**

Note:

Total Volume of Buildings = 203,863 m^3

For both years examined, the Sandwell General Hospital is **A-rated** hospital with respect to the actual annual energy consumption benchmarks as they are stated in the Estatecode (NHS, Estates) document.

The resulting model from this exercise is presented as follows: -

BLOCK	TITLE	AREA	VOLUME HEATED	Fossil Fuels		Electricity		Total		RATING		Average	
		(M2)	(M3)	GJ/100m^3		GJ/100m^3		GJ/100m^3					
				2004	2005	2004	2005	2004	2005	2004	2005		
1	Main Building	33081	118998	33	27	12	14	46	41	A	A	43	A
1a	Emergency Services Centre	4676	16834	19	15	15	18	34	33	A+	A+	34	A+
2	Nurses Home & Offices	2635	7000	36	29	7	8	43	37	A	A	40	A
3	Residential Accommodation	493	1100	49	40	8	10	58	49	B	A	53	A
4	Residential Accommodation	722	1600	36	29	8	10	44	39	A	A	42	A
5	Garages	65											
6	Post Graduate Centre	1285	3540	39	31	13	16	52	47	A	A	50	A
8	Kitchen/Dining Room	2265	6050	47	38	21	24	68	62	C	B	65	B
9	Training & Development	205	700	56	45	5	6	61	51	B	A	56	B
10	Anti-natal / Social Club	869	3250	49	40	5	6	54	45	A	A	50	A
11	Doctor's Mess	382	925	47	38	8	9	55	47	A	A	51	A
12	Women's Health Unit	3890	10304	39	31	14	16	53	48	A	A	50	A
12a	Medical Gas Manifold House	31											
13	Medical Physics	96	256	88	71	14	16	102	87	D	D	95	D
14	Estates Department	1550	5593	40	32	5	6	45	38	A	A	42	A
15	G.U.M (Dartmouth) Clinic	337	865	52	42	14	17	67	59	C	B	63	B
16	Hallam Day Hospital/Finance	1141	3723	48	39	11	13	59	52	B	A	56	B

17	Diabetes Centre	1320	4200	38	31	12	14	50	44	A	A	47	**A**
18	Primary Care & Child Health	1140	3500	50	41	12	14	62	55	B	B	58	**B**
19	Child Development	715	2370	73	59	11	13	84	72	D	C	78	**D**
20	Oxygen Store	26											
21	Soft Water House	510	1530	45	36	19	22	63	57	B	B	60	**B**
22	Boiler House	588	2850	44	35	11	13	55	49	B	B	52	**B**
23	Estate Stores	68	420	66	54	3	3	69	57	C	B	63	**B**
25	Stores	29											
26	Generator House	36	108	87	70	19	22	105	91	D	D	98	**D**
27	Creche	271	802	60	48	13	15	73	63	C	B	68	**C**
29	Medical Gas Store	94											
30	-----	-----											
31	Residential Accommodation	765	1790	56	45	8	9	64	54	B	A	59	**B**
32	Residential Accommodation	765	1790	56	45	8	9	64	54	B	A	59	**B**
33	Residential Accommodation	765	1790	56	45	8	9	64	54	B	A	59	**B**
34	Residential Accommodation	765	1790	56	45	8	9	64	54	B	A	59	**B**
35	Hallam Cl. Garages / Laundry	249											
36	Car Park Attendants House	4	7	121	97	11	12	132	110	D	D	121	**D**
37	Gardener's Store / G'house	13	27	99	80	9	10	108	90	D	D	99	**D**
39	Gas Meter House	9											
40	Ducts	2565											
41	Hospital Radio	66	152	82	66	24	28	106	94	D	D	100	**D**
42	Water Filtration Building	19											

It has to be mentioned that the dimension, area and volume figures used are those provide from the Estates Department[1] and not those listed in the '2004 Estates Strategy'[2].

The data presented in the '2004 Estates Strategy' do not match with those of the Estates Department and information gathered from visual inspection on site.

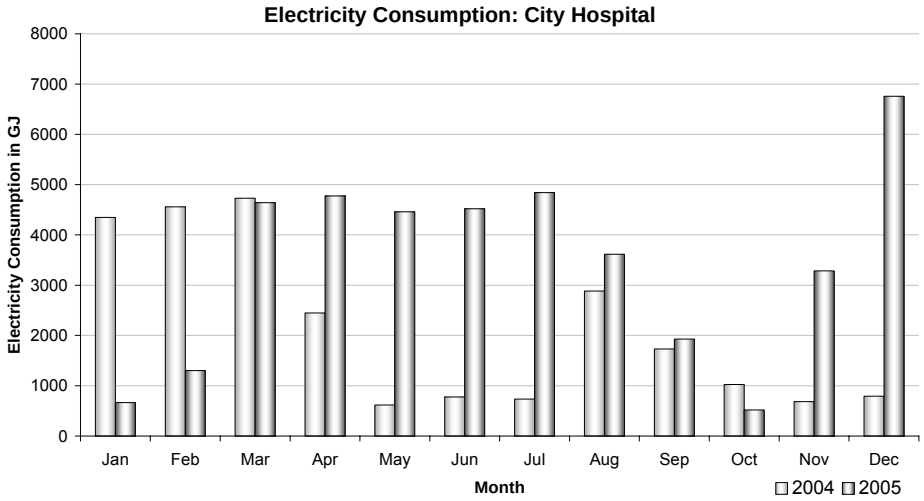
Please find a comparison table in Appendix 1.

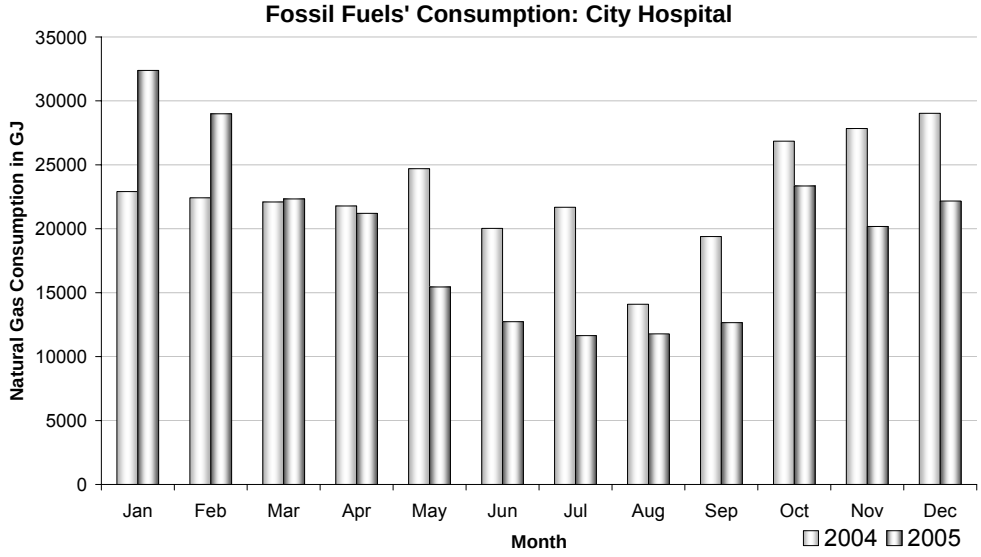
[1] Based on Survey dated on July 2001

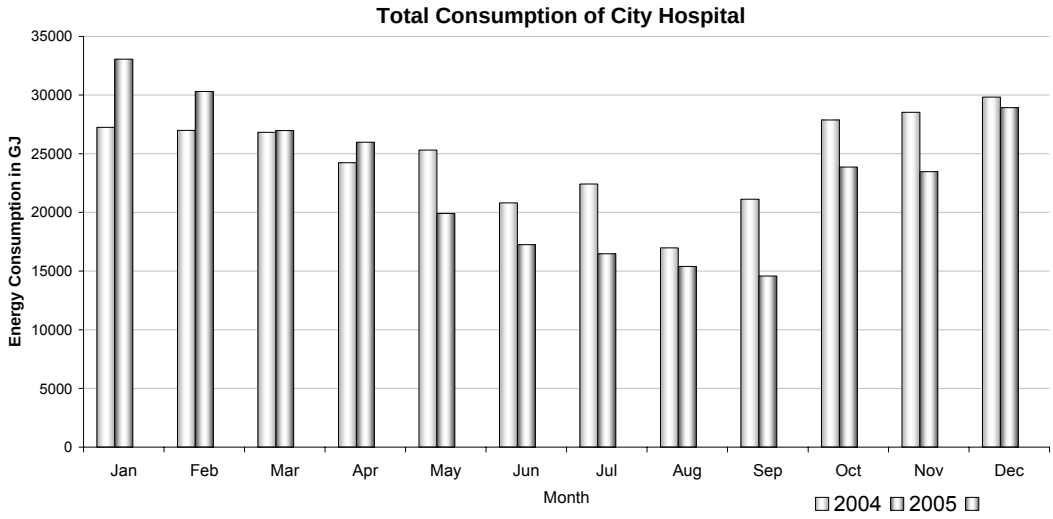
[2] French Thorpe Consultancy, Malcolm Lamb Associates, AYH plc (December 2002), Sandwell and West Birmingham Hospitals NHS Trust: Condition Survey: City Hospital Birmingham and Sandwell General Hospita, French Thorpe Consultancy

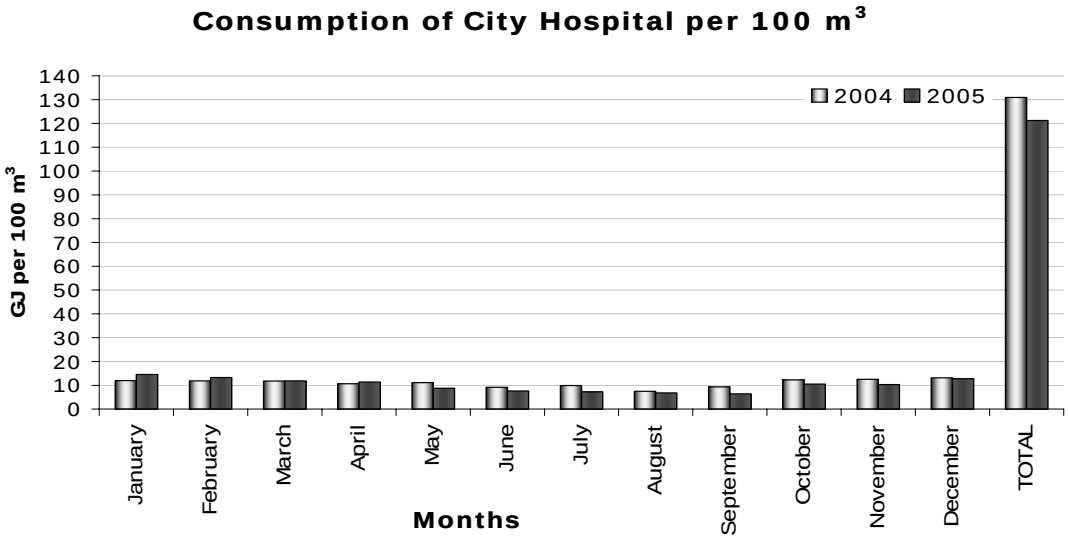
2.2 Energy Assessment: City Hospital

Baseline data has been obtained from the Trust with regard to annual and month by month consumption of gas and electricity by the site. This data is presented as follows:









Annual energy consumption used can be summarised as follows (this information has also been used to complete the NEAT Assessment:

For 2004

Energy	kWh per annum	GJ per annum	GJ per 100 m^3 per annum
Natural Gas	74,711,111	268,960	
Fuel Oil	1,078,333	3,882	
Electricity	7,033,888	25,322	
Total	82,283,332	298,164	**131**

Note:

Total Volume of Buildings = 227,723 m^3

For 2005

Energy	kWh per annum	GJ per annum	GJ per 100 m^3 per annum
Natural Gas	65,197,500	234,711	
Fuel Oil	44,444	160	
Electricity	11,475,000	41,310	
Total	77,716,944	276,180	**121**

Note:
Total Volume of Buildings = 227,723 m^3

For both years examined, the City Hospital is **D-rated** hospital with respect to the actual annual energy consumption benchmarks as they are stated in the Estatecode (NHS, Estates) document.

The resulting model from this exercise, using areas and volumes figures given by the Trust, is presented as follows.

Table: City Hospital: Heated Volumes and Estimated Annual Energy Consumption Rating: January 2006

Block No.	Description of Plans	Year Built	2004-5 Energy Consumption Rating According to Estate-code	TOTAL HEATED VOLUME m^3	BUILDING USAGE
001	Casualty/OPD Ground Floor West ENT OPD 1st Floor West Medical Records 2nd floor West	1966	D	10259	CLINICAL AREAS
002	OPD Plant Room Basement OPD Physio/O.T. Ground Floor East OPD Medical/Surgical 1st Floor	1966	D	6246	CLINICAL AREAS
003	Radiotherapy/Medical Oncology/Rec Hall/C-Cubicles (St. Chads) Ward D41, 1st Floor Med. Secs/Consultants/Dieticians/Coding Offices, 2nd floor	1887	D	8146	PATIENT TREATMENT/ WARD/ OFFICES
004	X-Ray Department Ward D42, 1st Floor Clinical Tech/Research 2nd Floor East	1887	D	8722	CLINICAL ACUTE WARD

005	Nuclear Medicine Department	1972	D	705	UNIVERSITY LABORATORIES
006	Hilda Lloyd Diabetes Centre Ground Floor Hilda Lloyd Diabetes Centre 1st Floor	1946	D	873	UNIVERSITY STUDENT RESIDENCE
007	Doctors Bungalow	1961	D	216	OFFICES
008	Ellis House Basement Ellis House Ground Floor Ellis House 1st Floor Ellis House 2nd Floor	1961	D	3058	RESIDENCE
009	Police Bungalow (formerly Ellis House-Matron's Bungalow)	1961	D	176	RESIDENCE
010	Pharmacy Basement Pharmacy Ground Floor Administration Block	1887	D	4893	LABORA-TORIES, OFFICES
011	Endoscopy (formerly Anaesthetic Offices) Endoscopy (formerly Pharmacy Storage) Endoscopy (formerly External Affairs Offices) Endoscopy (formerly Registration of Deaths)	1887	D	356	OFFICES
012	ITU/HDU, Ward D1 Ward D11 Ward D21	1887	D	4308	WARDS
013	MRI (formerly Admin. UGM Acute)	1940	D	1989	IMAGING
014	HSSU	1972	D	2725	STERILISATION AREA
015	Windmill Operating Theatres 1, 2 and 3 2nd Floor Plant Room above Windmill Theatres	1970	D	2933	OPERATING THEATRES, PLANT ROOM
016	Twin Operating Theatres Suite, Theatres 9 and 10 1st Floor Plant Room Twin Operating Theatres Suite	1989	D	1312	OPERATING THEATRES, PLANT ROOM
017	Emergency Operating Theatre 4, Basement Emergency Operating Theatre 4 B' Operating Theatre - Endoscopy Operating Theatre 5	1900	D	1647	OPERATING THEATRES
018	Ward D5, Ground floor Ward D15, 1st floor Ward D25, 2nd floor	1887	D	3936	WARDS ACUTE SHORT STAY
019	Staff Changing Facilities, Poison Unit Offices Uniform Exchange	1950	D	1674	UPGRADED 1994
020	Ward D6, Ground floor Ward D16, 1st Floor Ward D26, 2nd Floor	1887	D	4071	WARDS ACUTE SHORT STAY
021	Demolished				
022	Oral Surgery (Dental Department) Ground Floor	1950	D	634	DENTAL & ORTHO-DONTIC

023	Ward D7 (including Link to Ward D5), G.F Ward D17 (including Link to Ward D15), 1F Ward D27 (including Link to Ward D25), 2F	1887	D	5720	WARDS LINKS BUILT 1992
024	Clinical Investigation Unit	1970	D	1049	LABORA-TORIES
025	Ward D8, Ground Floor Ward D18, 1st Floor Ward D28, 2nd Floor	1887	D	3868	WARDS ACUTE SHORT STAY
026	Twin Operating Theatres Suite, Theatres 6 and 7	1965		917	OPERATING THEATRES
027	Ward D9 Ground floor (Children's) Ward D19 1st Floor (Children's) Ward D29	1887	D	3547	WARDS ACUTE SHORT STAY UPGRADED 1994
028	Ward D10 Ground floor (Children's) Ward D20 1st Floor Ward D30 2nd floor	1887	D	3474	WARDS ACUTE SHORT STAY
029	EBME, Ground floor Chapel, 1st Floor	1890	D	1098	EBME WORKSHOP/ OFFICES, CHAPEL
030	Post-Graduate Education Centre Ground floor Post-Graduate Education Centre 1st floor Post-Graduate Education Centre 2nd floor	1988	D	2652	EDUCATION
031	Millers Restaurant - catering admin, kitchens Ground floor Millers Restaurant - staff dining rooms, servery 1st Floor	1972	D	3926	MILLERS CATERING KITCHENS & ADMIN UPGRADED 2005
032	Nurses Home Basement Nurses Home Ground floor Nurses Homes 1st Floor Nurses Home 2nd Floor Nurses Home 3rd Floor	1910	D	11397	RESIDENCE - PARTIAL DEMOLITION SUPPOSED TO HAVE BEEN COMPLETED JULY 1995
033	Arden House Ground floor Arden House 1st Floor Arden House 2nd Floor	1930	D	5775	LEARNING & DEVE-LOPMENT
034	Residential Block Ground Floor Residential Block 1st Floor Residential Block 2nd Floor	1960	D	912	RESIDENCE
035	Transport Department	1970	D	73	GARAGE/WORKSHOPS/ OFFICES
036	Demolished				
037	Boiler-house Ground floor (see also 120) Boiler-house 1st floor	1900	D		BOILER-HOUSE
038	Receipt & Distribution Centre Ground Floor Engineering Stores Basement Building Maintenance Workshops Facilities Stores (Building & Engineering)	1897	D	5169	REGIONAL DISTRIBUTION CENTRE & FACILITIES/ESTATES STORES

039	Laundry	1972	D	10953	LAUNDRY
040	Pump Station/Bulk Water Storage Area	1972			STORAGE
041	Telephone Exchange	1975	D	447	TELEPHONE EXCHANGE
042	PAS Computer Centre	1985	D	194	COMPUTER BUILDING
043	Sisters' Home/Occupational Health GF Sisters' Home/Occupational Health 1st Floor Sisters' Home/Occupational Health 2nd Floor	1951	D	6460	OCCUPATIONAL HEALTH & RESIDENCE
O44	Regional Toxicology	1981	D	864	LABO-RATORIES
045	Social Workers	1970	D	506	OFFICES
046	Old Pathology Department Basement Old Pathology Department Ground Floor Old Pathology Department 1st Floor	1935 1935 1986	D	7168	LABO-RATORIES
047	New Pathology Department Extension	1992			
048	Immunology	1967	D	212	LABORA-TORIES
051	Special Care Baby Unit Maternity 1st Floor Ward M1 Ground floor Ward M4 1st Floor Ward M7 2nd Floor Maternity 2nd Floor	1939	D	11729	WARDS, MATERNITY, SHORT STAY
052	Maternity Labour Ward	1985	D	3505	WARDS, MATERNITY
056	Child Development Centre Ground Floor Child Development Centre 1st Floor	1900	D	2314	CHILD DEVELOPMENT CENTRE
059	Archway Ground Floor Archway 1st Floor Archway 2nd Floor	1852			NOT IN USE
064	Sickle Cell & Thalassaemia Centre 1st Floor Sickle Cell & Thalassaemia Centre GF	1932	D	1373	
	Geriatric Day Centre Ground Floor East Geriatric Ground Floor Link Geriatric Ward D43 Ground Floor West	1975	D	14919	GROUND FLOOR: WARD 43 AND DAY CENTRE, 1ST FLOOR: WARDS D44 & D45 NOW OPHTHALMOLOGY, 2ND FLOOR: WARDS D46 & D47 ACUTE ELDERLY CARE, 3RD FLOOR: WARDS D48 & D49 (DERMATOLOGY), OPD & LASERCARE
	X-Ray Department Extension Ground floor	1992			
	Geriatric Ward D45 1st Floor East Geriatric 1st Floor Link Geriatric Ward D44 1st Floor West Geriatric Ward D47 2nd Floor East Geriatric 2nd Floor Link Geriatric Ward D46 2nd Floor West Geriatric Ward D49 3rd Floor East Geriatric 3rd Floor Link Geriatric Ward D48 3rd Floor West Roof Top East Plant Room Roof Top Centre Plant Room Roof Top West Plant Room	1975			
066	Stephens House Ground floor Stephens House 1st Floor	1932	D	226	FACILITIES MANAGEMENT

067	Health & Safety/Fire Offices	1978	D	235	OFFICES
068	Brookfield House Ground Floor Brookfield House Ground Floor Brookfield House Ground Floor Brookfield House 1st Floor Brookfield House 2nd Floor	1880	D	2812	FINANCE DEPART-MENT OFFICES
069	Trust Headquarters, 1st Floor Trust Headquarters, Ground Floor Extension Trust Headquarters, Ground Floor Extension	1947 1947 1991	D	2899	TRUST EXECUTIVE OFFICES
070	Catering Cook/Chill Central Production Unit, Ground Floor Catering Cook/Chill Central Production Unit, 1st Floor	1987	D	3039	CATERING PRO-DUCTION
071	Centre for the Hearing Impaired (Pre-fabricated building) Centre for the Hearing Impaired (Brick building) Centre for the Hearing Impaired (3 Portakabins)	1969 1976 1994	D	1456	HEARING AID CENTRE, OFFICES AND STORES
073	Security Lodge/Gatehouse (by Main Entrance), Ground Floor	1984		62	SECURITY LODGE
074	Nuclear Physics Portakabin, Ground Floor	1970	D	162	OFFICES
075	Dudley Road OP Sub-Station/Plant Room, Ground Floor	1966	D	218	GENERATOR HOUSE
076	Dudley Road Gas/Water Meter House, Ground floor	1948	D	27	METER HOUSE
077	OPD Generator Room No. 1, Ground Floor	1966	D	0	GENERATOR ROOM
079	Squash Court (Sub-station/Generator House) (see also 122, 123)	1970	D	71	ELECTRICAL SWITCH-GEAR
080	Hairdressing Salon	1970	D	72	SALON
081	Nurses Home Calorifier Room	1940	D	539	PLANT ROOM
082	Patient Transport Call Centre, Ground Floor Patient Transport Drivers' Mess, 1st Floor	1960	D	216	CALL CENTRE/ DRIVERS MESS
085	Oil Storage (Fuel Oil)	1964			FUEL OIL STORAGE
088	Generator Room, Ground Floor (by telephone exchange)	1988			GENERATOR
090	Store (former air raid shelter)	1940	D		STORE
091	Store (former air raid shelter)	1940	D		STORE
092	Calorifier Plant Room/Switchroom (by Sheldon Block)	1975			PLANT ROOM
093	Regional Toxicology Bottle Store, Ground Floor	1980			STORE
095	Pathology Department Spirit Stores, Ground Floor	1982			STORES
098	Gas/Water Meter House, Ground Floor	1960			METER HOUSE
099	Facilities Design/Project Management Offices	1970	D	601	OFFICES
101	Summerfield Ho. Sub-Station and Generator Room No. 3	1965			GENERATOR ROOM
114	Medical Compressor Plant/Generator House, Ground Floor	1950			GENERATOR
115	Estates Department Offices	1920	D	373	OFFICES

117	Main (Spine) Service Duct, Basement Main (Spine) Corridor, Ground floor Main (Spine) Corridor, 1st floor Main (Spine) Corridor, 2nd floor	1887	D	9693	CORRIDORS
118	Ward D2 Ward D12 Ward D22	1887	D	3936	WARDS ACUTE SHORT STAY
119	Ward D14 Ward D24	1887	D	1684	WARDS ACUTE
120	Generator House (included in Block no. 37)				GENERATOR
121	Outpatients Department, Central Block	1966	D		OFFICES
122	Generator (Back Road) (included in Block no. 79)				GENERATOR
123	Electricity Sub-Station (included in Block no. 79)				SUB-STATION
124	Western Road Electricity Sub-Station (included in Block no. 101)	1965			SUB-STATION
125	N/H (Nurses Home) Sub-Station	1940			SUB-STATION
126	Offices adjacent to Block 118	1993	D		OFFICES - 1993
127	Domestic Services Supervisors'and other Facilities Offices	1990	D	490	OFFICES
128	Audit Department Offices	1990			OFFICES
129	Doctors' Annexe: Ground Floor Doctors' Annexe: 1st Floor Doctors' Annexe: 2nd Floor		C	1863	RESIDENCE
130	Liquid Oxygen Plant	1970			PLANT COMPOUND
134	Geriatrics Offices (near Sheldon Block), Ground floor Geriatrics Offices (near Sheldon Block), 1st floor	1992	C	2118	OFFICES BROUGHT INTO USE MAY 1992
135	Staff Changing Block, Ground Floor Staff Changing Block, 1st Floor	1992	C	3115	CHANGING ROOMS BROUGHT INTO USE
136	Catering Department Storage	1992	D	85	STORE
137	Medical Engineering Workshop Clinical Infection Research, Ground Floor	1992	D	250	WORKS
138	Transport Department Portakabin Offices	1993	D	79	OFFICES
139	CHI Portakabin A CHI Portakabin B CHI Portakabin C	1993	D	242	OFFICES
140	Dental Portakabin	1990	D	50	WORKSHOP
141	British Gas Compound (CHP)	1995			
142	Vacuum Insulated Evaporator (VIE)	1995			
143	Birmingham and Midland Eye Hospital	1996	C	11532	COMPLETE MARCH 1996

3. CONCLUSIONS

The Trust is committed to the provision of an environment that ensures the health and well being of the community it serves as both the hospitals achieve a '***Very Good***' rating according to NHS Environmental Assessment Tool (NEAT).

For both years examined, the City Hospital is ***D-rated*** and the Sandwell General Hospital is ***A-rated*** with respect to the actual annual energy consumption benchmarks as they are stated in the Estatecode (NHS, Estates) document.

Considering the energy use of City Hospital, energy performance is an important factor in determining the overall efficiency of the hospitals. The rating presented in chapter 2 will only give a broad indication of the energy performance of the estate. The buildings types, their major specialisations and the mix of continuous energy use of City Hospital, compared to the intermittent energy use in a typical 9-5 premises, have a marked effect. It has also to be mentioned that the Combined Heat and Power (CHP) unit was not in operation for long periods during the examined period. No operation of such energy efficiency equipment influences negatively the energy consumption figures of the property. Furthermore, the volume of the property has to be re-calculated according to 'NHS Estates Return Information Collection (ERIC)'[3] document, as the average 'volume to area' ratio of the properties[4], i.e. the average height of each heated floor, found to be equal 2.58m, a figure that is well bellow the expected 2.9-3.2m. Such potential modification of the volumes figures may reduce the annual consumption in GJ/100m^3 up to 20%. However, if City Hospital had a consumption of 80GJ/m^3 instead of 121 and 131GJ/m^3 will not have an effect "for strategic planning purposes" according to "NHS Estates – Estatecode", p.4.14.

In particular, the Trust should seek to:

- Measure and reduce, where practicable, pollution to air, land and water;
- Have regard for both environmental issues and value for money in all centrally purchased goods and services and promote the use of products and services of suppliers, who have environmentally friendly policy;

[3] NHS Estates Return Information Collection (ERIC) 2005/2006. This data collection has been approved by: - The Review of Central Returns Steering Committee and Gate
way. The Review of Central Returns Steering Committee and Gateway. ROCR ID: ROCR/OR/0042/003 Available from http://www.dh.gov.uk/assetRoot/04/11/85/51/04118551.xls

[4] According to figures provided by the Trust within the excel spreadsheet 'City Areas & Volimes.xls'.

- Provide environmental education and training to appropriate staff and ensure all staff are aware of the environmental policy and how they can contribute to the Trust's overall environmental performance;
- Ensure that all relevant staff have access to up to date information on environmental legislation and guidance, i.e. all the energy efficient and environmental policies should be documented and widely distributed in the hospital;
- Continue to promote the efficient use of energy in an economical and environmentally sound manner by energy conservation measures and, where economically viable, investing in energy saving technology and management in both existing and new buildings and equipment;
- Promote waste minimisation and reduce the environmental impact of waste through beneficial use, where practicable, or safe disposal where not enhance the natural beauty of the hospital site and protect natural habitats by maintaining the grounds in an environmentally sound manner and promoting visual amenity through the design, location and finishes of buildings and structures; and,
- Communicate openly the organisation's environmental performance to staff, patients, government authorities and other interested parties on request.

APPENDIX.1 – SANDWELL GENERAL HOSPITAL SURVEYED AREAS

TITLE	Estates Figures [5] (M2)	Old Survey [6] (M2)
Main Building	33081	23437
Emergency Services Centre		
Nurses Home & Offices	2635	1630
Residential Accommodation	493	497
Residential Accommodation	722	725
Garages	65	
Post Graduate Centre	1285	1527
Kitchen/Dining Room	2265	1833
Training & Development	205	1024
Anti-natal / Social Club	869	886
Doctor's Mess	382	368
Women's Health Unit	3890	3532
Medical Gas Manifold House	31	
Medical Physics / EBME	96	
Estates Department	1550	324
G.U.M (Dartmouth) Clinic	337	371
Hallam Day Hospital/Finance	1141	1184
Medical Dir' / Diabetes Centre	1320	1076
Primary Care & Child Health	1140	992
Child Development/Primary Care	715	708
Oxygen Store	26	
Soft Water House	510	131
Boiler House	588	602
Estate Stores	68	81
Stores	29	81
Generator House	36	
Creche	271	
Sub Station	19	
Medical Gas Store	94	
Residential Accommodation	765	765
Residential Accommodation	765	765
Residential Accommodation	765	765
Residential Accommodation	765	765
Hallam Cl. Garages / Laundry	249	28
Car Park Attendants House	4	
Gardener's Store / G'house	13	
Gas Meter House	9	
Ducts	2565	
Hospital Radio	66	69
Water Filtration Building	19	
	Sum	**Sum**
Total	59848	
Total of those buildings listed in both columns	56600	44166
Difference of Total Floor Area between the Two Surveys	12,434m^2	

[5] Based on figures provided by the Trust for Survey dated on July 2001
[6] French Thorpe Consultancy, Malcolm Lamb Associates, AYH plc (December 2002), Sandwell and West Birmingham Hospitals NHS Trust: Condition Survey: City Hospital Birmingham and Sandwell General Hospita, French Thorpe Consultancy

NEAT NHS Environmental Assessment Tool

NHS Estates An Executive Agency of the Department of Health

dti Department of Trade and Industry

BRE

Version 27/05/03

For existing sites

This is an assessment of *SANDWELL GENERAL HOSPITAL*
This is a site within *Sandwell and West Birmingham NHS TR*

NEAT aims: Raise awareness of environmental issues within NHS facilities and services;

Estimate the environmental impact of NHS facilities and services.

Seek to establish an environmental improvement programme.

	%	Rating
	0	Fail
more than	25	Pass
more than	40	Good
more than	55	Very Good
more than	70	Excellent

Total Score 59.04

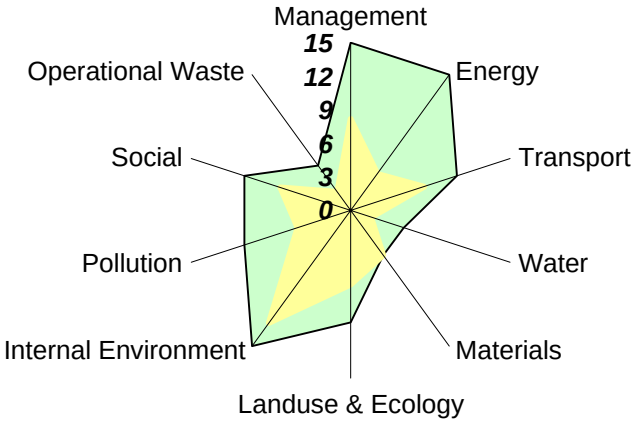
Rating Very Good

	Score	Weighting	Weighted score
Management	55%	15	8.18
Energy	27%	15	4.09
Transport	69%	10	6.92
Water	38%	5	1.92
Materials	100%	5	5.00
Landuse/Ecology	67%	10	6.67
Internal Environment	83%	15	12.50
Pollution	50%	10	5.00
Social	67%	10	6.67
Operational Waste	42%	5	2.08
		Total	59.04

You have entered **1** **Unit Name**

The development of this spreadsheet was funded by DTI and NHS Estates

Environmental Assessment of an Existing NHS Site



NEAT NHS Environmental Assessment Tool

NHS Estates An Executive Agency of the Department of Health

dti Department of Trade and Industry

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For existing sites

This is an assessment of *City Hospital*

This is a site within *Sandwell and West Birmingham NHS Tr*

NEAT aims: Raise awareness of environmental issues within NHS facilities and services;

Estimate the environmental impact of NHS facilities and services.

Seek to establish an environmental improvement programme.

	%	Rating
	0	Fail
more than	25	Pass
more than	40	Good
more than	55	Very Good
more than	70	Excellent

	Score	Weighting	Weighted score
Management	48%	15	7.27
Energy	32%	15	4.77
Transport	54%	10	5.38
Water	54%	5	2.69
Materials	100%	5	5.00
Landuse/Ecology	33%	10	3.33
Internal Environment	83%	15	12.50
Pollution	50%	10	5.00
Social	67%	10	6.67
Operational Waste	50%	5	2.50
		Total	55.12

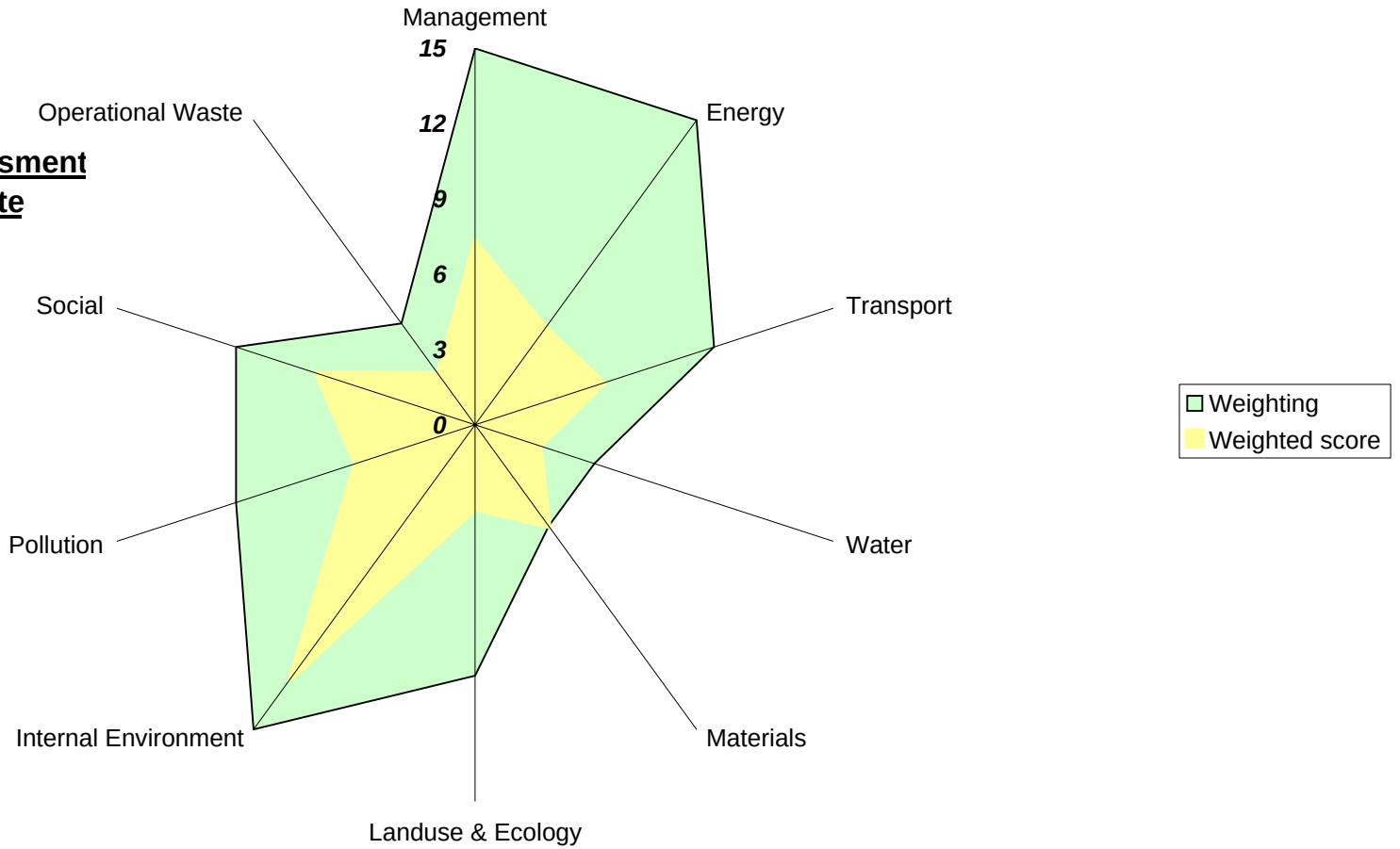
Total Score 55.12

Rating Very Good

You have entered **1** **Unit Name**

The development of this spreadsheet was funded by DTI and NHS Estates

Environmental Assessment of an Existing NHS Site



Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 6

Energy and Environment Action Plan 2008/09

Energy & Environmental Action Plan -2008/09

	Issue	Action	Responsibility	Date	Position
1	Establish Energy & Environment Steering Group (EESG)	• Contact & meeting previous members of EEG • Prepare draft terms of reference for reformed EESG • Arrange meeting for EESG	Rob Banks	Dec-08	• Ex members to be contacted to reestablish EESG. • Delayed due to long term illness. • Energy consultant to be appointed to move this forward.
2	Draft new Energy & Environment Policy	• Draft policy to be produced • Policy implemented 31/03/09	Phil Foley Phil Foley	Dec-08	
3	Energy Saving Schemes Submitted to SHA for Bids Against Government Energy & Sustainability Fund	• Completion of bidding stage 1 for the following energy saving schemes • Expansion of Building Management System (BMS) • Energy saving controls on Refrigeration units • Installation of high efficient lighting Insulation • Enhanced thermal insulation to pipework and fittings • Replacement of Steam condensate pumps	Completed Kevin Reynolds Kevin Reynolds Kevin Reynolds Kevin Reynolds Kevin Reynolds	 Sep-08 Sep-08 Sep-08 Sep-08 Sep-08	• Bids submitted. Advised bids unsuccessful as Dept of Health funding had run out. No further funding identified to date. • SIRG approved interim funding to progress these schemes. • Schemes in progress. • Funding still being pursued via Department of Health.
4	Display Energy Certificates (DEC)	• Implementation of DEC upon final approval from Government • Obtain Final details of scheme when finally approved by Government, • Obtain necessary resources appointment of accredited surveyors • Collate & Provide all necessary data to enable surveyor to issues Display Energy Certificates	Phil Foley	Oct-08	• Display Energy certificates (DEC) were due to be implemented from April 2008 have now been delayed; the revised date is now October 2008. • One DEC for each site required from October 2008.
5	Energy Awareness Campaign.	• Plan energy awareness campaign • Contact The Carbon Trust, Communications Department, for help/assistance	Phil Foley	Aug-08 Oct-08	• Energy awareness campaign provided to July Team Brief. • NIFES to assist in developing this initiative by October 2008.

6	Site Energy Survey	• Reconciliation of Trusts consumptions indicating the loss of City Laundry – Complete • Energy Consultants appointed to undertake site energy position and inability of continued use of CHP. • Energy consultants appointed to establish further site energy reduction.	Phil Foley Phil Foley Phil Foley	Dec-07 Jan-08 Dec-08 Dec-08	• Completed.
7	NHS Environmental Assessment Tool (NEAT)	• Review Neat assessments for City, Sandwell & Rowley or Building Research Establishment Environmental Assessment Method (BREEAM)	Phil Foley	Dec-08	• Subject to availability of BREEAM Healthcare assessors. Minimal assessors trained at present.

Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 7

Waste Minimisation Action Plan 2008/09

Waste Action Plan (20th August 2008) **Appendix 7**

Action plan for the implementation of HTM 07- 01 the Safe Disposal of Clinical Waste

Status	
Dark Green	Complete
Light Green	On Track
Amber	Some delay but expected to be completed as planned
Red	Significant delay
White	Not yet commenced

No	General & Clinical Waste Bin Replacement Programme	Who By	When By	Progress	Rating
1	Update and complete spread sheet indicating number of bins required in each area	PR	Feb 08	Completed	**Dark Green**
2	Prepare order for the number of bins and types required in various area's	PR	Feb 08	Completed	**Dark Green**
3	Prepare schedules with timescale for the delivery of bins when delivered	PR/SS	June 08	Ongoing	**Dark Green**
4	Arrange agency staff to assist with distribution of the bins to be delivered	SS	Feb 08	Arranged with agency to start implementation programme 9th March 08	**Dark Green**
5	Arrange for disposal of scrap bins	SS	June 08	Already arranged needs sample for weight payment	**Dark Green**
6	Discuss with Estates to get bins in reasonable condition refurbished then to go into store	PR	June 08	Cost prohibitive (new bins, VfM)	**Dark Green**
7	Reorder additional stock for shortfall.	PR	August 08	On going	**Light Green**
8	Make arrangements for the disposable of cardboard and packaging	PR	March 08	Completed	**Dark Green**
9	Identify new skips for City site corridors liasing with Hotel Services and Fire Department	SS/PR	Feb 08	Ground floor removed, 1st & 2nd floor being monitored	**Dark Green**
10	Assess all waste storage sites. Ensuring they are clean and environmentally friendly	PR	Ongoing	Ongoing audit of all storage areas (PEAT)	**Dark Green**
No	**Implementation of New Waste Regulations**	**Who By**	**When By**	**Progress**	**Rating**
11	Develop an information pack to brief all staff on the changes	SS/PR	Feb 08	Completed	**Dark Green**
12	Arrange to attend Matrons meetings to discuss the changes	SS/PR	Feb 08	Completed	**Dark Green**
13	Arrange with each Matron to attend ward managers meetings for each of the disciplines	SS/PR	Feb 08	Completed	**Dark Green**
14	Article for the March team brief concerning the changeover of yellow bags to orange. Colour segregation of sharps bins. Bin replacement	PR	Feb 08	Completed	**Dark Green**

15	Arrange meeting with individual departments to inform of changes	SS/PR	April 08	Completed	**Dark Green**
16	Discuss with supplies the ordering of orange bags together with codes. Order bags for new bins	PR	March 08	Completed	**Dark Green**
17	Develop a training programme for waste operatives across the Trust	SS/PR	Aug 08	On going	**Light Green**
18	Identify on all sites sufficient space for the segregation of each of the waste streams	SS/PR	Aug 08	On going	**Light green**
19	Redesign the consignment notes	BH/SS/PR	Aug 08	Template to be approved with users	**Amber**
20	Training exercises for the staff completing consignment notes	SS	Aug 08	Programme being developed	**Amber**
21	Correct segregation of sharps bins	PR/SS	Sept 08	Designated areas to be agreed on all wards and departments	**Light Green**
No	**General Waste Management Issues**	**Who By**	**When By**	**Progress**	**Rating**
22	Establish a waste management group inviting all key stake holders	SS/PR	Feb 08	Completed	**Dark Green**
23	Arrange and set up regular contract review meetings with the Waste Management Contractor	SS/PR	Feb 08	Completed	**Dark Green**
24	Finalise Waste Management Policy	DH/BH	July 08	Policy agreed at OMB	**Dark Green**
25	Develop ongoing training programme for new staff via Induction Programme	DH/SS/PR	June 08	Induction training programme produced for mandatory training	**Dark green**
26	Draw up business case for compactors at City	SS	June 08	Feasibility study being udnertaken	**Amber**
27	Continue ongoing audits of existing clinical waste arrangements on all three sites and the community	SS/PR/BH	June 08	Ongoing	**Dark Green**
28	Agree service requirements with the PCT's and BCMH	BH/SS	June 08	Ongoing discussions being done	**Amber**
29	Draw up a proposal plan to move all clinical waste to City WTS, (subject to approval of No. 25) and arrangements with the EA. License change	SS/PR	June 08	Subject to approval of compactors	**Amber**
30	Formulate and assess recycling opportunities	PR	Dec 08	To form part of new waste contract to be awarded February 2009	**White**
31	Full review of the DGSA audit	PR/SS	October 08	Develop action plan, to be presented at Facilities Governance	**Light Green**

Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 8

ERIC Returns for 2007/08

Appendix 8a	Trust Data Report
Appendix 8b	Trust Performance Indicator Report
Appendix 8c	Performance Indicator Median Report

Appendix 8a

Trust Name	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
Trust Code	RXK
Trust Type	LARGE ACUTE OUTSIDE LONDON
Strategic Health Authority	WEST MIDLANDS STRATEGIC HEALTH AUTHORITY
Reporting Year	2007/2008
Trust Data Report	Printed 25/07/2008

Trust Profile	**Unit**	**Value**
Occupied beds	No.	955
Available beds	No.	1,086
Total number of wards	No.	53
Number of sites - General Acute Hospital	No.	2
Number of sites - Multi-service Hospital	No.	0
Number of sites - Short Term Non-Acute Hospital	No.	1
Number of sites - Long Stay Hospital	No.	0
Number of sites - Specialist Hospital	No.	0
Number of sites - Community Hospital	No.	0
Number of sites - Treatment Centres	No.	0
Number of sites - Non-Hospital (Patient)	No.	0
Number of sites - Support Facilities	No.	0
Number of sites - GP Properties	No.	0
Total Number of sites	No.	3
GP owned properties not being reported on	No.	0
Estates Development Strategy	Yes/No	Y

Land and Property Transactions	**Unit**	**Value**
Net Land and Property Disposal Receipts	£	160,467
Forecast Net Land and Property Receipts	£	0
Forecast land available for disposal during 2008/09	Hectare	0
Forecast land available for disposal during 2009/10	Hectare	0
Forecast land available for disposal during 2010/11	Hectare	0

Contracted Out Service	**Unit**	**Value**
% of Estates and Hotel services Contracted Out	%	8.97
Value of Contracted out Services	£	1,794,000

Finance	**Unit**	**Value**
Total Capital Investment	£	13,251,000
Estates Service Costs	£	39,777,540
Total FM (Hotel Services) Costs	£	17,824,373
Investment to reduce Backlog Maintenance	£	3,200,000
Income from Leases	£	23,580
Cost of Leases	£	97,650

Staff	Unit	Value
Total number of staff employed	WTE	5,861
Total number of staff employed in relation to the Estates function	WTE	100
Total number of staff employed in relation to the Facilities (Hotel Services) function	WTE	767
Complaints	No.	35
Staff Receiving Health & Safety Training	%	41
Staff Receiving Fire Training who require training	%	55
Staff who have undergone customer-care training who require training	%	59

Safety - RIDDOR	Unit	Value
RIDDOR incidents	No.	27
Non-RIDDOR incidents	No.	6,299

Telecommunications	Unit	Value
Average Response Time	Sec's	32
Telecommunication service cost	£	1,047,044

Transport services	Unit	Value
Green transport plan	Yes/No/None	Yes
Patient journey cost	£	1,997,600
% of fleet vehicles which operate on 'green' fuels	%	100
Patient transport mileage	Miles	0
Visitor transport mileage	Miles	0
Staff transport mileage	Miles	0

Sterile Services	Unit	Value
Sterile Services cost	£	2,097,000
Number of type TSSU main sterilisation department(s)	No.	2
Number of type CSSD main sterilisation department(s)	No.	0
Number of type HSDU main sterilisation department(s)	No.	0
Number of type SDU main sterilisation department(s)	No.	0
Number of type Other main sterilisation department(s)	No.	0
Main sterilisation units on/off site - TSSU	On/Off/None	Off
Main sterilisation units on/off site - CSSD	On/Off/None	None
Main sterilisation units on/off site - HSDU	On/Off/None	None
Main sterilisation units on/off site - SDU	On/Off/None	None
Main sterilisation units on/off site - Other	On/Off/None	None
Activity - Theatre trays	No.	10,056
Activity - Supplementary packs	No.	28,816
Activity - Single instrument packs	No.	110,929
Number of staff	WTE	8

Appendix 8a

Electro Biomedical Equipment	Unit	Value
EBME service cost	£	2,439,372
Assets maintained	No.	14,088

Site Name	Site Code
SANDWELL GENERAL HOSPITAL	RXK01
CITY HOSPITAL	RXK02
ROWLEY REGIS HOSPITAL	RXK10

Areas	Unit	RXK01	RXK02	RXK10
Gross internal site floor area	m²	65,806	103,326	8,735
Occupied floor area	m²	62,156	94,394	8,735
NHS estate Occupied Floor Area	%	100	100	100
Site Heated Volume	m³	192,062	248,092	22,760
Site building footprint	m²	27,790	63,888	4,868
Site land area	Hectare	9.97	19.47	2.76
Patient occupied floor area	m²	32,487	54,356	5,158
Non-patient occupied floor area	m²	21,657	32,738	2,745
Unoccupied floor area	m²	3,650	8,932	0
Main circulation area	m²	8,012	7,300	832
Leased in floor area	m²	0	0	0
Leased out floor area	m²	60	884	0
Temporary buildings and portacabins	m²	176	0	0

Function and Space	Unit	RXK01	RXK02	RXK10
Functional suitability	%	31	43	0
Space utilisation	%	10	16	15
Available beds	No.	381	583	122
Number of Wards	No.	13	21	3
Total number of specialist wards	No.	2	12	2
Percentage of single bedrooms for patients	%	15	10	17
Number of Nightingale wards in use - Acute	No.	0	16	0
Number of Nightingale wards in use - Elderly	No.	0	0	0
Number of Nightingale wards in use - Mental Health	No.	0	0	0
Number of Nightingale wards in use - Children	No.	0	0	0
Number of Nightingale wards in use - Maternity	No.	0	0	0
Number of Nightingale wards in use - Other	No.	0	16	0
Total Number of Nightingale Wards in Use	No.	0	32	0
Occupied beds	No.	331	507	117
Beds with Patient Power services	%	80	90	0

Appendix 8a

Age & Asset Profile	Unit	RXK01	RXK02	RXK10
Age Profile - 2005 to present	%	28	13	0
Age Profile - 1995 to 2004	%	0	2	0
Age Profile - 1985 to 1994	%	0	10.5	100
Age Profile - 1975 to 1984	%	48	8	0
Age Profile - 1965 to 1974	%	15	21	0
Age Profile - 1955 to 1964	%	0	8	0
Age Profile - 1948 to 1954	%	0	4	0
Age Profile - pre 1948	%	9	33.5	0
Age Profile - Total (must equal 100)	%	100	100	100
Building Asset Value by Age - 2005 to present	£	23,243,297	30,404,693	0
Building Asset Value by Age - 1995 to 2004	£	0	1,514,773	0
Building Asset Value by Age - 1985 to 1994	£	18,247	9,467,332	12,751,257
Building Asset Value by Age - 1975 to 1984	£	40,192,682	7,573,865	0
Building Asset Value by Age - 1965 to 1974	£	12,627,119	17,419,890	0
Building Asset Value by Age - 1955 to 1964	£	60,824	7,573,865	0
Building Asset Value by Age - 1948 to 1954	£	0	4,544,319	0
Building Asset Value by Age - pre 1948	£	7,682,106	27,265,916	0
Total Building Asset Value	£	83,824,275	105,764,653	12,751,257

Quality of Buildings	Unit	RXK01	RXK02	RXK10
High Risk Backlog Cost	£	95,000	405,000	0
Significant Risk Backlog Cost	£	610,000	2,725,000	0
Moderate Risk Backlog Cost	£	39,342,000	47,488,000	30,000
Low Risk Backlog Cost	£	3,467,082	5,474,340	182,478
Risk Adjusted Backlog Cost	£	2,181,175	4,956,287	7,326

Estate Maintenance	Unit	RXK01	RXK02	RXK10
Building and Engineering maintenance costs	£	844,779	1,921,131	137,522
Grounds and Gardens maintenance costs	£	52,487	102,608	8,829

CHP	Unit	RXK01	RXK02	RXK10
Total CHP units operated on the site	No.	0	1	0
Total Installed Electrical Capacity	KW	0	1,600	0
Total Energy input to the CHP Plant(s)	KWh	0	63,444,000	0
Total thermal energy output of the CHP system for site	KWh	0	50,016,000	0
Total electrical energy output of the CHP system for site	KWh	0	5,700,000	0
Total Exported electricity for site	KWh	0	0	0
Total Exported thermal energy for site	KWh	0	0	0
Total annual financial saving resulting from operation of the CHP unit for site	£	0	0	0

Energy - Utility	Unit	RXK01	RXK02	RXK10
Electricity Consumed	GJ	29,911	15,185	3,799
Gas Consumed	GJ	75,793	222,737	8,205
Oil Consumed	GJ	0	0	0
Coal Consumed	GJ	0	0	0
Total Energy Cost (all energy supplies, utility, local & renewable)	£	1,044,969	1,416,684	130,488
Electricity Cost	£	606,667	345,371	82,094
Gas Cost	£	438,302	1,071,313	48,394
Oil Cost	£	0	0	0
Coal Cost	£	0	0	0

Appendix 8a

Energy - Local	Unit	RXK01	RXK02	RXK10
Electricity Consumed	GJ	0	0	0
Steam Consumed	GJ	0	0	0
Hot Water Consumed	GJ	0	0	0
Electricity Cost	£	0	0	0
Steam Cost	£	0	0	0
Hot Water Cost	£	0	0	0

Renewable Energy	Unit	RXK01	RXK02	RXK10
Electricity Consumed	GJ	15,070	10,667	1,955
Non-fossil fuel Consumed	GJ	0	0	0
Electricity Cost	£	305,653	227,735	42,466
Non-fossil fuel Cost	£	0	0	0

Process Energy	Unit	RXK01	RXK02	RXK10
Electrical Energy used in centralised Processing Units	GJ	0	1,204	0
Fossil Energy used in centralised Processing Units	GJ	0	12,583	0

Energy Normalisation	Unit	RXK01	RXK02	RXK10
Energy Days	No.	328.5	328.5	319
Degree Days (18.5 °C)	No.	3,055	3,055	3,055
Site Base Load	GJ	3,125	10,545	229

Water Services	Unit	RXK01	RXK02	RXK10
Water volume (including Borehole)	m^3	85,046	193,748	5,685
Water Cost	£	68,080	129,093	5,019
Water Volume (Borehole)	m^3	0	0	0
Sewage Volume	m^3	82,435	168,082	5,308
Sewage Cost	£	63,455	130,244	4,744
Water and sewage cost for non metered premises	£	0	0	0
Surface water highways and drainage charges	£	30,938	43,376	14,964

Waste	Unit	RXK01	RXK02	RXK10
High Temperature Disposal Waste Weight	Tonnes	416.29	638	34
High Temperature Disposal Waste Cost	£	141,746	214,350	9,392
Total Waste Cost	£	192,789	263,032	17,074
Non Burn Treatment (Alternative Treatment Plant) Disposal Waste Weight	Tonnes	0	0	0
Landfill Disposal Waste Weight	Tonnes	955	810	156
Waste Electrical and Electronic Equipment (WEEE) Weight	Tonnes	0	0	0
Waste Electrical and Electronic Equipment (WEEE) Cost	£	0	0	0
Waste recovery/recycling volume	%	0	5	0
Waste recovery/recycling cost	%	0	0	0
Landfill Disposal Waste Cost	£	51,073	48,682	7,682
Non Burn Treatment (Alternative Treatment Plant) Disposal Waste Cost	£	0	0	0

Fire Safety	Unit	RXK01	RXK02	RXK10
Fires reported	No.	2	5	0
False alarms	No.	38	118	2

Car Parking	Unit	RXK01	RXK02	RXK10
Total parking spaces available	No.	1,077	1,838	110
Average fee charged per hour for patient/visitor parking	£	1	1	0.08
Total disabled parking spaces	No.	49	102	6
Total parking spaces available for patients/visitors	No.	265	431	50
Average fee charged per hour for Staff parking	£	0.06	0.06	0.03
Total parking spaces available for staff	No.	763	1,305	54
Income from staff	£	111,875	154,495	0
Income from visitors	£	561,771	770,295	11,248

Cleanliness	Unit	RXK01	RXK02	RXK10
Cleaning services costs	£	1,841,608	2,507,804	300,344
Audit score against National Specification of Cleanliness for the NHS	%	94	92	90
Number of cleaning staff	WTE	120	190	34
Cleaning hours	Hrs	130,000	242,000	28,500

Food Services	Unit	RXK01	RXK02	RXK10
Cost of feeding one patient per day (patient meal day)	£	7.12	6.97	4.5
Food waste - untouched meals	%	24	17.5	26
Total patient main meals requested	No.	363,000	438,000	119,355
Meal Service - Main meal in the evening	%	100	100	100
Meal Service - NHS Snack Box on request	%	100	100	100
Meal Service - The ward kitchen service - 24 hours per day	%	100	100	100
Meal Service - 3, or more, leading chef dishes per day	%	100	100	100
Meal Service - The new NHS menu design	%	100	100	100
Meal Service - Snacks twice per day	%	0	0	100
Protected Mealtimes	%	0	0	100
Nutritional Analysis of Menus	Yes/No/None	Yes	Yes	Yes
Gross cost of catering operations	£	1,704,811	1,844,140	288,602
Net cost of catering operations	£	1,148,996	1,270,530	214,832
Gross cost of patient services	£	968,348	837,622	201,314
Gross cost of non-patient activity	£	740,825	748,321	88,912
Labour costs	£	1,042,543	929,423	165,131
Catering Management labour costs	£	138,024	134,650	13,788
Patient services labour costs	£	641,675	299,703	131,338
Non-patient services labour costs	£	343,675	370,720	33,793
Patient provisions cost	£	307,157	486,816	57,887
Non-pay costs - Non patient trading activity	£	423,314	377,601	55,119
Income - Non patient trading activity	£	555,815	573,610	73,770
Net trading balance - non patient trading activity	£	-61,486	-284,716	-9,142
Income from commercial businesses	£	0	0	0
Type of service - Cook chill plated	%	0	0	0
Type of service - Cook chill bulk	%	0	100	0
Type of service - Conventional plated	%	0	0	0
Type of service - Conventional bulk	%	100	0	100
Type of service - Cook freeze plated	%	0	0	0
Type of service - Cook freeze bulk	%	0	0	0
Type of service - Other	%	0	0	0
Type of service - Total (must equal 100%)	%	100	100	100
Costed Menus	Yes/No/None	Yes	Yes	Yes

Laundry & Linen	Unit	RXK01	RXK02	RXK10
Laundry and Linen cost	£	309,595	486,280	35,331
Pieces per annum	No.	930,605	1,882,440	138,950
Returned to laundry	%	10	10	10
Type of service - Linen Hire	%	99	99	99
Type of service - Disposable	%	0	0	0
Type of service - Wash and Squash	%	0	0	0
Type of service - Other	%	1	1	1
Type of service - Total (must equal 100%)	%	100	100	100
Located on site	Yes/No	N	N	N
Number of Laundry and Linen Staff	WTE	0	0	0

Portering Services	Unit	RXK01	RXK02	RXK10
Portering service cost	£	664,300	1,093,133	93,420
Number of Porters	WTE	35	51	6

Postal Services	Unit	RXK01	RXK02	RXK10
Postal service costs	£	215,570	199,000	24,323
Number of Postal staff	WTE	3.4	4	0.5

Appendix 8b

Trust Name	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
Trust Code	RXK
Trust Type	LARGE ACUTE OUTSIDE LONDON
Strategic Health Authority	WEST MIDLANDS STRATEGIC HEALTH AUTHORITY
Reporting Year	2007/2008
Trust Performance Indicator Report	Printed 11/08/2008

Trust Profile	**Unit**	**Value**
Occupied Beds per Available Beds	%	87.94
Available Beds per Ward	Beds per Ward	20.49
Total In-patient Days	Bed Days	348,575

Contracted Out Service	**Unit**	**Value**
Contracted Out Services per Occupied Floor Area	£/m²	10.85

Finance	**Unit**	**Value**
Total Estates and Facilities Management Costs per Occupied Floor Area	£/m²	348.5
Income from Leases per Leased Out Floor Area	£/m²	24.98
Cost of Leases per Leased In Floor Area	£/m²	XXXX
Total Capital Investment per Occupied Floor Area	£/m²	80.2
Estates Services Cost per Total Estates and Facilities Cost	%	69.06

Staff	**Unit**	**Value**
Estates WTE Staff per Total Trust WTE Staff	%	1.71
FM Services WTE Staff per Total WTE Staff	%	13.09
Total Estates and FM Services Staff per Total WTE Staff	%	14.79
Number of Complaints per 10,000 Total Estates and FM Services Staff	No.	403.69
Estates WTE Staff per Total Estates and FM Services WTE Staff	%	11.53

Safety - RIDDOR	**Unit**	**Value**
Number of RIDDOR Incidents per 1,000m² of Occupied Floor Area	No.	0.16
Number of Non-RIDDOR incidents per 1,000m² of Occupied Floor Area	No.	38.11
Total Number of RIDDOR and Non-RIDDOR incidents per WTE Staff	No.	1.08
RIDDOR Incidents per Total Incidents	%	0.43

Telecommunications	Unit	Value
Cost of telecommunication Services per Occupied Floor Area	£/m²	6.33

Transport services	Unit	Value
Patient Journey Cost per Patient Transport Mileage	£/Mile	XXXX

Sterile Services	Unit	Value
Cost of Sterile Services per Occupied Floor Area	£/m²	12.69

Electro Biomedical Equipment	Unit	Value
Cost of EBME per Occupied Floor Area	£/m²	14.76
Cost of EBME per Item Maintained	£/item	173.15

Contract Status	Unit	Value
Total Contract Value of all Out Sourced Services reported below	£	4,131,045
Total Contract Value of all Out Sourced Services reported below per Occupied Floor Area	£/m²	24.99
Total Contract Value of all Out Sourced Services reported below per Total Estates & FM Services Cost	%	7.17

Site Name	Site Code
SANDWELL GENERAL HOSPITAL	RXK01
CITY HOSPITAL	RXK02
ROWLEY REGIS HOSPITAL	RXK10

Areas	Unit	RXK01	RXK02	RXK10
Site Building Footprint per (Land Area*10,000)	%	27.87	32.81	17.64
Occupied Floor Area per Gross Internal Floor Area	%	94.45	91.36	100
Unoccupied Floor Area per Gross Internal Floor Area	%	5.55	8.64	0
Leased In Floor Area per Occupied Floor Area	%	0	0	0
Leased Out Floor Area per Occupied Floor Area	%	0.1	0.94	0
Patient Occupied Area per Occupied Floor Area	%	52.27	57.58	59.05
Non-Patient Occupied Area per Occupied Floor Area	%	34.84	34.68	31.43
Main Circulation Area per Occupied Floor Area	%	12.89	7.73	9.52
Heated Volume per Occupied Floor Area	m	3.09	2.63	2.61

Function and Space	Unit	RXK01	RXK02	RXK10
Occupied Beds per Available Beds	%	86.88	86.96	95.9
Available Beds per Ward	Beds	25.4	17.67	24.4
Floor Area per Available Bed	m²/Bed	163.14	161.91	71.6
% of Specialist Wards to All Wards	%	13.33	36.36	40

Age & Asset Profile	Unit	RXK01	RXK02	RXK10
Total Building Asset Value per GIA	£/m²	1,273.81	1,023.60	1,459.79

Quality of Buildings	Unit	RXK01	RXK02	RXK10
Total Backlog Cost	£	43,514,082	56,092,340	212,478
Total Backlog Cost per Occupied Floor Area	£/m²	700.08	594.24	24.32
Total Risk Adjusted Backlog Cost per Occupied Floor Area	£/m²	35.09	52.51	0.84
% Risk Adjusted Backlog to Total Backlog	%	5.01	8.84	3.45

Estate Maintenance	Unit	RXK01	RXK02	RXK10
Total Building & Engineering Maintenance Cost per Occupied Floor Area	£/m²	13.59	20.35	15.74
Total Grounds & Gardens Maintenance Cost per Land Area	£/Hectare	5,264.49	5,270.06	3,198.91

CHP	Unit	RXK01	RXK02	RXK10
Total Energy output from the CHP Plant(s)	KWh	0	55,716,000	0
Total Energy Output per Total Energy Input	%	XXXX	88	XXXX
Total Exported Energy per Total output energy	%	0	0	0
Financial Saving per Energy Output	£/KWh	0	0	0

Energy - Utility	Unit	RXK01	RXK02	RXK10
Total Site Energy Consumed per Heated Volume	GJ/100m³	62.88	88.99	61.33
Total Electrical Energy Consumed per Occupied Floor Area	GJ/m²	0.72	0.49	0.66
Total Fossil & Renewable Non-Fossil Energy Consumed per Occupied Floor Area	GJ/m²	1.22	2.36	0.94
CO_2 Emission	Tonnes	7,578.95	13,580.18	887.52
CO_2 Emission per Occupied Floor Area	Kg/m²	121.93	143.87	101.61
Total Energy Cost per Occupied Floor Area	£/m²	16.81	15.01	14.94
Total Electrical Energy Cost per Occupied Floor Area	£/m²	14.68	6.07	14.26
Cost per unit of Electricity Consumed	Pence/KWh	7.3	4.45	7.79

Total Fossil & Renewable Non-Fossil Energy Cost per Occupied Floor Area	£/m²	7.05	11.35	5.54
Cost per Unit of Fossil & Renewable Non-Fossil Load	Pence/KWh	2.08	1.73	2.12
Sum of Cost per Unit of Electricity and per Unit of Fossil & Renewable Non-Fossil Load	Pence/KWh	9.38	6.18	9.91
Average cost for all Units of Energy Consumed	Pence/KWh	4.03	2.2	4.46
All Energy Costs per Occupied Floor Area	£/m²	21.73	17.42	19.8

Renewable Energy	**Unit**	**RXK01**	**RXK02**	**RXK10**
Total Renewable Energy Consumption per Occupied Floor Area	GJ/m²	0.24	0.11	0.22
% Renewable Energy to Total Energy Consumption	%	12.48	4.83	14.01
Total Renewable Electrical Energy Cost per Occupied Floor Area	£/m²	4.92	2.41	4.86
Total Renewable (non-fossil fuel) Cost per Occupied Floor Area	£/m²	0	0	0
Total Renewable Energy Cost per Occupied Floor Area	£/m²	4.92	2.41	4.86

Process Energy	**Unit**	**RXK01**	**RXK02**	**RXK10**
Total Process Energy per Occupied Floor Area	GJ/m²	0	0.15	0

Water Services	**Unit**	**RXK01**	**RXK02**	**RXK10**
Water Cost per Total Water Volume	£/m³	0.8	0.67	0.88
Water cost per Occupied Floor Area	£/m²	1.1	1.37	0.57
Water Vol(Borehole) per Total Water Vol	%	0	0	0
Water Vol per Occupied Floor Area	m³/m²	1.37	2.05	0.65
Total Water Vol per Occupied Bed	Ltrs/Bed/day	703.94	1,046.98	133.12
Sewage Cost per Total Sewage Volume	£/m³	0.77	0.77	0.89
Sewage Cost per Occupied Floor Area	£/m²	1.02	1.38	0.54
Sewage Vol per Total Water Vol	%	96.93	86.75	93.37
Sewage Vol per Occupied Floor Area	m³/m²	1.33	1.78	0.61
Total Water & Sewage Cost per Occupied Floor Area	£/m²	2.12	2.75	1.12
Total Water & Sewage Cost per Total Water & Sewage Volume	£/m³	0.79	0.72	0.89
Total Water & Sewage Volume per Occupied Floor Area	m³/m²	2.69	3.83	1.26

Waste	**Unit**	**RXK01**	**RXK02**	**RXK10**
High Temperature Waste Cost per Tonne	£/tonne	340.5	335.97	276.24
Non Burn Treatment Waste Cost per Tonne	£/tonne	XXXX	XXXX	XXXX
Landfill Waste Cost per Tonne	£/tonne	53.48	60.1	49.24

Cost of High Temperature Waste per Occupied Floor Area	£/m²	2.28	2.27	1.08
Cost of Non Burn Treatment Waste per Occupied Floor Area	£/m²	0	0	0
Cost of Landfill Waste per Occupied Floor Area	£/m²	0.82	0.52	0.88
Cost of Waste Electrical and Electronic Equipment (WEEE) per Occupied Floor Area	£/m²	XXXX	XXXX	XXXX
Cost of Waste Electrical and Electronic Equipment (WEEE) per Tonne	£/tonne	XXXX	XXXX	XXXX
Total Cost of Waste (high temperature, non burn, landfill & WEEE) per Occupied Floor Area	£/m²	3.1	2.79	1.95
Total Waste Volume (high temperature, non burn, landfill & WEEE) per Occupied Floor Area	Kg/m²	22.06	15.34	21.75

Fire Safety	**Unit**	**RXK01**	**RXK02**	**RXK10**
False Alarms per Number of Fires Reported	No.	19	23.6	0
Fires reported per 1,000m² of Occupied Floor Area	No./1,000m²	0.03	0.05	0

Car Parking	**Unit**	**RXK01**	**RXK02**	**RXK10**
Disabled Car Parking per Total Car Parking	%	4.55	5.55	5.45
Annual Income from Staff per Total Staff Car Parking Spaces	£/space	146.63	118.39	0
Annual Income from Visitors per Total Patient/Visitor Car Parking Spaces	£/space	2,119.89	1,787.23	224.96
Total Annual Income from Car Parking per Total Car Parking Spaces	£/space	625.48	503.15	102.25
Total Car Parking Spaces per Available Bed	No./Bed	2.83	3.15	0.9

Cleanliness	**Unit**	**RXK01**	**RXK02**	**RXK10**
Total Cost of Cleaning per Occupied Floor Area	£/m²	29.63	26.57	34.38
Total Cost of Cleaning per WTE	£/WTE	15,346.73	13,198.97	8,833.65
Number of Cleaning Hours per WTE	Hrs/WTE	1,083.33	1,273.68	838.24

Food Services	**Unit**	**RXK01**	**RXK02**	**RXK10**
Gross Cost of Catering Operations per Occupied Floor Area	£/m²	27.43	19.54	33.04
Net Cost of Catering Operations per Gross Cost of Catering Operations	%	67.4	68.9	74.44
Gross Cost of Patient Services per Occupied Floor Area	£/m²	15.58	8.87	23.05

Gross Cost of Patient Services per Main meals requested	£/meal	2.67	1.91	1.69
Gross Cost of Non-Patient Activity per Occupied Floor Area	£/m²	11.92	7.93	10.18
Total Income from Commercial & Non-Patient Activity per Gross Catering Cost	%	32.6	31.1	25.56

Laundry & Linen	**Unit**	**RXK01**	**RXK02**	**RXK10**
Cost of Laundry and Linen Services per Occupied Floor Area	£/m²	4.98	5.15	4.04
Cost of Laundry and Linen Services per Item	£/item	0.33	0.26	0.25
Laundry & Linen Items per WTE staff	No/WTE	XXXX	XXXX	XXXX

Portering Services	**Unit**	**RXK01**	**RXK02**	**RXK10**
Total Cost of Portering Services per Occupied Floor Area	£/m²	10.69	11.58	10.69
Total Cost of Portering Services per WTE	£/WTE	18,980	21,433.98	15,570
Occupied Floor Area per WTE	m²/WTE	1,775.89	1,850.86	1,455.83

Postal Services	**Unit**	**RXK01**	**RXK02**	**RXK10**
Total Cost of Postal Services per Occupied Floor Area	£/m²	3.47	2.11	2.78
Total Cost of Postal Services per WTE	£/WTE	63,402.94	49,750	48,646
Occupied Floor Area per WTE	m²/WTE	18,281.18	23,598.50	17,470

Performance Indicator Median Report
Organisation Type : LARGE ACUTE OUTSIDE LONDON, Foundation Status: All
Year: 2007/2008
Date Generated: 04/07/2008 09:06:52

Trust Profile	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Occupied Beds per Available Beds	%	78.71	82.87	87.97	87.94	36
Available Beds per Ward	Beds per Ward	17.63	19.69	22.18	20.49	39
Total In-patient Days	Bed Days	252,945	316,820	374,581	348,575	36

Contracted Out Service	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Contracted Out Services per Occupied Floor Area	£/m²	4.47	29.78	64.26	10.85	36

Finance	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Total Estates and Facilities Management Costs per Occupied Floor Area	£/m²	162.21	195.71	276.34		37
Income from Leases per Leased Out Floor Area	£/m²	26.15	74.47	162.08	24.98	23
Cost of Leases per Leased In Floor Area	£/m²	29.17	72.28	160.53	0.00	19
Total Capital Investment per Occupied Floor Area	£/m²	37.43	70.99	119.71	80.20	38
Estates Services Cost per Total Estates and Facilities Cost	%	30.75	41.78	58.43	69.06	37

Staff	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Estates WTE Staff per Total Trust WTE Staff	%	1.42	1.88	2.09	1.71	33
FM Services WTE Staff per Total WTE Staff	%	8.56	10.24	11.19	13.09	33
Total Estates and FM Services Staff per Total WTE Staff	%	9.98	11.84	13.07	14.79	33
Number of Complaints per 10,000 Total Estates and FM Services Staff	No.	176.07	342.92	623.71	403.69	32
Estates WTE Staff per Total Estates and FM Services WTE Staff	%	13.27	15.83	20.98	11.53	34

Safety - RIDDOR	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Number of RIDDOR Incidents per 1,000m² of Occupied Floor Area	No.	0.19	0.31	0.43	0.16	36
Number of Non-RIDDOR incidents per 1,000m² of Occupied Floor Area	No.	14.24	34.30	52.36	38.11	36
Total Number of RIDDOR and Non-RIDDOR incidents per WTE Staff	No.	0.47	0.92	1.43	1.08	33
RIDDOR Incidents per Total Incidents	%	0.56	0.97	2.15	0.43	36

Telecommunications	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Cost of telecommunication Services per Occupied Floor Area	£/m²	5.22	6.37	7.47	6.33	30

Transport services	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample

Patient Journey Cost per Patient Transport Mileage	£/Mile	0.00	0.00	0.00	0.00	0

Sterile Services	**Unit**	**Lower Quartile**	**Median**	**Upper Quartile**	**SWBH**	**No. in Sample**
Cost of Sterile Services per Occupied Floor Area	£/m²	8.41	11.21	15.05	12.69	29

Electro Biomedical Equipment	**Unit**	**Lower Quartile**	**Median**	**Upper Quartile**	**SWBH**	**No. in Sample**
Cost of EBME per Occupied Floor Area	£/m²	10.74	14.35	16.14	14.76	29
Cost of EBME per Item Maintained	£/item	136.85	188.26	224.61	173.15	29

Contract Status	**Unit**	**Lower Quartile**	**Median**	**Upper Quartile**	**SWBH**	**No. in Sample**
Total Contract Value of all Out Sourced Services reported below	£	1,803,771.00	4,131,045.00	10,228,599.00	4,131,045.00	25
Total Contract Value of all Out Sourced Services reported below per Occupied Floor Area	£/m²	15.25	25.17	76.33	24.99	25
Total Contract Value of all Out Sourced Services reported below per Total Estates & FM Services Cost	%	6.49	17.68	31.81	7.17	24

Areas	**Unit**	**Lower Quartile**	**Median**	**Upper Quartile**	**SWBH**	**No. in Sample**
NHS estate Occupied Floor Area	%	95.70	99.91	100.00	100.00	39
Site Building Footprint per (Land Area*10,000)	%	18.47	21.20	24.70	26.06	39
Occupied Floor Area per Gross Internal Floor Area	%	94.37	96.89	99.34	92.93	39
Unoccupied Floor Area per Gross Internal Floor Area	%	0.00	1.83	4.97	7.07	36
Leased In Floor Area per Occupied Floor Area	%	0.00	2.36	11.75	0.00	35
Leased Out Floor Area per Occupied Floor Area	%	0.62	1.86	6.37	0.57	35
Patient Occupied Area per Occupied Floor Area	%	50.04	51.88	57.13	55.66	37
Non-Patient Occupied Area per Occupied Floor Area	%	35.47	38.96	41.77	34.57	37
Main Circulation Area per Occupied Floor Area	%	5.21	6.36	9.08	9.76	35
Heated Volume per Occupied Floor Area	m	2.53	2.72	2.98	2.80	39

Function and Space	**Unit**	**Lower Quartile**	**Median**	**Upper Quartile**	**SWBH**	**No. in Sample**
Occupied Beds per Available Beds	%	78.71	82.87	87.97	87.93	36
Available Beds per Ward	Beds	17.63	19.69	22.18	29.35	39
Floor Area per Available Bed	m²/Bed	116.58	126.21	139.87	152.19	39
% of Specialist Wards to All Wards	%	14.40	18.67	22.34	43.24	39

Age & Asset Profile	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Total Building Asset Value per GIA	£/m²	726.29	1,003.46	1,123.35	1,137.58	36

Quality of Buildings	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Risk Adjusted Backlog Cost	£	1,379,182.75	5,119,640.50	16,247,074.50	7,144,788.00	38
Total Backlog Cost	£	5,308,423.25	16,798,371.00	34,361,984.00		38
Total Backlog Cost per Occupied Floor Area	£/m²	47.83	111.04	249.89	603.91	38
Total Risk Adjusted Backlog Cost per Occupied Floor Area	£/m²	8.43	36.52	99.84	43.22	38
% Risk Adjusted Backlog to Total Backlog	%	16.60	32.29	50.25	7.15	38

Estate Maintenance	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Total Building & Engineering Maintenance Cost per Occupied Floor Area	£/m²	18.83	24.49	29.27		39
Total Grounds & Gardens Maintenance Cost per Land Area	£/Hectare	2,260.42	3,461.98	5,287.96	5,090.80	39

CHP	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Total Energy output from the CHP Plant(s)	KWh	897,388.50	5,857,242.00	13,882,753.25		18
Total Energy Output per Total Energy Input	%	43.28	69.52	76.47	87.82	18
Total Exported Energy per Total output energy	%	0.00	0.00	0.00	0.00	18
Financial Saving per Energy Output	£/KWh	0.000	0.000	0.001	0.000	18

Energy - Utility	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Total Site Energy Consumed per Heated Volume	GJ/100m³	61.42	69.30	81.40	76.82	39
Total Electrical Energy Consumed per Occupied Floor Area	GJ/m²	0.51	0.58	0.66	0.30	39
Total Fossil & Renewable Non-Fossil Energy Consumed per Occupied Floor Area	GJ/m²	1.23	1.38	1.68	1.85	39
CO_2 Emission	Tonnes	15,129.89	17,541.35	22,152.27	22,045.00	39
CO_2 Emission per Occupied Floor Area	Kg/m²	128.71	135.07	149.06	133.37	39
Total Energy Cost per Occupied Floor Area	£/m²	15.75	17.12	19.60	15.68	39
Total Electrical Energy Cost per Occupied Floor Area	£/m²	8.16	9.62	11.89	6.25	35
Cost per unit of Electricity Consumed	Pence/KWh	5.19	6.40	6.81	7.61	35
Total Fossil & Renewable Non-Fossil Energy Cost per Occupied Floor Area	£/m²	6.62	7.72	9.05	9.42	34
Cost per Unit of Fossil & Renewable Non-Fossil Load	Pence/KWh	1.79	2.00	2.22	1.91	34
Sum of Cost per Unit of Electricity and per Unit of Fossil & Renewable Non-Fossil Load	Pence/KWh	7.35	8.32	8.93	9.52	34
Average cost for all Units of Energy Consumed	Pence/KWh	2.55	3.11	3.64	3.11	34
All Energy Costs per Occupied Floor Area	£/m²	15.92	17.11	19.79	15.68	34

Source: ERIC 2007/2008 MedianReport

Renewable Energy	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Total Renewable Energy Consumption per Occupied Floor Area	GJ/m²	0.00	0.00	0.00	0.16	39
% Renewable Energy to Total Energy Consumption	%	0.00	0.00	336.33	7.70	39
Total Renewable Electrical Energy Cost per Occupied Floor Area	£/m²	0.00	0.00	0.80	3.48	38
Total Renewable (non-fossil fuel) Cost per Occupied Floor Area	£/m²	0.00	0.00	0.00	0.00	38
Total Renewable Energy Cost per Occupied Floor Area	£/m²	0.00	0.00	1.07	3.48	38

Process Energy	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Total Process Energy per Occupied Floor Area	GJ/m²	0.00	0.03	0.10	0.00	33

Water Services	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Water Cost per Total Water Volume	£/m³	0.70	0.80	1.08	0.71	39
Water cost per Occupied Floor Area	£/m²	1.12	1.38	1.77	1.22	39
Water Vol(Borehole) per Total Water Vol	%	0.00	0.00	0.00	0.00	37
Water Vol per Occupied Floor Area	m³/m²	1.48	1.68	1.96	1.73	39
Total Water Vol per Occupied Bed	Ltrs/Bed/day	638.24	745.84	819.61	818.68	35
Sewage Cost per Total Sewage Volume	£/m³	0.79	0.88	1.24	0.77	36
Sewage Cost per Occupied Floor Area	£/m²	1.22	1.34	1.62	1.20	36
Sewage Vol per Total Water Vol	%	82.33	88.83	100.00	89.64	36
Sewage Vol per Occupied Floor Area	m³/m²	1.34	1.47	1.78	1.54	36
Total Water & Sewage Cost per Occupied Floor Area	£/m²	2.21	2.78	3.27	2.42	36
Total Water & Sewage Cost per Total Water & Sewage Volume	£/m³	0.74	0.91	1.07	0.82	36
Total Water & Sewage Volume per Occupied Floor Area	m³/m²	2.76	3.18	3.60	2.92	36

Waste	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
High Temperature Waste Cost per Tonne	£/tonne	335.84	454.12	571.52	335.92	37
Non Burn Treatment Waste Cost per Tonne	£/tonne	271.01	327.34	363.00	0.00	21
Landfill Waste Cost per Tonne	£/tonne	60.38	85.62	100.09	55.92	34
Cost of High Temperature Waste per Occupied Floor Area	£/m²	0.42	1.37	2.43	2.21	39
Cost of Non Burn Treatment Waste per Occupied Floor Area	£/m²	0.00	0.52	1.58	0.00	35
Cost of Landfill Waste per Occupied Floor Area	£/m²	0.41	0.60	0.81	0.65	36
Cost of Waste Electrical and Electronic Equipment (WEEE) per Occupied Floor Area	£/m²	0.00	0.00	0.00	0.00	0
Cost of Waste Electrical and Electronic Equipment (WEEE) per Tonne	£/tonne	0.00	0.00	0.00	0.00	0
Total Cost of Waste (high temperature, non burn, landfill & WEEE) per Occupied Floor Area	£/m²	2.42	3.08	3.43	2.86	35
Total Waste Volume (high temperature, non burn, landfill & WEEE) per Occupied Floor Area	Kg/m²	12.76	14.39	17.29	18.20	35

Source: ERIC 2007/2008 MedianReport

Fire Safety	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
False Alarms per Number of Fires Reported	No.	4.72	23.59	44.75	22.57	36
Fires reported per 1,000m² of Occupied Floor Area	No./1,000m²	0.01	0.02	0.04	0.04	36

Car Parking	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Disabled Car Parking per Total Car Parking	%	3.84	4.43	5.19	5.19	35
Annual Income from Staff per Total Staff Car Parking Spaces	£/space	0.00	120.66	152.31	139.12	32
Annual Income from Visitors per Total Patient/Visitor Car Parking Spaces	£/space	308.17	843.19	1,217.01	1,800.69	32
Total Annual Income from Car Parking per Total Car Parking Spaces	£/space	260.26	384.31	517.88	583.19	31
Total Car Parking Spaces per Available Bed	No./Bed	2.06	2.41	2.68	2.78	35

Cleanliness	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Total Cost of Cleaning per Occupied Floor Area	£/m²	24.19	29.73	33.56	28.13	39
Total Cost of Cleaning per WTE	£/WTE	13,509.97	17,575.16	20,218.79	13,516.73	35
Number of Cleaning Hours per WTE	Hrs/WTE	1,221.39	1,766.74	1,949.08	1,164.24	32

Food Services	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Gross Cost of Catering Operations per Occupied Floor Area	£/m²	24.78	27.85	34.07	23.21	33
Net Cost of Catering Operations per Gross Cost of Catering Operations	%	62.94	71.41	78.78	68.64	30
Gross Cost of Patient Services per Occupied Floor Area	£/m²	12.07	18.44	23.41	12.14	32
Gross Cost of Patient Services per Main meals requested	£/meal	2.00	2.59	3.00	2.18	30
Gross Cost of Non-Patient Activity per Occupied Floor Area	£/m²	6.42	7.82	12.26	9.54	32
Total Income from Commercial & Non-Patient Activity per Gross Catering Cost	%	14.79	27.15	34.52	31.35	28

Laundry & Linen	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Cost of Laundry and Linen Services per Occupied Floor Area	£/m²	6.25	7.41	9.66	5.02	36
Cost of Laundry and Linen Services per Item	£/item	0.26	0.30	0.37	0.28	36
Laundry & Linen Items per WTE staff	No/WTE	0.00	0.00	0.00	0.00	0

Portering Services	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Total Cost of Portering Services per Occupied Floor Area	£/m²	11.63	14.55	17.17	11.19	34
Total Cost of Portering Services per WTE	£/WTE	20,145.11	21,552.93	23,413.51	20,117.96	34
Occupied Floor Area per WTE	m²/WTE	1,232.87	1,497.16	1,702.30	1,796.57	34

Source: ERIC 2007/2008 MedianReport

Postal Services	Unit	Lower Quartile	Median	Upper Quartile	SWBH	No. in Sample
Total Cost of Postal Services per Occupied Floor Area	£/m²	2.27	2.64	3.09	2.65	34
Total Cost of Postal Services per WTE	£/WTE	44,583.38	63,476.67	72,784.06	55,556.07	33
Occupied Floor Area per WTE	m²/WTE	18,367.58	21,085.20	26,651.31	20,922.15	33

Number of trusts: 40

Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 9

Trust High Level Performance Indicators for 2006/07

TRUST HIGH LEVEL

PERFORMANCE INDICATORS

Estate Strategic Performance Indicators

Overview

We all recognise that the National Health Service is a very complex organisation with a high political profile. The estate and capital investment are essential to the provision of health and health services, and to delivering a modern NHS, fit for the 21st Century. To this end, our overall strategy is to secure buildings and equipment that are in the right place, in the right condition, of the right type and which will be able to respond to the complex and uncertain future needs of the Service.

Why?

Revenue expenditure on the infrastructure of land, buildings and equipment is 20% of the NHS's running costs. The NHS estate is the largest and one of the most complex property portfolios in Europe. It contains a range of buildings, from the most modern hospitals and primary care facilities, located and designed specifically to meet the demands of modern and future health care, to hospitals that can trace their roots back hundreds of years and which require considerable investment or radical reshaping or relocation to make them appropriate for the modern day. Health is a major part of the social infrastructure, and decisions on health must be taken in the context of a wide range of the Government's work, including social services, housing, the environment, transport and regional development. In 1991, Crown immunity was lifted, adding an additional imperative to the need to ensure that the estate met Health & Safety, and Fire Regulations.

What?

Current use value of NHS assets is around £34bn although it would cost significantly more to replace these assets with good, modern facilities. Considerable resources will be required to procure, operate and dispose of our infrastructure to develop a modern and dependable NHS. In support of this, capital funding made available to the NHS is rising to historic levels to enable the delivery of a very large building programme over the forthcoming years.

How?

These PIs allow informed judgement on the efficiency and condition of the estate. All are based on indicators that are expressed as ratios of a trust's building and land areas. A simple traffic light exercise classifies performance management information into three categories: green – no or very limited problems, amber – some problems, red – serious concerns.

The use of radar capacity charts using Performance Indicators demonstrates the potential for a trust to improve its asset management against similar organisations and the national average for its cluster. They also assist trusts, Health Authorities, and Regional Offices to compare high level performance and will provide a basis for identifying potential areas for improvement as well as role models.

The generic trust used in the following example has been grouped with others using the Department of Health's, basic level clustering, ie: Acute, Teaching, Multi-Service, Community, PCT, Ambulance etc., so that comparisons are of like organisations.

Table of Trust Performance

The Trust is generally using floor space efficiently, because its income, activity levels and asset values are all good.

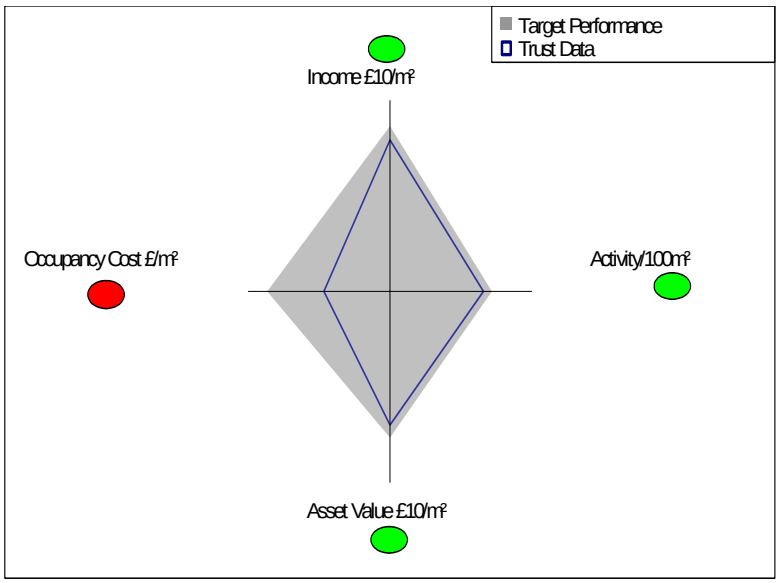
However, the PIs suggest an estate which may be near the end of its designed life and possibly in need of rationalisation to achieve a more modern and functionally suitable estate. There are also strong indications that the quality of this estate is generally below acceptable standards.

It is not possible to deduce strong messages from some of these PIs, and therefore it will be necessary to use local knowledge and interpretation to fully understand the data.

			Grouping PI (Percentile Bands)		
PI SUMMARY	**Trust PI**		**33%**	**34%**	**33%**
Space Efficiency					
Income £10/m²	119		89	90 and 106	107
Activity/100m²	99		61	62 and 73	74
Asset Value £10/m²	105		77	78 and 90	91
Occupancy Cost £/m²	70		115	116 and 130	131
Asset Productivity					
Asset Value £10/m²	105		77	78 and 90	91
Capital Charges £/m²	39		82	83 and 94	95
Total Backlog £/m²	200		47	48 and 128	129
Rent & Rates £/10m²	73		86	87 and 114	115
Asset Deployment					
Land £/m²	100		70	71 and 121	122
Building £10/m²	85		60	61 and 71	72
Equipment £/m²	99		61	62 and 87	88
Capital Charges £/m²	39		82	83 and 94	95
Estate Quality					
Asset Value £10/m²	105		77	78 and 90	91
Depreciation £/m²	11		36	37 and 42	43
Critical Backlog £/m²	100		31	32 and 98	99
Risk Adjusted Backlog £/m²	140		75	76 and 226	227
Cost of Occupancy					
Rent & Rates £/10m²	73		86	87 and 114	115
Energy/Utility £/10m²	64		74	75 and 86	87
Maintenance Costs £/10m²	144		136	137 and 163	164
Capital Charges £/m²	39		82	83 and 94	95

Space Efficiency

Aim: To relate the estate and its annual occupancy cost to the output of the Trust.



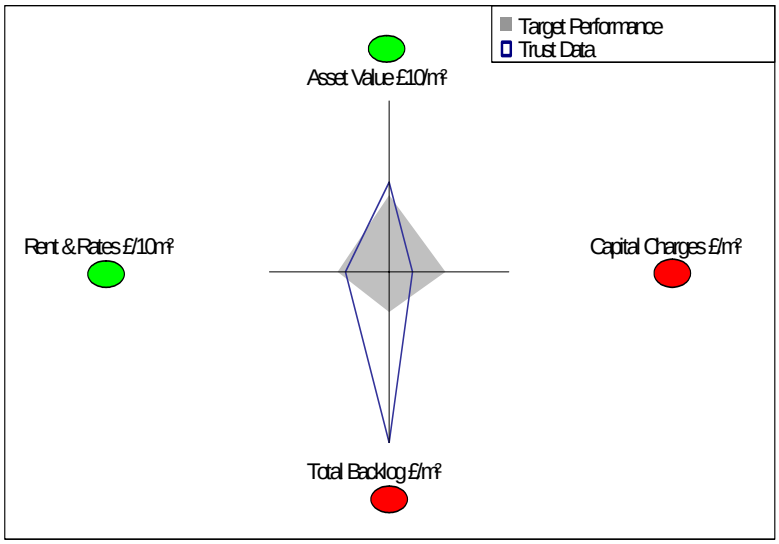
Income £10/m2
Activity/100m2
Asset Value £10/m2
Occupancy Cost £/m2

This PI indicates that the Trust is generally using floor space efficiently, because its income, activity levels and asset values are all good, relative to the gross internal floor area, when compared with similar NHS Trusts.

There is however a concern that the Trust is not investing sufficient in occupancy costs, which, if not reviewed, may lead to increasing financial pressures in future years (for example from backlog maintenance expenditure requirements or lack of capital for reinvestment from capital charges).

Asset Productivity

Aim: To demonstrate the actual cost of owning/renting assets.



Asset Value £10/m2
Capital Charges £/m2
Total Backlog £/m2
Rent & Rates £/10m2

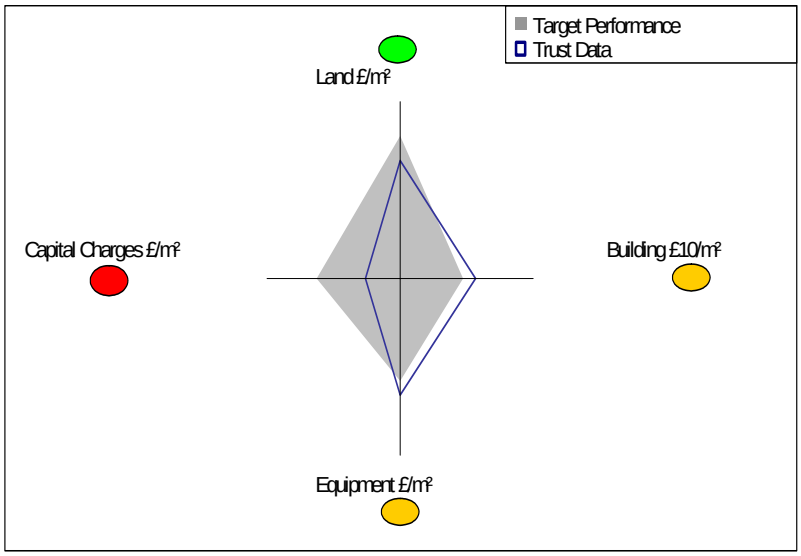
This PI suggests that the Trust needs to improve its performance with respect to capital charges and backlog. It should aim to increase spending on capital charges, possibly by rationalisation, to achieve a more modern and functionally suitable estate. Similarly, their

backlog PI, which is relatively high, suggests an estate which may be near the end of its designed life with an increasing number of backlog failure and replacement pressures. While rent and rates figures are relatively low, this could also be a reflection of an older estate, which may be less appropriate for the provision of modern healthcare.

Despite the PI comments noted above, there is also a suggestion in these PIs that the value of the Trust's assets is high when compared with the rest of the cluster group.

Asset Deployment

Aim: To compare the makeup of the asset base.



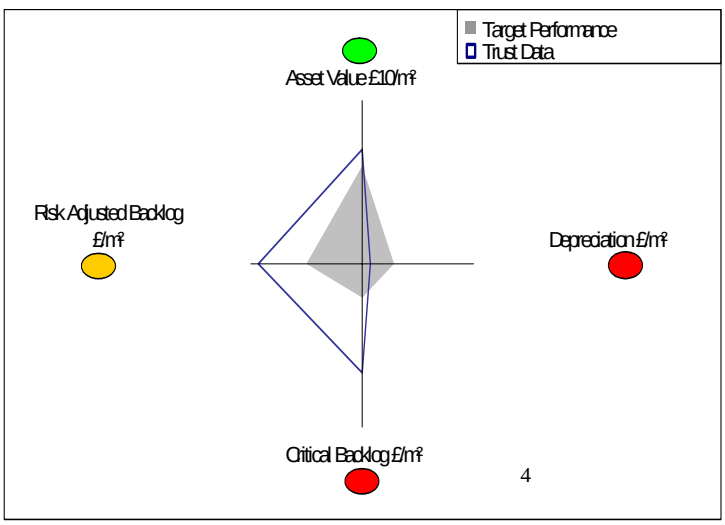
Land £/m2
Building £10/m2
Equipment £/m2
Capital Charges £/m2

These PIs suggest that the Trust utilises an 'average' quantity of land for its needs, but the value of its buildings and equipment are generally higher than the cluster group. The reason for this is not immediately clear and requires local knowledge and interpretation.

The capital charges PI suggests that the Trust needs to improve its performance. They should aim to increase spending on capital charges possibly by rationalising their estate to achieve a more modern and functionally suitable estate.

Estate Quality

Aim: To give a balanced view of the overall condition of the estate relative to value and age.

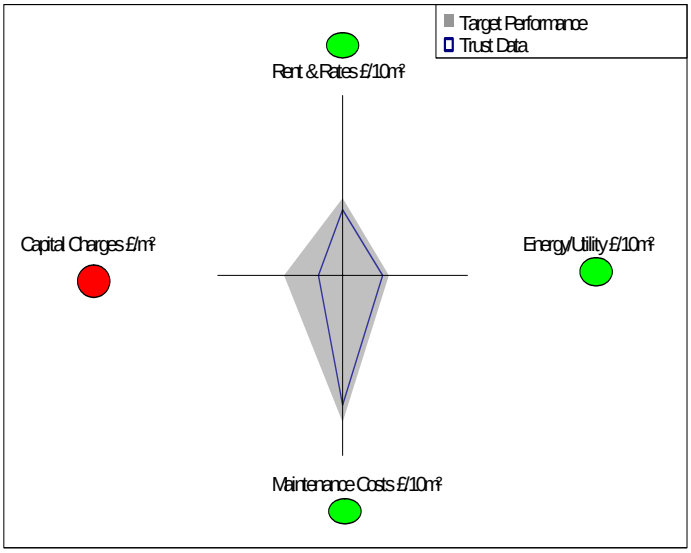


Asset Value £10/m2
Depreciation £/m2
Critical Backlog £/m2
Risk Adjusted Backlog £/m2

The poor critical backlog position (high and significant risk backlog) indicates urgent attention and investment is necessary to avoid serious risk to patient safety and business continuity. This is also reflected in the relatively poor risk adjusted backlog performance figures. Low asset values and depreciation costs suggest this is a relatively old estate which has suffered from long term underinvestment and is now in need of priority refurbishment/replacement.

Cost of Occupancy

Aim: To identify the profile of occupancy costs (revenue).



Rent & Rates £/10m2
Energy & Utility Costs £/10m2
Maintenance Costs £/10m2
Capital Charges £/m2

The PIs for maintenance, energy and utilities suggest that the Trust is performing well. However, in context of the high backlog maintenance costs the Trust's it would be recommended that spending on maintenance should be increased so as to minimise the risk of backlog maintenance expenditure worsening in future years.

The capital charges PI suggests that the Trust needs to improve its performance. They should aim to increase spending on capital charges possibly by rationalisation to achieve a more modern and functionally suitable estate. Similarly, while their rent and rates figures are relatively low, this could also be a reflection of an older estate, which may be less appropriate for the provision of modern healthcare.

Annex 1

Definition of Terms

Income	Total income for the Trust
Activity	Finished Consultant Episodes
Capital Charges	Capital Charges for the Trust
Rent & Rates	Rent & Rates for the Trust
Maintenance Costs	Engineering, Building and Ground Works costs
Energy & Utility Costs	Energy & Utility costs (including water & sewage)
Occupancy Costs	Capital Charges + Rent & Rates + Maintenance Costs + Energy & Utility Costs
Critical Backlog	Cost to eradicate High and Significant Risk Backlog maintenance costs.
Risk Adjusted Backlog	Total backlog cost adjusted to account for risk in accordance with the document "A risk based methodology for establishing and managing backlog".
Total Backlog	Cost to eradicate all high, significant, moderate and low risk backlog and achieve acceptable condition A or B standards.
Land Value	Land asset value
Building Value	Building asset value
Equipment Value	Equipment asset value
Asset Value	Total Land, Building and Equipment asset value

TRUST HIGH LEVEL PERFORMANCE INDICATORS
2006/2007 DATA

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - 2006/2007

			Grouping PI (Percentile Bands)		
PI SUMMARY	**Trust PI**		**33%**	**34%**	**33%**
Space Efficiency					
Income £10/m²	198		189	190 and 213	214
Activity/100m²	4		83	84 and 94	95
Asset Value £10/m²	156		129	130 and 156	157
Occupancy Cost £/m²	210		147	148 and 195	196
Asset Productivity					
Asset Value £10/m²	156		129	130 and 156	157
Capital Charges £/m²	143		95	96 and 127	128
Total Backlog £/m²	373		62	63 and 192	193
Rent & Rates £/10m²	326		103	104 and 150	151
Asset Deployment					
Land £/m²	193		223	224 and 352	353
Building £10/m²	120		89	90 and 104	105
Equipment £/m²	161		133	134 and 170	171
Capital Charges £/m²	143		95	96 and 127	128
Estate Quality					
Asset Value £10/m²	156		129	130 and 156	157
Depreciation £/m²	89		55	56 and 78	79
Critical Backlog £/m²	55		17	18 and 46	47
Risk Adjusted Backlog £/m²	66		17	18 and 63	64
Cost of Occupancy					
Rent & Rates £/10m²	326		103	104 and 150	151
Energy/Utility £/10m²	159		177	178 and 203	204
Maintenance Costs £/10m²	190		210	211 and 257	258
Capital Charges £/m²	143		95	96 and 127	128

Groupings:
Trust Cluster & Type: Basic - Large Acute Outside London

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - 2006/2007

			Grouping PI (Percentile Bands)		
PI SUMMARY	**Trust PI**		**33%**	**34%**	**33%**
1					
Income £10/m²	198		189	190 and 213	214
Activity/100m²	4		83	84 and 94	95
Asset Value £10/m²	156		129	130 and 156	157
2					
Capital Charges £/m²	143		95	96 and 127	128
Land £/m²	193		223	224 and 352	353
Building £10/m²	120		89	90 and 104	105
Equipment £/m²	161		133	134 and 170	171
3					
Occupancy Cost £/m²	210		147	148 and 195	196
Capital Charges £/m²	143		95	96 and 127	128
Maintenance Costs £/10m²	190		210	211 and 257	258
Energy/Utility Costs £/10m²	159		177	178 and 203	204
Rent & Rates £/10m²	326		103	104 and 150	151
4					
Total Backlog £/m²	373		62	63 and 192	193
Critical Backlog £/m²	55		17	18 and 46	47
Risk Adjusted Backlog £/m²	66		17	18 and 63	64
Depreciation £/m²	89		55	56 and 78	79

Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 10

Summary of 2007/08 PEAT Inspections

Appendix 10

PEAT SUMMARY 2008

Unweighted Scores	
96% +	= Excellent
75 - 95%	= Good
60 - 74 %	= Acceptable
50 - 59%	= Poor
Less than 50%	= Unacceptable

CLASSIFICATION BY HOSPITAL SITE

City Hospital Total Scores	Actual Score	Max Score Possible	Actual %
Specific Cleanliness	262	300	87
Toilet & Bathroom Cleanliness	231	275	84
Environment	176	215	82
Environment (continued)	240	275	87
Access & External Areas	112	140	80
Food & Food Service	39	40	98
Privacy & Dignity	112	140	80
Overall Total	**1172**	**1385**	**85**

Sandwell Hospital Total Scores	Actual Score	Max Score Possible	Actual %
Specific Cleanliness	240	300	80
Toilet & Bathroom Cleanliness	220	275	80
Environment	175	215	81
Environment (continued)	239	275	87
Access & External Areas	112	140	80
Food & Food Service	39	40	98
Privacy & Dignity	112	140	80
Overall Total	**1137**	**1385**	**82**

Eye Hospital Total Scores	Actual Score	Max Score Possible	Actual %
Specific Cleanliness	245	300	82
Toilet & Bathroom Cleanliness	220	275	80
Environment	57	70	81
Environment (continued)	177	205	86
Access & External Areas	103	125	82
Food & Food Service	39	40	98
Privacy & Dignity	60	65	92
Overall Total	**901**	**1080**	**83**

Rowley Hospital Total Scores	Actual Score	Max Score Possible	Actual %
Specific Cleanliness	204	230	89
Toilet & Bathroom Cleanliness	190	220	86
Environment	61	70	87
Environment (continued)	171	205	83
Access & External Areas	80	100	80
Food & Food Service	39	40	98
Privacy & Dignity	36	45	80
Overall Total	**781**	**910**	**86**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 11

Summary of 2007/08 National Standards of Cleanliness Quarterly Audits

Appendix 11

NATIONAL STANDARDS OF CLEANLINESS

QUARTERLY AUDIT REPORTS

APRIL 2007 – MARCH 2008

CITY VERY HIGH RISK WEEKLY AUDITS

Period	Cleaning	Nursing	Estates	Overall
QTR 1	81%	95%	98%	91%
QTR 2	85%	93%	92%	92%
QTR 3	87%	91%	97%	92%
QTR 4	91%	96%	96%	95%
AVE 07/08	86%	94%	96%	93%
AVE 06/07	83%	93%	85%	87%

SANDWELL VERY HIGH RISK WEEKLY AUDITS

Period	Cleaning	Nursing	Estates	Overall
QTR 1	95%	97%	97%	96%
QTR 2	95%	96%	95%	95%
QTR 3	95%	94%	91%	93%
QTR 4	96%	95%	98%	97%
AVE 07/08	96%	95%	95%	95%
AVE 06/07	98%	96%	90%	95%

BTC VERY HIGH RISK WEEKLY AUDITS

Period	Cleaning	Nursing	Estates	Overall
QTR 1	94%	100%	100%	98%
QTR 2	96%	99%	100%	99%
QTR 3	96%	98%	100%	98%
QTR 4	97%	98%	100%	98%
AVE 07/08	96%	99%	100%	98%
AVE 06/07	95%	99%	80%	91%

CITY HIGH RISK MONTHLY AUDITS

Period	Cleaning	Nursing	Estates	Overall
QTR 1	84%	93%	96%	91%
QTR 2	83%	90%	94%	89%
QTR 3	86%	89%	87%	87%
QTR 4	90%	94%	96%	93%
AVE 07/08	86%	92%	93%	90%
AVE 06/07	86%	92%	85%	88%

SANDWELL HIGH RISK MONTHLY AUDITS

Period	Cleaning	Nursing	Estates	Overall
QTR 1	91%	90%	85%	89%
QTR 2	90%	96%	82%	89%
QTR 3	90%	95%	95%	93%
QTR 4	92%	95%	97%	95%
AVE 07/08	90%	94%	89%	92%
AVE 06/07	94%	97%	87%	92%

ROWLEY HIGH RISK MONTHLY AUDITS

Period	Cleaning	Nursing	Estates	Overall
QTR 1	95%	93%	95%	95%
QTR 2	96%	94%	99%	96%
QTR 3	95%	92%	94%	93%
QTR 4	95%	93%	96%	95%
AVE 07/08	95%	93%	96%	95%
AVE 06/07	88%	82%	79%	83%

BTC HIGH RISK MONTHLY AUDITS

Period	Cleaning	Nursing	Estates	Overall
QTR 1	88%	100%	100%	96%
QTR 2	93%	100%	100%	97%
QTR 3	92%	99%	100%	97%
QTR 4	94%	100%	100%	98%
AVE 07/08	92%	100%	100%	97%
AVE 06/07	88%	99%	81%	89%

CITY SIGNIFICANT RISK QUARTERLY AUDITS

Period	Cleaning	Nursing	Estates	Overall
QTR 1	82%	99%	100%	94%
QTR 2	78%	96%	99%	91%
QTR 3	79%	97%	93%	90%
QTR 4	85%	99%	95%	93%
AVE 07/08	81%	98%	97%	92%
AVE 06/07	80%	89%	79%	83%

SANDWELL SIGNIFICANT RISK QUARTERLY AUDITS

Period	Cleaning	Nursing	Estates	Overall
QTR 1	91%	100%	85%	92%
QTR 2	90%	92%	74%	85%
QTR 3	81%	91%	93%	88%
QTR 4	81%	100%	96%	92%
AVE 07/08	86%	96%	87%	89%
AVE 06/07	88%	96%	85%	89%

NOTE:

- No very high risk areas at Rowley
- No Significant or Low Risks at Rowley & BTC

Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 12

NPSA Confirmation of PEAT results for 2008

Appendix 12

NHS
National Patient Safety Agency

PEAT 2008 Results
Sandwell and West Birmingham
Hospitals NHS Trust

4-8 Maple Street
London
W1T 5HD

Tel: 020 7927 9500
Fax: 020 7927 9501
www.npsa.nhs.uk

June 2008

Dear Chief Executive,

PATIENT ENVIRONMENT ACTION TEAMS 2008

We are now able to confirm the PEAT results 2008 for environment, food and privacy and dignity for each hospital within your Trust. Note that we do not intend to send copies of your PEAT assessment as this would be a duplication of information already held locally.

Site Name	Environment	Food	Privacy & Dignity
Sandwell General Hospital	Good	Excellent	Good
City Hospital	Good	Excellent	Good
Birmingham & Midland Eye Hospital	Good	Excellent	Good
Rowley Regis Hospital	Good	Excellent	Good

No decisions have yet been made regarding the date on which individual hospital PEAT results will be published nationally on www.npsa.nhs.uk

If you have any queries regarding the factual accuracy of your hospital PEAT results, please send these by e-mail to gemma.ramsay@ic.nhs.uk. Queries should identify the Trust, hospital(s) affected and the nature of the enquiry.

Once again – my thanks to you all (and your staff and colleagues) for again making the PEAT process so productive and well organised.

A review of PEAT is currently underway and I will write to you again with details of any changes to be made to the process for 2009 nearer the date of commencement.

Yours sincerely

Dr Kevin Cleary
Medical Director
NPSA

Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

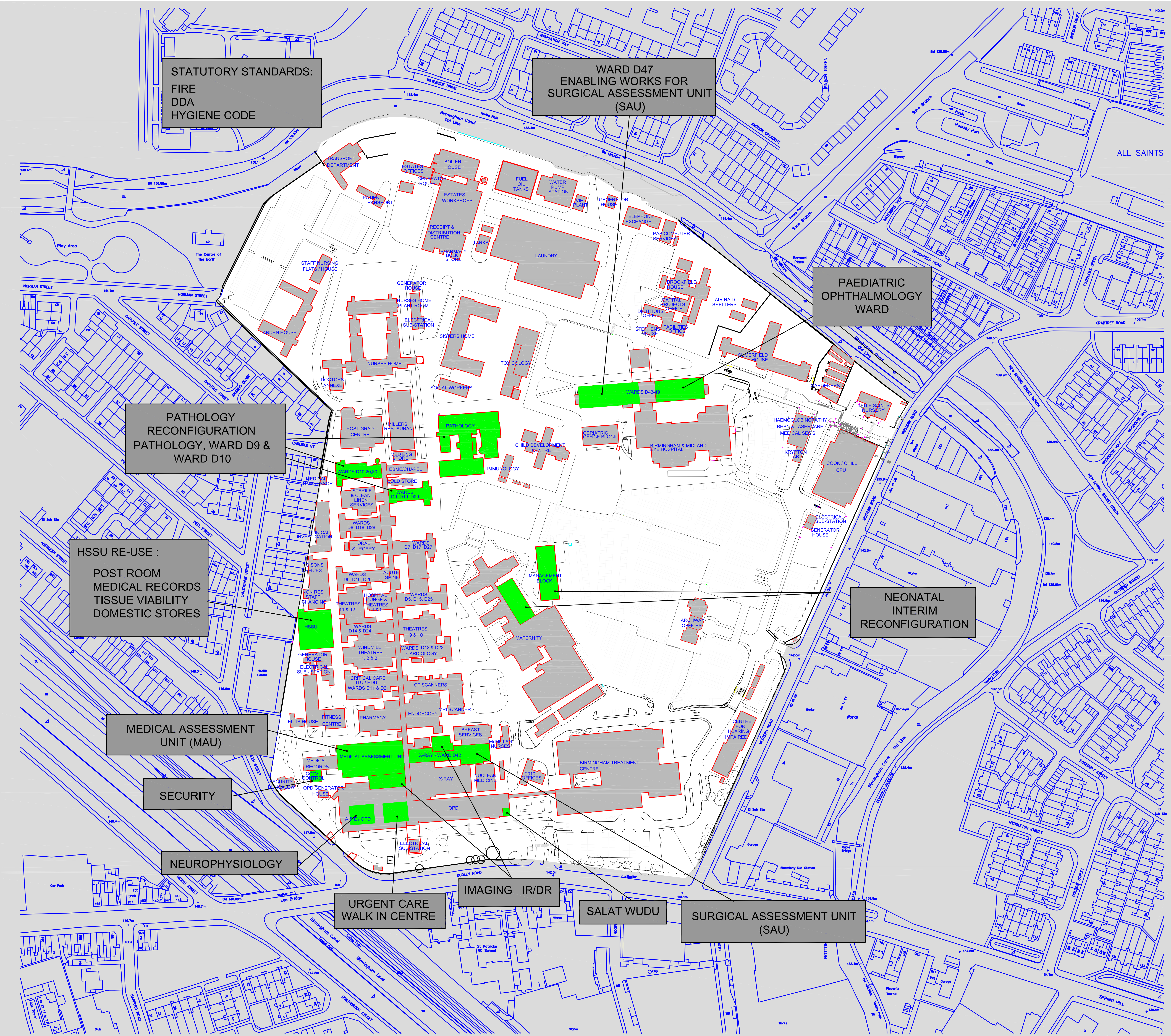
ESTATES STRATEGY 2008/2017

Appendix 13

Development Control Plan City Site 2008/09

Appendix 13

Note: This site plan is currently shown at one level and therefore does not show floor levels.



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N

KEY

EXISTING BUILDINGS

CAPITAL SCHEMES AND FEASIBILITY STUDIES 08- 09

Mark	Date	Details	By	Chkd

REVISIONS

Employer:

Sandwell & West Birmingham Hospitals NHS Trust NHS

Project Title:

City Hospital, Dudley Road Birmingham, B18 7QH

Principal Supply Chain Partner

Interserve Health

Interserve Health
George Road, Erdington, Birmingham, B23 7RZ
Tel: 0121 344 4888 Fax: 0121 344 4801

Scales: 1:2000 for the Original Drawing Size of: A2

Drn By: RS | Chkd By: RK | Passed By: RS/RK | Date: 22/07/2008

Drawing Status: CIty Hospital, Dudley Road Proposed Development Control Plan

Drawing Originator:

Capital Projects Department

Drawing Title:

PROPOSED DEVELOPMENT CONTROL PLAN APPROVED CAPITAL SCHEMES 08 - 09 AND FEASIBILITY STUDIES

Job No: City Hospital | Drawing No: CITY/2008/4 | Revision: 22/07/2008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

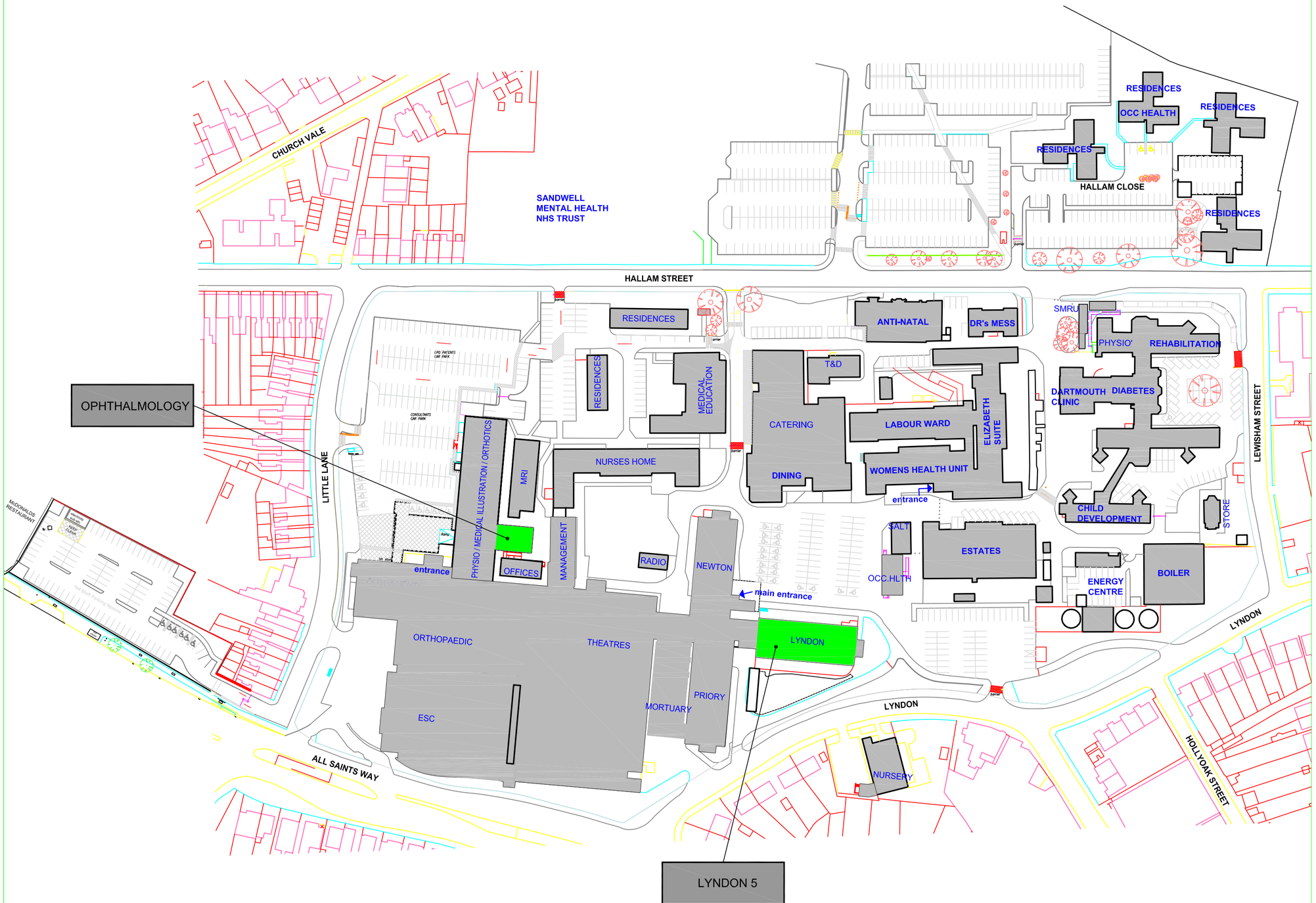
2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 14

Development Control Plan Sandwell Site 2008/09

Note: This site plan is currently shown at one level and therefore does not highlight at which level changes occur only the area/block in which they will change



0 10 20 30 40

KEY

EXISTING BUILDINGS

CAPITAL SCHEMES AND FEASIBILITY STUDIES 08- 09

Mark	Date	Details	By	Chkd

REVISIONS

Employer:

Sandwell & West Birmingham Hospitals NHS Trust

Principal Supply Chain Partner

Interserve Health
George Road, Erdington, Birmingham, B23 7RZ
Tel: 0121 344 4888 Fax: 0121 344 4801

Project Title:

Sandwell General Hospital

Scales: 1:1000 for the Original Drawing Size of: A2

Drn By: RS | Chkd By: RK | Passed By: RS/RK | Date: 22/07/2008

Drawing Status: Sandwell General Hospital Proposed Development Control Plan

Drawing Originator:

Capital Projects Department

Drawing Title:

PROPOSED DEVELOPMENT CONTROL PLAN APPROVED CAPITAL SCHEMES 08 - 09 AND FEASIBILITY STUDIES

Job No:	Drawing No:	Revision:
Sandwell	SWBH - SGH 2008/4	22/07/2008

Sandwell and West Birmingham Hospitals NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 15

Summary 10 Year Capital Programme Forecast

Appendix 15

Sandwell & West Birmingham Hospitals NHS Trust
Long Term 10 Year Capital Planning Forecast

Section Heading	Description Scheme		Year 2009/10 £000's	Year 2010/11 £000's	Year 2011/12 £000's	Year 2012/13 £000's	Year 2013/14 £000's	Year 2014/15 £000's	Year 2015/16 £000's	Year 2016/17 £000's	Year 2017/18 £000's	Year 2018/19 £000's	Year 2019/20 £000's	Lifecycle Yrs £000's
Land: Acquistion & Sale														
	Grove Lane		10,150	11,800	0	0	0	0	0	0	0	0	0	21,950
	Rowley		0	0	0	0	0	0	0	0	0	0	0	0
	Sandwell		0	0	0	0	0	0	0	-7,500	0	0	0	-7,500
	City		0	0	0	0	0	0	0	-21,900	0	0	0	-21,900
	BTC		0	0	0	0	0	0	0	0	0	0	0	0
		Sub Total	10,150	11,800	0	0	0	0	0	-29,400	0	0	0	-7,450
Buildings														
	New Development													
	Grove Lane		0	0	0	0	0	0	5,333	5,333	5,333	5,333	5,333	26,667
	Rowley		0	0	0	0	0	0	0	0	0	0	0	0
	Sandwell		0	0	0	0	0	0	0	0	0	0	0	0
	City		800	800	5,800	800	800	500	0	0	0	0	0	9,500
	BTC		1,000	1,000	1,000	1,000	1,000	1,000	3,500	1,000	1,000	1,000	1,000	13,500
		Sub Total	1,800	1,800	6,800	1,800	1,800	1,500	8,833	6,333	6,333	6,333	6,333	37,000
	Stat Standards: Legal Compliance													
	Grove Lane		0	0	0	0	0	0	0	0	0	0	0	0
	Rowley		25	25	25	25	0	0	0	0	0	0	0	100
	Sandwell		350	350	200	100	50	50	0	0	0	0	0	1,100
	City		500	500	400	250	100	50	0	0	0	0	0	1,800
	BTC		0	0	0	0	0	0	0	0	0	0	0	0
		Sub Total	875	875	625	375	150	100	0	0	0	0	0	3,000
	Stat Standards: Maintenance& Replacement													
	Grove Lane		0	0	0	0	0	0	0	0	0	0	0	0
	Rowley		50	40	25	25	0	0	0	0	0	0	0	140
	Sandwell		900	400	300	200	75	75	0	0	0	0	0	1,950
	City		1,000	500	400	250	100	50	0	0	0	0	0	2,300
	BTC		0	0	0	0	0	0	0	0	0	0	0	0
		Sub Total	1,950	940	725	475	175	125	0	0	0	0	0	4,390
IT & Telecommunication	**IT EQUIPMENT**													
	Grove Lane		0	0	0	0	2,925	2,976	740	770	770	740	770	9,691
	Rowley		30	30	30	30	0	0	0	0	0	0	0	120
	Sandwell		50	50	50	50	50	50	0	0	0	0	0	300
	City		900	850	820	790	820	0	0	0	0	0	0	4,180
	BTC		30	30	30	30	30	30	30	30	30	30	30	330
		Sub Total	1,010	960	930	900	3,825	3,056	770	800	800	770	800	13,051
Medical Equipment	**MEDICAL EQUIPMENT**													
	Grove Lane		0	0	0	0	7,900	16,700	11,300	3,000	3,000	3,000	3,000	47,900
	Rowley		346	100	100	100	0	0	0	0	0	0	0	646
	Sandwell		1,160	1,000	790	1,290	0	460	0	0	0	0	0	4,700
	City		2,557	1,150	1,622	890	0	0	0	0	0	0	0	6,219
	Neptune		0	0	0	0	0	0	0	0	0	0	0	0
	BTC		100	100	300	188	100	100	340	100	100	100	1,100	2,628
		Sub Total	4,163	2,350	2,812	2,468	8,000	17,260	11,640	3,100	3,100	3,100	4,100	54,893
Other Equipment	**OTHER EQUIPMENT**													
	Grove Lane		0	0	0	0	0	500	500	500	500	500	500	3,000
	Rowley		0	0	0	0	0	0	0	0	0	0	0	0
	Sandwell		0	0	120	300	300	80	0	0	0	0	0	800
	City		0	400	380	700	700	320	0	0	0	0	0	2,500
	BTC		0	0	0	0	0	0	0	0	0	0	0	0
		Sub Total	0	400	500	1,000	1,000	900	500	500	500	500	500	5,300
OTHER	**OTHER**													
	Grove Lane		0	0	0	0	0	0	-1,171	1,171	0	0	0	0
	Rowley		0	0	0	0	0	0	0	0	0	0	0	0
	Sandwell		0	0	0	0	0	0	0	0	0	0	0	0
	City		0	0	0	0	0	0	0	0	0	0	0	0
	BTC		0	0	0	0	0	0	0	0	0	0	0	0
		Sub Total	0	0	0	0	0	0	-1,171	1,171	0	0	0	0
	All Areas		19,948	19,125	12,392	7,018	14,950	22,941	20,572	-17,496	10,733	10,703	11,733	132,621
	Grove Lane		10,150	11,800	0	0	10,825	20,176	16,702	10,774	9,603	9,573	9,603	109,208
	Rowley		451	195	180	180	0	0	0	0	0	0	0	1,006
	Sandwell		2,460	1,800	1,460	1,940	475	715	0	-7,500	0	0	0	1,350
	City		5,757	4,200	9,422	3,680	2,520	920	0	-21,900	0	0	0	4,599
	Neptune		0	0	0	0	0	0	0	0	0	0	0	0
	BTC		1,130	1,130	1,330	1,218	1,130	1,130	3,870	1,130	1,130	1,130	2,130	16,458
	All Site Tota		19,948	19,125	12,392	7,018	14,950	22,941	20,572	-17,496	10,733	10,703	11,733	132,621
	Internally Generated		15,250	15,000	15,000	15,000	15,000							
	Borrowing Requirement		4,698	4,125	0	0	0							
	Non Land Profile		9,798	7,325	12,392	7,018	14,950	22,941	20,572	11,904	10,733	10,703	11,733	

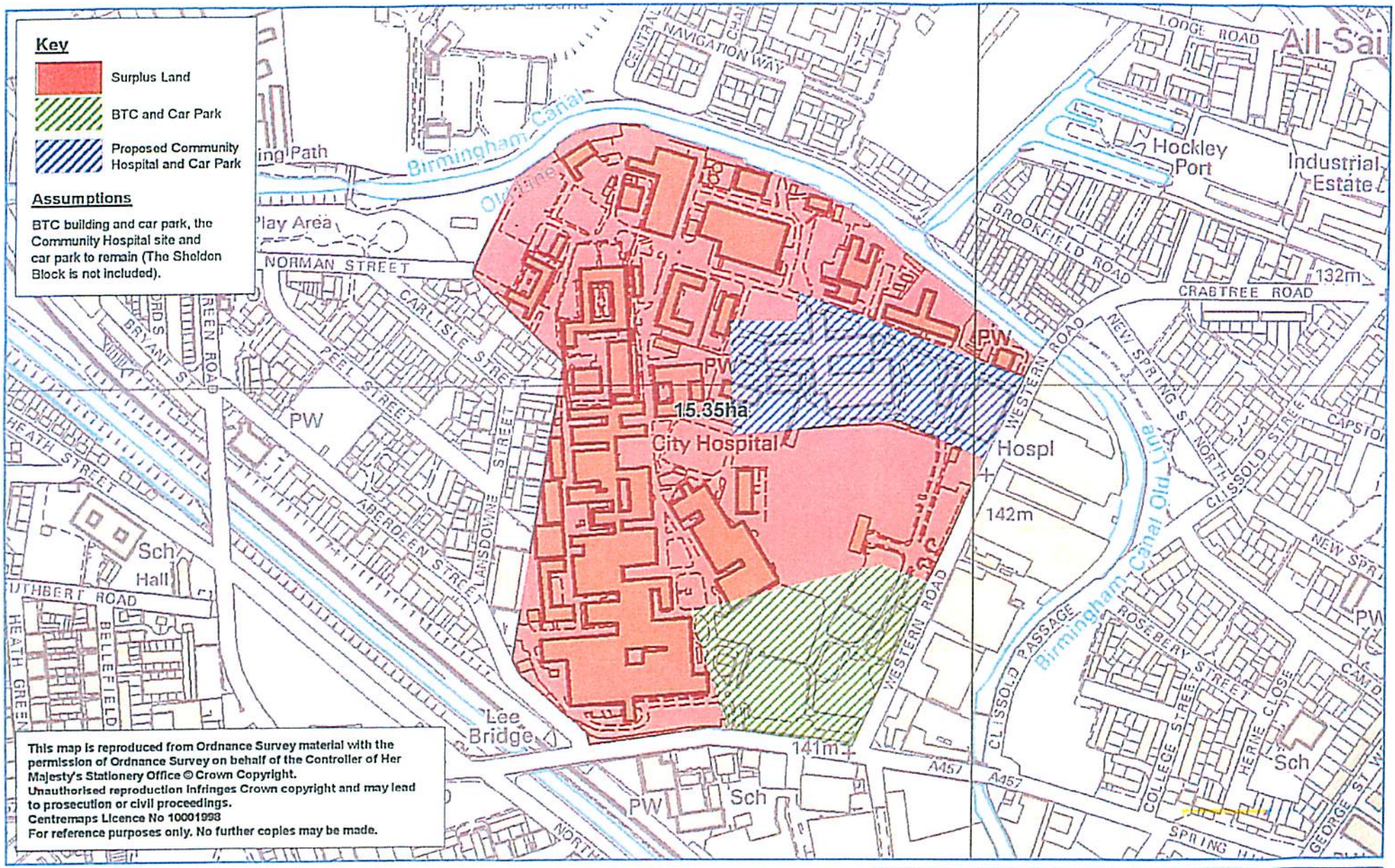
Sandwell and West Birmingham Hospitals NHS
NHS Trust

2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 16

Indicative Plans for Surplus Land Sales – City Hospital 2016/17



Towards 2010 Project

City Hospital Disposal Diagram v2 (22/02/2007)

GVA Grimley

Sandwell and West Birmingham Hospitals NHS Trust

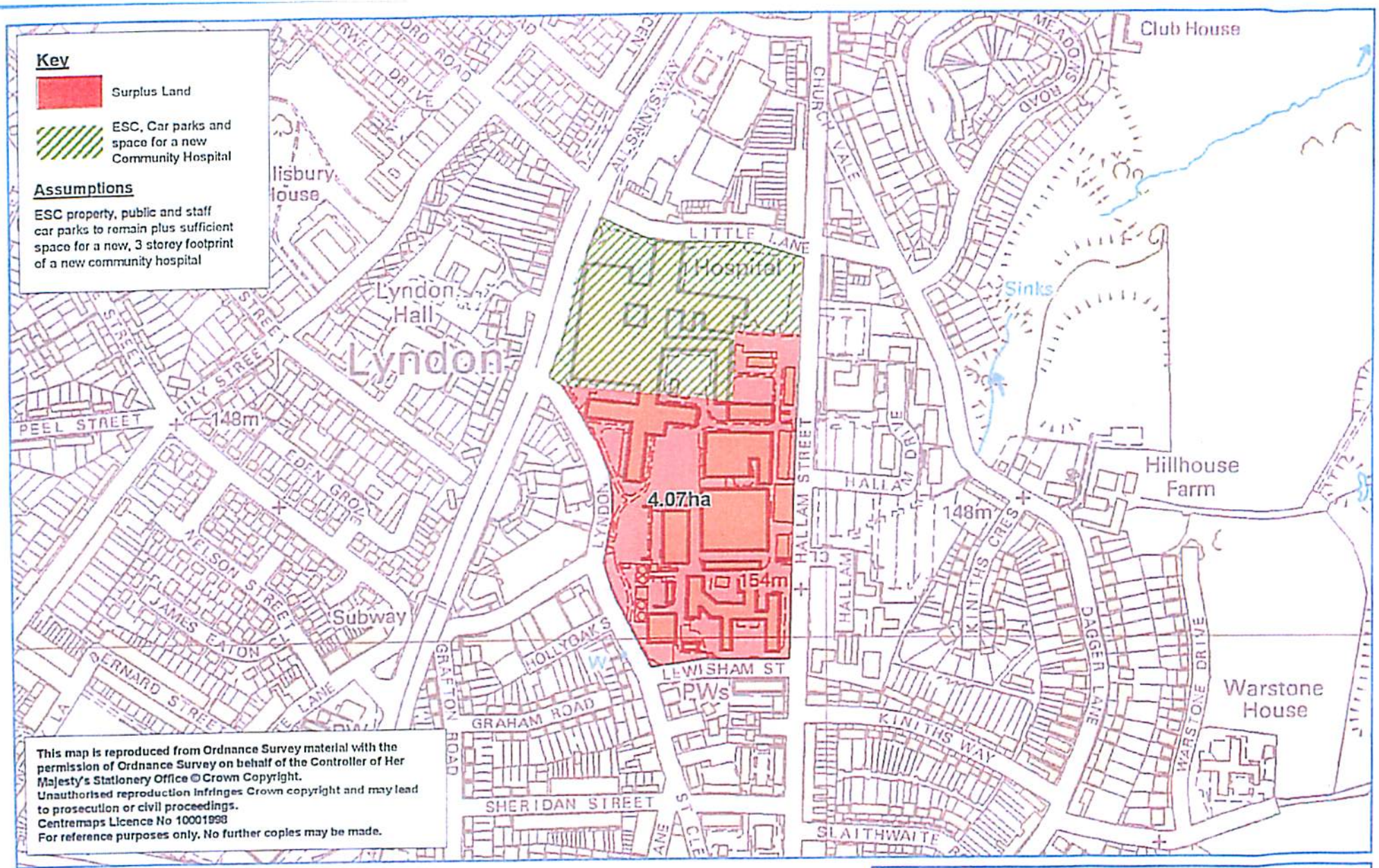
2010 Acute Hospital Services Development

ESTATES STRATEGY 2008/2017

Appendix 17

Indicative Plans for Surplus Land Sales – Sandwell Hospital 2016/17

Appendix 17



Towards 2010 Project

Sandwell Hospital Disposal Programme v1 (30/01/2007)

GVA Grimley

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	"High Quality Care for All". Developments in Regional and National Policy
SPONSORING DIRECTOR:	Director of Strategy
AUTHOR:	Director of Strategy
DATE OF MEETING:	4 September 2008

KEY POINTS:

"High Quality Care for All", the final report of the NHS Next Stage Review (NSR) led by Lord Darzi, was published in June 2008 along with accompanying regional reports. Although much of the regional and national vision set out in these reports is consistent with our long-standing local vision developed through the Towards 2010 Programme, these reports set significant elements of our future strategic context.

The paper assesses the potential impact of these developments on the Trust against the five key themes in national and regional policy identified as part of our planning for NHS Foundation Trust status:

1. Focus on prevention, early intervention and tackling inequalities.
2. Patient choice, personalisation and responsiveness.
3. Clinical safety and quality.
4. Care closer to home.
5. Value for money.

The paper poses a series of questions for consideration by the Trust Board and identifies four critical areas for success (clinical quality, patient satisfaction, commercial focus and an engaged workforce) that the Trust will need to ensure are addressed in our future plans.

PURPOSE OF THE REPORT:

✓ **For Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATIONS:

1. NOTE recent policy developments including the final report of the NHS Next Stage Review;

2. CONSIDER the impact of the key issues arising from recent developments on the Trust's service strategy and future plans.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

The Trust's strategic objective to be "An Effective NHS FT" requires the Trust Board to review our service strategy and plans in the light of developments in national and regional policy.

IMPACT ASSESSMENT:

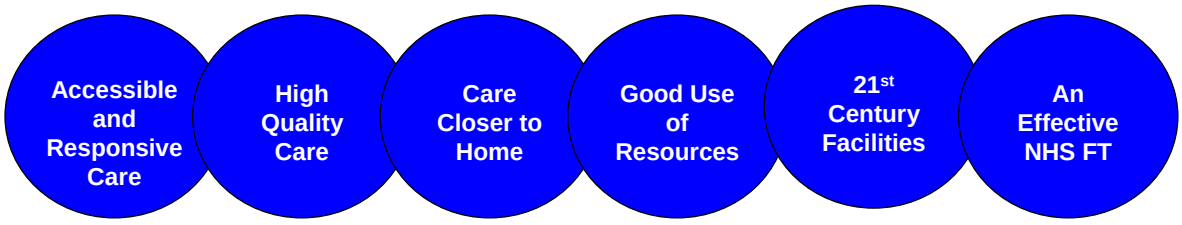
FINANCIAL	✓	Some of the changes in High Quality Care for All affect our financial planning (e.g. payment linked to quality).
ALE		
CLINICAL	✓	High Quality Care for All places a renewed emphasis on clinical outcomes and clinical quality.
WORKFORCE	✓	High Quality Care for All includes proposals for developing a more engaged, clinically led workforce.
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI	✓	High Quality Care for All includes plans to make greater use of patient reported outcome measures.
RISKS		There are a range of risks (and opportunities) for the Trust arising from recent policy developments. These are set out in the section of the paper that considers impact on our strategy.

APPENDIX ONE
TRUST VISION AND STRATEGIC OBJECTIVES (IBP3)

Vision

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

Strategic Objectives



Accessible and Responsive Care	High Quality Care	Care Closer to Home	Good Use of Resources	21st Century Facilities	An Effective NHS FT
• We will provide services that are quick and convenient to use and responsive to individual needs treating patients with dignity and respect. • Our access times and patient survey results will compare well with similar trusts	• We will provide the highest quality clinical care. • Our clinical outcomes will compare well with those of similar trusts.	• In partnership with our PCTs we will deliver a range of services outside of the acute hospital.	• We will make good use of public money. • On a set of key measures we will be among the most efficient Trusts of our size and type.	• We will ensure our services are provided from modern buildings fit for 21st Century health care.	• An effective organisation will underpin all we do. • We will develop our workforce, promote education, training and research, and make good use of technologies.

APPENDIX TWO
PRINCIPLES AND RULES FOR COOPERATION AND COMPETITION
(DH 2007)

1. Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and population.

2. Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries and to ensure service continuity and sustainability

3. Commissioning and procurement should be transparent and non-discriminatory.

4. Commissioners and providers should foster patient choice and that patients have accurate and reliable information to exercise choice and control over their healthcare.

5. Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and reputation of the NHS.

6. Providers must not discriminate against patients and must promote equality.

7. Payment regimes must be transparent and fair.

8. Financial intervention in the system must be transparent and fair.

9. Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to in patient and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money.

10. Vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money.

NHS

East of England
East Midlands
London
North East
North West
South East Coast
South Central
South West
West Midlands
Yorkshire and the Humber

High Quality Care For All

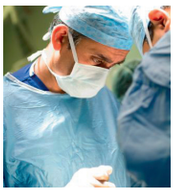
NHS Next Stage Review Final Report – Summary

DH Department of Health

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning / Performance	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Policy
Gateway Reference	10106
Title	High Quality Care For All NHS Next Stage Review Final Report
Author	Professor the Lord Darzi of Denham KBE, HonFREng, FmedSci
Publication Date	30 Jun 2008
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs
Circulation List	
Description	Final report of Lord Darzi's NHS Next Stage Review. It responds to the 10 SHA strategic visions and sets out a vision for an NHS with quality at its heart.
Cross Ref	Framing Document - May 2008 Interim Report October 2007
Superseded Docs	Update
Action Required	N/A
Timing	**N/A**
Contact Details	NHS Next Stage Review Team Department of Health Room 544, Richmond House 79 Whitehall, London SW1A 2NS 020 7210 3000 Email: ournhs@dh.gsi.gov.uk http://www.nhs.uk/ournhs
For Recipient's Use	



Summary letter

Our NHS – Secured today for future generations by Lord Darzi

An NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart.

Dear Prime Minister, Chancellor of the Exchequer, and Secretary of State for Health,

This year the NHS is 60 years old. We are paying tribute to a service founded in adversity, from which were established enduring principles of equal access for all based on need and not ability to pay. We are celebrating a national institution that has made an immeasurable difference to millions of people's lives across the country.

Quite simply, the NHS is there when we need it most. It provides round the clock, compassionate care and comfort. It plays a vital role in ensuring that as many of us as possible can enjoy good health for as long as possible – one of the things that matters most to us and to our family and friends.

The journey so far

I know the journey we have all been on from my own experience as an NHS clinician working in partnership with professional colleagues across the service.

I used to be the only colo-rectal surgeon in my hospital; today I am a member of a team of four surgeons, working in a network that reaches out into primary care. Ten years ago, we had one part-time stoma nurse. Today we have two full-time stoma nurses, two specialist nurses and a nurse consultant.

Ten years ago, my patients would sometimes wait over a year for treatment, and now they wait just a few weeks – and even less if cancer is suspected. My patients are treated using keyhole surgery enabling them to leave hospital in days rather than weeks. My team's conversations about quality take place in weekly multidisciplinary meetings rather than in corridors. Together, these changes have meant real improvements for patients.

I have seen for myself the NHS getting better, and I have heard similar stories from other clinical teams throughout the country over the course of this Review. These achievements were enabled by the investment of extra resources,[1] by giving freedom to the frontline through NHS foundation trusts, and by ensuring more funding followed patient choices. They were delivered by the dedication and hard work of NHS staff who were determined to improve services for patients and the public.

1 In 1996/7, the budget for the NHS in England was £33 billion; in 2008/9 it is £96 billion.

The next stage of the journey

My career is dedicated to improving continuously the quality of care we provide for patients. This is what inspires me and my professional colleagues, and it has been the guiding principle for this Review. We need to continue the NHS journey of improvements and move from an NHS that has rightly focused on increasing the quantity of care to one that focuses on improving the quality of care.

There is still much more to do to achieve this. I have continued my clinical practice while leading the Review nationally. I have seen and treated patients every week. Maintaining that personal connection with patients has helped me understand the improvements we still need to make. It has driven me to focus this Review on practical action.

It is because of this that I have been joined in this Review by 2,000 clinicians and other health and social care professionals from every NHS region in England. Their efforts, in considering the best available evidence and in setting out their own visions for high quality services (described in *Chapter 1*), have been the centrepiece of this process.

Their visions – developed in discussion with patients, carers and members of the general public – set out bold and ambitious plans. I am excited by the local leadership they demonstrate and the commitment of all those who have been involved.

In developing the visions, the NHS has had to face up to significant variations in the quality of care that is provided. Tackling this will be our first priority. The NHS needs to be flexible to respond to the needs of local communities, but people need to be confident that standards are high across the board.

Delivering the visions will mean tackling head on those variations in the quality of care and giving patients more information and choice. The message they send is that the programme of reform that has been put in place has been unevenly applied and can go much further.

We also need to accelerate change for other reasons. *Chapter 2* describes the changes facing society and healthcare systems around the world. It sets out how the NHS in the 21st century faces a particular set of challenges, which I would summarise as: rising expectations; demand driven by demographics; the continuing development of our 'information society'; advances in treatments; the changing nature of disease; and changing expectations of the health workplace. These are challenges we cannot avoid. The NHS should anticipate and respond to the challenges of the future.

My conclusions, and the measures described in this report, focus on how we can accelerate the changes that frontline staff want to make to meet those challenges, whilst continuing to raise standards.

The vision this report sets out is of an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart – quality defined as clinically

effective, personal and safe. It will see the NHS deliver high quality care for all users of services in all aspects, not just some. I set out below the key steps we must take to deliver this vision.

High quality care for patients and the public

Throughout this Review, I have heard clearly and consistently that people want a greater degree of control and influence over their health and healthcare. If anything, this is even more important for those who for a variety of reasons find it harder to seek out services or make themselves heard.

Personalising services means making services fit for everyone's needs, not just those of the people who make the loudest demands. When they need it, all patients want care that is personal to them.[2] That includes those people traditionally less likely to seek help or who find themselves discriminated against in some way. The visions published in each NHS region make clear that more support is needed for all people to help them stay healthy and particularly to improve the health of those most in need. *Chapter 3* explains how we will do this including by introducing new measures to:

Create an NHS that helps people to stay healthy. For the NHS to be sustainable in the 21st century it needs to focus on improving health as well as treating sickness. This is not about the 'nanny state'. As a clinician, I believe that the NHS has a responsibility to promote good health as well as tackle illness.

Achieving this goal requires the NHS to work in partnership with the many other agencies that also seek to promote health. Much progress on closer working has been made in recent years. In line with my terms of reference,[3] this reports focuses on what the NHS can do to improve the prevention of ill health.

The immediate steps identified by this Review are:

- **Every primary care trust will commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations**. Our efforts must be focused on six key goals: tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates, improving sexual health and improving mental health.

- **A Coalition for Better Health, with a set of new voluntary agreements between the Government, private and third sector organisations on actions to improve health outcomes**. Focused initially on combatting obesity, the Coalition will be based on agreements to ensure healthier food, to get more people more physically active, and to encourage companies to invest more in the health of their workforce.

2 Opinion Leader Research, Key findings of 18 September 2007 *Our NHS, Our Future* nationwide consultative event.

3 Terms of Reference available at www.ournhs.nhs.uk

- **Raised awareness of vascular risk assessment through a new 'Reduce Your Risk' campaign**. As we roll out the new national programme of vascular risk assessment for people aged between 40 and 74, we will raise awareness through a nationwide 'Reduce Your Risk' campaign – helping people to stay healthy and to know when they need to get help.

- **Support for people to stay healthy at work**. We will introduce integrated Fit for Work services, to help people who want to return to work but are struggling with ill health to get back to appropriate work faster.

- **Support GPs to help individuals and their families stay healthy**. We will work with world-leading professionals and patient groups to improve the Quality and Outcomes Framework to provide better incentives for maintaining good health as well as good care.

We will give patients more rights and control over their own health and care. I have heard the need to give patients more information and choice to make the system more responsive to their personal needs. We will:

- **Extend choice of GP practice**. Patients will have greater choice of GP practice and better information to help them choose. We will develop a fairer funding system, ensuring better rewards for GPs who provide responsive, accessible and high quality services. The NHS Choices website will provide more information about all primary and community care services, so that people can make informed choices.

- **Introduce a new right to choice in the first NHS Constitution**. The draft NHS Constitution includes rights to choose both treatment and providers and to information on quality, so that, wherever it is relevant to them, patients are able to make informed choices.

- **Ensure everyone with a long-term condition has a personalised care plan**. Care plans will be agreed by the patient and a named professional and provide a basis for the NHS and its partners to organise services around the needs of individuals.

- **Pilot personal health budgets**. Learning from experience in social care and other health systems, personal health budgets will be piloted, giving individuals and families greater control over their own care, with clear safeguards. We will pilot direct payments where this makes most sense for particular patients in certain circumstances.

- **Guarantee patients access to the most clinically and cost effective drugs and treatments**. All patients will receive drugs and treatments approved by the National Institute for Health and Clinical Excellence (NICE) where the clinician recommends them. NICE appraisals processes will be speeded up.

The common theme of these new measures for patients is improving quality. It must be the basis of everything we do in the NHS.

Quality at the heart of the NHS

In my career as a surgeon, I try to do my best to provide patients with high quality NHS care – just like hundreds of thousands of other staff. This has been my guiding principle as I have led this Review.

High quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual.

As independent research has shown,[4] the NHS has made good progress over the past decade in improving the overall quality of care for patients. During this period, improvements in quality were focused primarily on waiting times, as basic acceptable standards of access to A&E and secondary care were established, and on staffing levels and physical infrastructure.

Today, with the NHS budget approaching £2 billion a week, more staff, and improvements in the quality and availability of information, quality can be at the heart of everything we do in the NHS. It means moving from high quality care in some aspects to high quality care in all.

We will raise standards. The visions set out for each NHS region and formed by patients' expectations are ambitious for what the NHS can achieve. *Chapter 4* of this report sets out the measures that will enable us to meet these standards:

- **Getting the basics right first time, every time**. We will continue to seek improvements in safety and reductions in healthcare associated infections. The Care Quality Commission will have new enforcement powers. There will be national campaigns to make care even safer.

- **Independent quality standards and clinical priority setting**. NICE will be expanded to set and approve more independent quality standards. A new National Quality Board will offer transparent advice to Ministers on what the priorities should be for clinical standard setting by NICE.

- **For the first time we will systematically measure and publish information about the quality of care from the frontline up**. Measures will include patients' own views on the success of their treatment and the quality of their experiences. There will also be measures of safety and clinical outcomes. All registered healthcare providers working for, or on behalf of, the NHS will be required by law to publish 'Quality Accounts' just as they publish financial accounts.

4 S Leatherman and K Sutherland, *The Quest for Quality: Refining the NHS Reforms*, Nuffield Trust, May 2008 and K Davis et al., *Mirror, Mirror on the Wall: An international update on the comparative performance of American healthcare*, Commonwealth Fund, May 2007.

- **Making funding for hospitals that treat NHS patients reflect the quality of care that patients receive**. For the first time, patients' own assessments of the success of their treatment and the quality of their experiences will have a direct impact on the way hospitals are funded.

- **For senior doctors, the current Clinical Excellence Awards Scheme will be strengthened, to reinforce quality improvement**. New awards, and the renewal of existing awards, will become more conditional on clinical activity and quality indicators; and the Scheme will encourage and support clinical leadership of service delivery and innovation.

- **Easy access for NHS staff to information about high quality care**. All NHS staff will have access to a new NHS Evidence service where they will be able to get, through a single web-based portal, authoritative clinical and non-clinical evidence and best practice.

- **Measures to ensure continuous improvement in the quality of primary and community care**. We have just completed our consultation on proposals to bring all GP practices and dental practices within the scope of the new health and adult social care regulator, the Care Quality Commission.[5] We will introduce a new strategy for developing the Quality and Outcomes Framework which will include an independent and transparent process for developing and reviewing indicators. We will support practice accreditation schemes, like that of the Royal College of General Practitioners.

- Developing **new best practice tariffs focused on areas for improvement**. These will pay for best practice rather than average cost, meaning NHS organisations will need to improve to keep up.

We will strengthen the involvement of clinicians in decision making at every level of the NHS. As this Review has shown, change is most likely to be effective if it is led by clinicians. We will do this by ensuring that:

- **Medical directors and quality boards feature at regional and national level.** These will complement the arrangements at PCT level that are developing as part of the World Class Commissioning programme.

- **Strategic plans for delivering the visions will be published later this year by every primary care trust**. Change will be based on the five principles I set out earlier this year in *Leading Local Change*.[6]

- There is clear **local support for quality improvement**. A new 'Quality Observatory' will be established in every NHS region to inform local quality improvement efforts.

5 Department of Health, *The future regulation of health and adult social in England*, 25 March 2008.

6 *NHS Next Stage Review: Leading Local Change,* Department of Health, May 2008.

We will foster a pioneering NHS. Throughout my career, in all the clinical teams I have worked in, my colleagues and I have challenged one another to improve the way we provide care for patients. Continuous advances in clinical practice mean the NHS constantly has the opportunity to improve. My review will enable this through:

- **Introducing new responsibilities, funds and prizes to support and reward innovation.** Strategic health authorities will have a new legal duty to promote innovation. New funds and prizes will be available to the local NHS.

- **Ensuring that clinically and cost effective innovation in medicines and medical technologies is adopted**. We will strengthen the horizon scanning process for new medicines in development, involving industry systematically to support better forward planning and develop ways to measure uptake. For new medical technologies, we will simplify the pathway by which they pass from development into wider use, and develop ways to benchmark and monitor uptake.

- **Creating new partnerships between the NHS, universities and industry.** These 'clusters' will enable pioneering new treatments and models of care to be developed and then delivered directly to patients.

These changes will help the NHS to provide high quality care across the board. Throughout this Review, it has been clear that high quality care cannot be mandated from the centre – it requires the unlocking of the talents of frontline staff.

Working in partnership with staff

I have heard some people claim that there is 'change fatigue' in the NHS. I understand that NHS staff are tired of upheaval – when change is driven top-down. It is for this reason that I chose to make this Review primarily local, led by clinicians and other staff working in the NHS and partner organisations. In my own practice and across the country I have seen that, where change is led by clinicians and based on evidence of improved quality of care, staff who work in the NHS are energised by it and patients and the public more likely to support it.

We will empower frontline staff to lead change that improves quality of care for patients. *Chapter 5* sets out how we will do this by:

- **Placing a new emphasis on enabling NHS staff to lead and manage the organisations in which they work**. We will re-invigorate practice-based commissioning and give greater freedoms and support to high performing GP practices to develop new services for their patients, working with other primary and community clinicians. We will provide more integrated services for patients, by piloting new integrated care organisations, bringing together health and social care professionals from a range of organisations – community

services, hospitals, local authorities and others, depending on local needs.

- **Implementing wide ranging programme to support the development of vibrant, successful community health services**. Where PCTs and staff choose to set up social enterprise organisations, transferred staff can continue to benefit from the NHS Pension Scheme while they work wholly on NHS funded work. We will also encourage and enable staff to set up social enterprises by introducing a 'staff right to request' to set up social enterprises to deliver services.

- **Enhancing professionalism**. There will be investment in new programmes of clinical and board leadership, with clinicians encouraged to be practitioners, partners and leaders in the NHS. We challenge *all* organisations that do business as part of, or with, the NHS to give clinicians more control over budgets and HR decisions.

- **No new national targets** are set in this report.

We will value the work of NHS staff. NHS staff make the difference where it matters most and we have an obligation to patients and the public to enable them to make best use of their talents. That is why the Review announces in *Chapter 6*:

- **New pledges to staff**. The NHS Constitution makes pledges on work and wellbeing, learning and development, and involvement and partnership. All NHS organisations will have a statutory duty to have regard to the Constitution.

- **A clear focus on improving the quality of NHS education and training**. The system will be reformed in partnership with the professions.

- **A threefold increase in investment in nurse and midwife preceptorships**. These offer protected time for newly qualified nurses and midwives to learn from their more senior colleagues during their first year.

- **Doubling investment in apprenticeships**. Healthcare support staff – clinical and non-clinical – are the backbone of the service. Their learning and development will be supported through more apprenticeships.

- **Strengthened arrangements to ensure staff have consistent and equitable opportunities to update and develop their skills**. Sixty per cent of staff who will deliver NHS services in 10 years time are already working in healthcare.We need to make sure that they are able to keep their skills and knowledge up to date.

The first NHS Constitution

You asked me to consider the case for an NHS Constitution. In *Chapter 7*, I set out why I believe it will be a powerful way to secure the defining features of the service for the next generation. I have heard that whilst changes must be made to improve quality, the best of the NHS, the values and core principles which

underpin it, must be protected and enshrined. An NHS Constitution will help patients by setting out, for the first time, the extensive set of legal rights they already have in relation to the NHS. It will ensure that decision-making is local where possible and more accountable than it is today, providing clarity and transparency about who takes what decisions on our behalf.

Finally, *Chapter 8* sets out how we will deliver this ambitious programme.

Conclusion

In the 21st century, there remains a compelling case for a tax-funded, free at the point of need, National Health Service. This Report celebrates its successes, describes where there is clear room for improvement, looks forward to a bright future, and seeks to secure it for generations to come through the first NHS Constitution. The focus on prevention, improved quality and innovation will support the NHS in its drive to ensure the best possible value for money for taxpayers. It is also an excellent opportunity to pursue our duties to promote equality and reduce discrimination under the Equality and Human Rights Act.

Through this process, we have developed a shared diagnosis of where we currently are, a unified vision of where we want to be and a common language framework to help us get there. This Review has built strong foundations for the future of the service. It outlines the shape of the next stage of reform, with the clarity and flexibility to give confidence for the future.

Leadership will make this change happen. All of the 2,000 frontline staff that have led this Review have shown themselves to be leaders by having the courage to step up and make the case for change. Their task has only just begun – it is relatively easy to set out a vision, much harder to make it a reality. As they strive to make change happen, they can count on my full support.

I would like to thank everyone who has participated in this Review. I am grateful for the help they have given to me in forming and shaping the conclusions of this Report.

Best wishes,

Professor the Lord Darzi of Denham KBE
Hon FREng, FMedSci
Parliamentary Under Secretary of State

Paul Hamlyn Chair of Surgery,
Imperial College London
Honorary Consultant Surgeon,
Imperial College Healthcare NHS Trust
and the Royal Marsden Hospital
NHS Foundation Trust

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investing for health

ourNHS our future

NHS West Midlands

JUNE 2008

Investing for Health

Step 2: Delivering our clinical vision for a world-class health service

Our vision – from reaction to prediction

Our vision for health services in the West Midlands over the next five to ten years is that we will:

- work with patients, staff, carers, partner organisations and the public to provide a service that 'adds years to life and life to years'
- aim to achieve levels of care comparable to the best in the world by transforming services from reacting to patients to being driven by them
- deliver patient-centred care of the highest quality and also a step-change towards great management of population health and support for people to manage their own health.

Inside

In November 2007, NHS West Midlands published *Investing for Health – a Strategic Framework for the West Midlands*. This set out how health services in the West Midlands could build on the improvements already made during the previous ten years.

While we were developing this plan, the Government announced *Our NHS, our future*, a review that is intended to ensure that the NHS as a whole is capable of meeting the challenges it faces in the next ten years. This review is being led by Lord Ara Darzi.

Lord Darzi's views on the case for change mirror our findings in *Investing for Health* and his review process fits perfectly with the plans for the next steps of our work into the development of meaningful clinical pathways for patients and staff.

This document is a summary of a report that is both the West Midlands' *Our NHS, our future* vision and step two of *Investing for Health*. The report is the next stage in what Lord Darzi calls a 'ten-year journey of change'. This is not the end of the process, however; local solutions need to be found to deliver the changes and these will involve dialogue and consultation with patients, carers, the public and NHS staff across the region.

You can see a copy of the full report and the reports from the nine clinical pathway groups at **www.westmidlands.nhs.uk**

Investing for Health in the West Midlands

Investing for Health identified seven big challenges that we need to address if we are to create a health service that meets the needs and rising expectations of local people and moves our services from good to great.

Challenge 1: Despite improvements in overall health status, inequalities in health have increased

People in better-off areas live longer than people in more deprived areas – and the gap is getting wider.

Challenge 2: There remains an unjustifiable variability in the quality and safety of services and individual care, and a significant number of complaints are received about standards of fundamental care

For example, we know that things go wrong too often in hospitals in the West Midlands. There are approximately 134,000 errors each year, 40,000 of which are preventable. In addition to the effect on the people concerned, such errors cost the health service in our area around £315m through the extra time people have to spend in hospital. The quality of primary care is also highly variable.

Challenge 3: Patients expect services to be joined up and to have co-ordination across teams caring for them, yet at present, patients and the public often struggle to understand how health services work

The NHS aims to provide services in the right place at the right time, but often the public is not clear what we mean by 'the right place'. Sometimes, even NHS staff are not clear what we mean. Changes in the NHS will also lead to more organisations providing services in the future in a wider range of settings, so the potential for confusion is even greater.

Challenge 4: The public – our 'customers' – have little confidence that their local NHS will get better

In a survey in 2006 of what West Midlands residents thought about healthcare in the region, just 26 per cent of the respondents thought that local NHS services would get better or much better over the next year or so.

Challenge 5: We are not investing enough in prevention

We know that investing in preventing ill health will produce enormous benefits. However, many people continue to ignore the advice that helps to keep them healthy, while the services commissioned by the NHS to support them in improving their own health are highly variable. The way the health service is set up does not provide the right incentives to encourage those delivering services to invest more in prevention.

Challenge 6: We continue to spend substantial resources on clinical activities that, the evidence suggests, bring little or no return on the investment in terms of improved health, or where the evidence shows that there are other, better and more cost-effective alternatives

The NHS estimates that £9.5m could have been saved in the West Midlands in the first half of 2006/07 by better control over five procedures that are often overused and from which patients derive little or no benefit.

Challenge 7: Cost pressures arising from doing 'more of the same'. An ageing population, a rising tide of long-term conditions and an accelerating pace of technological development combine to outstrip any conceivable rate of increased funding

In recent years, the Government has increased the amount of money going into health, but this increase is likely to slow down. The NHS, therefore, will have to get better value for money from existing resources.

Strategic priorities

Investing for Health also identified five themes – our strategic priorities – that must guide health services now and in the years to come if we are to be successful in responding to the big challenges. The five strategic priorities are listed below.

Full engagement

This is about getting people more involved in their own healthcare – for example, adopting lifestyles that promote good health, avoiding things that are a risk to health and doing more to look after themselves, with guidance from health professionals. It is also about ensuring a rich supply of information for patients on health and health services, and about extending the availability of services that can support people in managing their own health.

Improving quality and safety

This is a priority, not because the quality and safety of care in the West Midlands is worse than elsewhere in the NHS, but because our ambitions are higher than achieving the average – we want to be the best. We are sure the quality of our services can be improved.

Care closer to home

The focus here is particularly on patients with long-term conditions. By developing a skilled and flexible workforce, we will be able to provide high-quality, integrated care in the community. Informed patients will be true partners in their own care, while care closer to home should also mean earlier interventions for those with long-term conditions.

We also need to do more to ensure greater ease of access to a wider range of primary care services – including dentistry – alongside informed choice for patients.

Sustainable services

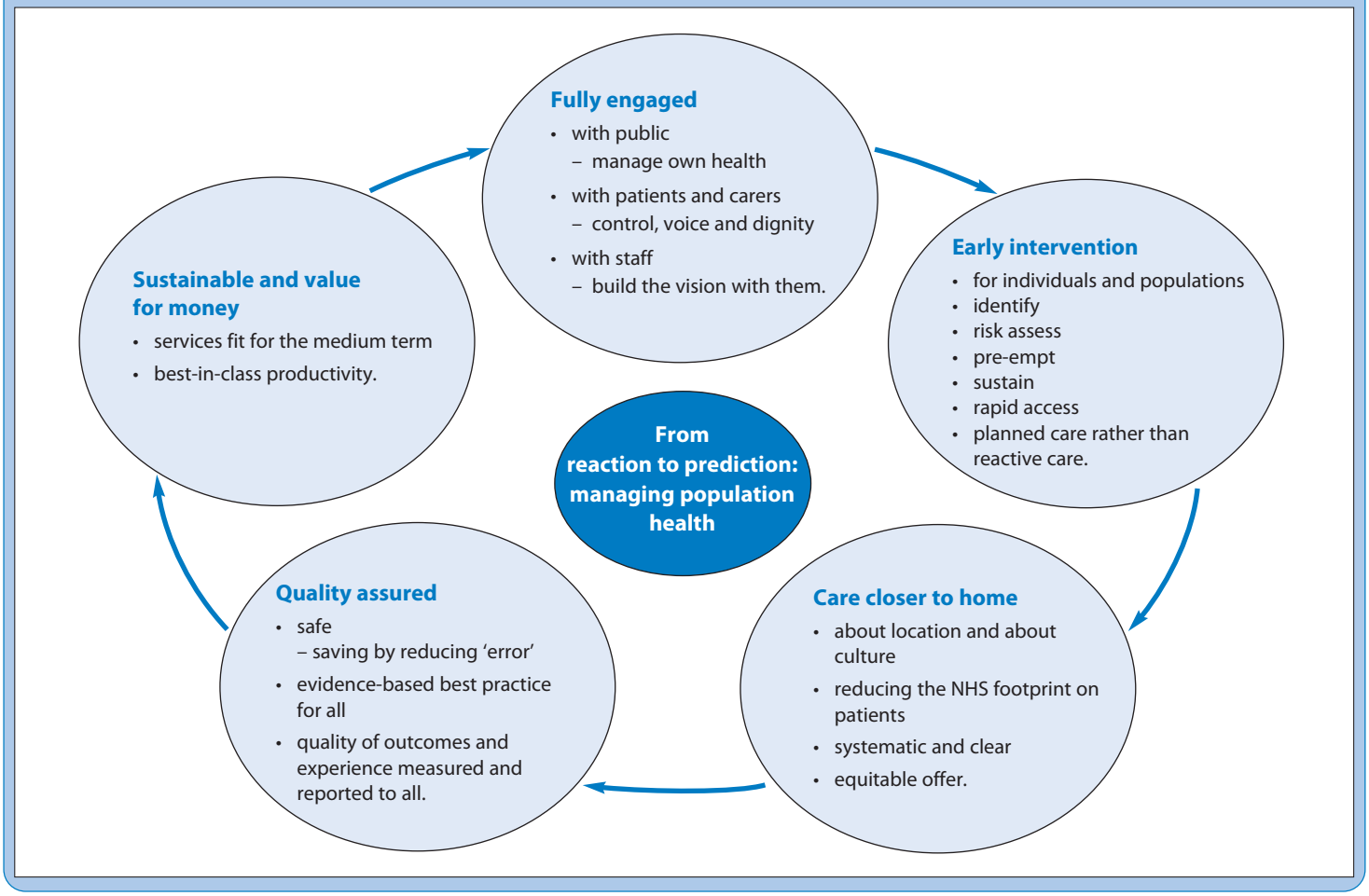
Health services need to change to respond to the changing needs of patients, staff and the public. This means making sure that services are based on clear and efficient pathways and meet the highest standards of best practice, as defined by clinical evidence. The changes made must be sustainable; they must be the right services, be affordable and make good use of resources.

'Improving quality is a priority because our ambitions are higher than achieving the average. We want to be the best'

Organisations fit for purpose

This priority is about ensuring that health organisations in the West Midlands – those who commission health services and those who provide them – have the capability to deliver a high-quality, accountable and safe health service.

Delivering our clinical vision – from reaction to prediction, managing population health



'More than 1,000 frontline staff took part in the ten regional summits sponsored by NHS West Midlands'

What patients, carers and the public told us

Surveys of patient and public opinion played a big part in our Vision report and we built significantly on these foundations for the national review. Events that helped inform the reports of the clinical pathway groups included:

- two national consultative events in each region with public and staff
- a national survey of adults
- a national online survey open to all
- a West Midlands patient, carer and public summit with all clinical pathway groups
- a West Midlands Ipsos MORI poll of 1000 adults on clinical pathway group questions
- Ipsos MORI research on specific clinical pathway group areas of interest, with targeted patient groups[1].

At the West Midlands patient, carer and public summit, participants were asked:

- if they thought that the clinical pathway groups had addressed the right issues
- if they had any concerns about what the groups had told them
- what they thought of the proposals
- how did they think obstacles to improvement could be overcome.

Some general themes emerged from these local and national conversations with patients, carers and the public. These can be grouped under seven headings (see box below).

What people told us

1. We want services centred on patients and carers, with real choices.
2. We want care closer to home.
3. Give us more and better information. Information is power, so share it among yourselves too, and make your services easier to navigate for patients and staff.
4. It makes sense to prioritise prevention and early intervention.
5. We expect consistently high-quality and safe services and fairness in provision. We simply cannot understand or accept the extent of variability in quality and outcomes, nor the 'postcode lottery' of treatment/availability.
6. We want dignity in care and a new NHS culture of genuine engagement.
7. Actions speak louder than words.

More specifically, the consultative event we held in January 2008, where participants heard a summary of the clinical pathway group proposals, allowed us to identity participants' top priorities for each pathway.

What staff have told us

In addition to the direct involvement of clinical staff in the clinical pathway groups, NHS West Midlands sponsored ten staff summits, one in each area of the region. These were mainly intended for frontline staff from hospital, community, primary care and social services. More than 1000 staff took part.

The key messages to emerge from these summits are listed below.

The importance of care pathways – staff wanted to see pathways and standards of care developed and implemented rigorously. They wanted pathways to be properly communicated to staff and patients, and adherence to them measured.

Access – staff recognised the need for services to be much more accessible in order to raise standards and to tackle inequalities. Although many staff did not relish working outside conventional hours, there was a view that this is now necessary, particularly for primary care, diagnostics, social care, critical care and mental health care.

Service information and communication – staff commented on the noticeable difference between informed and uninformed patients and how that affects ease of access to services. They acknowledged that they too did not always have a full understanding of how the health system worked in their area. Staff also said they wanted more information that allowed them to compare their services and to see where inequalities were occurring.

Inter-agency working – staff felt that organisational boundaries were

1 *Ipsos MORI Social Research Institute, 2008*

inhibiting best care for patients and wanted a system that promoted inter-agency working.

Empowering patients – staff thought more should be done to empower patients and support them in managing their own health, and that they should be better equipped to do this.

Commissioning for quality – staff thought that quality should be driven by commissioning based on outcomes and on pathways, and carried out jointly with partners where appropriate.

The 'NHS footprint' on patients (the impact on their time and resources when the NHS does not deliver one-stop services) – staff accepted that current care models and organisational arrangements did not serve patients well and that this had not been given enough attention.

Prevention needs to be prioritised and incentivised – staff believed that prevention needed to be embedded within the culture of all services and within all pathways.

There should be a more intelligent approach to managing the need to get best value for money – this included: investing in the right areas to deliver the right outcomes; investing in new services where needed and ceasing to invest in those that are no longer needed; investing in training; empowering citizens to take more responsibility for their own health; and better partnership working.

Capital investment versus care closer to home – staff felt that there was an over-reliance on investment in buildings, which was constraining the movement of care closer to home and investment in primary care, resulting in an emphasis on treatment rather than prevention.

Effective information technology – staff felt that IT was developed in isolation from frontline services and needed to be driven by staff and patients' needs to maximise its benefits in their everyday work.

Give change time to work and invest in it properly – while staff were often positive about change, there was also frustration that it was sometimes not allowed to settle in before more changes were required. Change was seen to be often politically motivated rather than patient focused.

West Midlands Framework for Excellence

Having identified the seven main challenges for health services in the West Midlands, pinpointed the priorities for improvement and heard the views of patients, staff and the public, we have developed a framework against which we can test whether or not our plans meet the needs of our stakeholders.

We call this the West Midlands Framework for Excellence. It sets out the challenges alongside our aims for different groups, showing what we want for patients, for the NHS workforce, for the public, and for other organisations that work with NHS patients (see page 7).

'The Framework for Excellence allows us to test whether or not our plans meet the needs of our stakeholders'

Clinical pathway reports

The nine West Midlands clinical pathway groups were asked to consider for their services:

- what would a great service look like?
- how different is that from what we have now?
- why the difference?
- what would be the most important steps to take to bridge that gap?
- what are the obstacles that need to be tackled to make that easier?

While each group made recommendations specific to their service area/population group, eight key themes emerged across all the clinical pathway groups:

- the need for services to be centred on the needs of patients, carers and families
- the importance of pathways to deliver clinical excellence
- the opportunity to achieve much more care closer to home
- the power and importance of information and help to navigate the system – for patients and staff
- a balance of prevention and cure
- the need to target services at those with greater need for equality and impact
- the need for more and different skills, and new types of worker

Top priorities for clinical pathways

Staying healthy	• Ensure GPs are more proactive in general evaluation of health. • Promote self-care and help people to feel more in control of their own health. • Make it easier to identify lifestyle risks and assess the impact they might have; help people to access services with choice. • Introduce motivational services tailored to the individual, with attainable goals that are followed up.
Maternity and newborn	• Adopt an holistic approach, involving social, emotional, mental health and educational factors. • Introduce real choices, with services closer to home. • While pregnancy should be seen as a normal event, there should be rapid and equitable access to obstretic-led and specialist neonatal care when needed.
Children's services	• Put the emphasis on early detection and prevention, for example in obesity. • Involve families and schools in care plans. • Create key worker roles and promote intelligent use of communication with children.
Mental health	• Introduce a short referral-to-treatment time, and early diagnosis and intervention. • Clarify pathways for people who have depression. • Get rid of age discrimination. • Give more choice of treatment options. • Value groups and patient networking support. • Address physical health needs.
Planned care	• Offer diagnostics and pre-surgery checks in community settings. • Give GPs direct access to information so they can discuss issues with patients. • Provide opportunities for feedback on quality of care.
Acute care	• Offer the best possible treatment for life-threatening conditions. • Introduce consistent pathways for all patients.
Long-term conditions	• Empower people to care for themselves, with personalised care plans, supported as necessary by community workers. • Give better support and advice for carers.
Dementia	• Offer swift access to a memory-assessment service and appropriate diagnostic tests. • Enhance the quality of services in primary care, acute hospitals and within the care sector. • Introduce shared protocols for anti-dementia drugs.
End-of-life care	• Dignity is critical – end-of-life care should be top of the agenda. • Involve patients, carers and families in decisions. • Offer round-the-clock access to generalist and specialist services. • Always keep options under review.

West Midlands Framework for Excellence

What we want for patients

- You are treated with dignity.
- You receive the safest, highest-quality care as close to your home as possible – but where specialisation and centralisation is essential to ensure highest clinical outcomes, we will deliver it for you.
- You and your carers are involved in decision making about your care and are able to make informed choices about the care you receive – your preferences are sought, respected and documented in a personalised care plan. You are supported to manage your own health if that is what you want.
- You are able to access and receive care in a timely manner, including out of hours.
- You are assisted to be aware of the effect that lifestyle choices such as exercise, fruit and vegetable consumption, alcohol and smoking have on your health and can access and choose between a range of services you need to help you to make healthier choices. The NHS will support you in seeing these changes through.
- You receive care that is joined up in a way that makes sense to you and your family/carers, and that makes the minimum possible demands on your time and resources.
- You have clear information about what excellent services look like and about how the choices available to you compare with that.
- You can access regular health check-ups and that, at every contact you have with the NHS, your health professional will be working with you to spot health issues early and to offer preventive options.

What we want for the public

- All parts of the population can be confident that you, your families and loved ones have equitable access to high-quality care because the NHS is identifying and sharing best practice so that real improvements are quickly made available to all.
- The NHS makes available excellent information in a wide range of formats so that everyone has sufficient information about the services we offer and about their own health to make best use of those services.
- The NHS is offering taxpayers value for money, spending every pound to maximally improve health and reduce disabilities and so that fewer people are denied work through ill health and fewer children have disrupted schooling through ill health.
- The NHS is deciding how to develop its services and is in a full and serious dialogue with the public about that.
- You can be confident that the NHS is making its full contribution to the wider economic and social good through its role as employer and trainer, buyer of goods and services, developer of major infrastructure and in its demands for energy, transport and waste management.
- You can be confident that the NHS is fully prepared and able to respond to major **crises**.

Investing for Health

The seven challenges

Widening inequalities > *narrow the gap*

Variability in quality and safety > *reduce variability and raise the bar*

Too little prevention > *right the balance, effectively*

Low return on investment > *buy what works, consistently and robustly*

Cost pressures and opportunity costs > *the bold investment strategy in Investing for Health must be pursued*

Low public confidence > *build confidence through demonstrating progress in what matters to people, sharing information and joining up services, reducing the NHS footprint on patients*

Services difficult to navigate > *tackle that explicitly*

What we want for the NHS workforce

- You feel proud to work for your local NHS and not just for your own organisation.
- You work in an environment that champions good and safe practice and you receive excellent training, development and personal support.
- You are trusted and empowered to do what is right for patients, including working across organisational boundaries.
- Clinical pathways will be identified and respected.
- You will be given skills and support so that you can make every patient contact an opportunity for improving health.
- That you are treated with respect and dignity in healthy and safe work environments where there is zero tolerance of violence and aggression.
- You are given meaningful information to show you how services and health compare across areas.
- You are fully involved in designing the NHS of the future.

What we want for other organisations that work with the NHS

- Your contribution is respected and valued by the NHS.
- You are given clarity on which contributions are NHS priorities, so as to enable you to focus your energies in developing plans and proposals, and so that you can be clear about where to take those plans for consideration.
- You are part of co-ordination systems supporting the care of patients.
- You are given the opportunity to get involved as a partner in designing the NHS of the furure.
- You can make a contribution to how the NHS utilises its resources in pursuit of education, training and workforce development.

'The change will help people enjoy healthy lives, live longer and maximise independence'

- Vision into action – the importance of getting the basics right, with rigorous and consistent local planning within a regional framework of continuing clinical leadership.

Each group has produced a full report on its findings along with recommendations for action. Here, we present a brief outline of the vision set out in each report. For further details of specific pathways and the associated actions, however, it is essential to view the full report, which is published at www.westmidlands.nhs.uk

Staying healthy

Our overall vision is that the NHS as a whole should do more to support people in staying healthy. This means commissioning evidence-based and high-quality services that promote good health, targeting work on known health risks, encouraging healthy lifestyles and underlining people's need to take responsibility for their own health.

For individuals, the changes we envisage will help them enjoy healthier lives and live longer. Investing in the prevention of ill health can produce enormous benefits – it has been estimated that at least 80 per cent of all premature heart disease and over 40 per cent of all cancers could be prevented through healthy diet, regular exercise and by not smoking.

Patients in general will benefit from the changes in a number of ways. Communities will become actively engaged in improving their own health and everyone, throughout their life, will have better opportunities to take greater control of their health. This is what we call full engagement.

The changes will make it easier to get hold of information about specific services, as well as tailored information to help people improve their lifestyles. This will help people to stay as healthy as they can be, and maximise independence for as long as possible. The opportunity to tackle preventative health improvement will be incorporated in the clinical pathways for all other services, so that every clinical contact can be a health-improving contact. This will require extensive staff training and support to ensure the workforce can support people in managing their own health.

People with mental health problems will benefit from a wide range of services to promote mental health, for example schemes to improve their physical fitness. Mental health services will include schemes to help people back into the workplace and support them once they are there.

Differences in needs and expectations between ethnic minority groups, between age groups and between social groups will be reflected in our services.

The group identified seven essential elements of effective staying healthy pathways (see box, right).

Seven elements of staying healthy pathways

Everyone's business
Everyone – individuals, communities, organisations and society as a whole – needs to take more responsibility for good health.

Mainstream, not marginalised
All commissioning specifications should require providers to promote healthy lifestyles, and all clinical pathways should take account of 'staying healthy'.

The highest priority
All NHS organisations should expect to demonstrate a year-on-year shift of resources towards prevention.

Systematic and evidence based
Right across the NHS, we need to be better at implementing interventions that we know work well.

Led from the top
Promoting good health and disease-preventing services should be a priority for the most senior managers as well as for health promotion workers.

Effectively commissioned
Commissioners must ensure that the services they commission follow the good health pathway right through from primary prevention.

All inclusive
People and patients will be fully involved in their own health and healthcare, adopting healthier lifestyles on the basis of an assessment of their risks, with the option of support and guidance from a range of professionals.

Maternity and newborn

Maternity and newborn services represent the care provided to women and their babies before, during and after childbirth.

Our vision is for maternity services that are planned and delivered as a community-based service, integrated with primary care and embedded in the wider community provision, with a focus on health and well-being. While it is essential that pregnant women have rapid and equitable access to high-quality, obstetric-led and specialist neonatal care if needed, our vision is of a service that starts from the belief that pregnancy is a normal physiological event.

Care should be based on assessment of social as well as clinical risk, with targeted outreach support for the most vulnerable women. Midwives should be the named professionals for normal pregnancy, able to provide women with a network of social and clinical support. This should result in improved satisfaction, better detection and early treatment of high-risk mothers and babies, leading to long-term health gains.

Consideration should be given to meeting some of the current growth in the birth rate with community-based birthing units. Women should have much greater choice over where they receive their care.

The model of care

The model of care recognises the importance of a balance between the emotional, social and educational needs of all and the need for medical intervention for the few. It is based on:

- a mother- and baby-centred approach that treats pregnancy and maternity in general as a normal event
- an emphasis on the recognition and assessment of social and medical risk
- the available infrastructure and resources to provide 'high-risk' care where required.

The model involves actively assessing and managing personal and family factors that are recognised to cause problems – such as smoking, obesity, mental health and substance misuse. Women who have experienced domestic abuse or whose first language is not English will also need additional support.

Other important aspects of the model of care include:

- equity of access to pre-conception advice, antenatal screening and assessment, normal birthing centres, home visiting, mental health services, health improvement, social support, education and the obstetric service
- access for women and their babies to obstetric and neonatal services as clinically necessary, supported by a dedicated transfer service from the community base to the obstetric service
- a professional-development programme to extend the skills and competencies of maternity and neonatal staff to meet the wider needs of women, not just their immediate obstetric need
- pregnancy-support workers to provide additional support to meet women's more specific needs

'Midwives should be the named professionals for normal pregnancy, able to provide women with a network of social and clinical support'

- support from integrated maternity and neonatal networks across the region – it is essential that neonatal and maternity services are not planned in isolation from each other
- an emphasis on competencies, not professions. All professionals dealing with children should have appropriate training and experience. Skills and competencies of staff are more important than their professional alignment.

Children's services

The clinical pathway group covered all aspects of services for children from birth to 18 years of age, as well as services for the unborn child. Children's services interface with all of the other clinical pathways, and it is critical that there is a smooth transition between child and adult services. It should be recognised, however, that the needs of all children and young people differ from those of adults. Children's health, education and social care are all linked.

The clinical pathway group's vision is 'to provide high-quality children's healthcare that focuses on the needs of the child and is delivered at home, or as close to home as possible'.

The needs of children and their families will drive the organisation and provision of high-quality, family-centred health services, based at home or in the community wherever possible. All organisations, including local authorities and the

'Children will benefit from better health promotion and earlier detection and intervention'

education, health and voluntary sectors will integrate services. Organisational boundaries and contractual agreements will not stand in the way of providing the best possible care.

There will be a clear pathway for children between the universal and specialist services they require, so as to avoid unnecessary steps and duplication of effort. The pathway also helps the NHS to ensure staff have the appropriate skills and competencies.

The clinical pathway group put forward seven key messages (see box, below).

From the patient's point of view, this approach should mean fewer admissions to hospital, fewer inappropriate referrals, and less duplication and variation within the system. Children will benefit from better health promotion and early detection and intervention and there will be a smoother transition from child to adult services.

Family-centred services will allow children more chance of maintaining 'normality' in home and school life, especially those with long-term or complex conditions.

Eight care pathways have been expanded upon in the report: the sick newborn; the vulnerable child/ safeguarding; the child with trauma or head injury; the child with a long-term condition such as Duchenne muscular dystrophy; obesity; emotional health and well-being; palliative care; and paediatric surgery.

Mental health

Mental illness is common. It affects about one in six people in Britain. People with a mental illness can experience problems in the way they think, feel or behave. This can significantly affect their relationships, their work and their quality of life.

The clinical pathway group adopted the overarching message: 'There is no health without mental health'.

Our vision is for a pathway that aims to:

- promote and sustain good mental health
- provide easy access to services and prompt diagnosis
- offer a choice of effective interventions and swift treatment
- promote recovery and long-term health and well-being.

The pathway will result in coherent, consistent services for people with mental health problems, equity of access by age or additional disability and the delivery of services based on evidence.

It should lead to fewer premature deaths, a better quality of life for people with mental illness and a reduction in unnecessary treatments, especially for those who also have physical health problems.

Mental health cannot be just an NHS responsibility, since many mental health problems do not respond to clinical intervention alone. A range of other support is needed, for example, social support and help with housing or employment. Comprehensive care, structured through a care pathway, requires strategic commissioning and better partnership working across the health, social care, voluntary and community sectors.

Mental health problems must be identified early and tackled by ensuring that there are sufficient resources and appropriate skills available. All health and social care staff should have a basic understanding of mental health issues and actively work to reduce the stigma that surrounds them.

Children's services: seven key messages

1 More effective health and well-being promotion is needed.

2 Each local area must provide specialist services in the community for children with illnesses or long-term conditions.

3 Each local area must provide adolescent services.

4 The NHS should make it easier to identify and share good practice.

5 Providers must work together to construct integrated, seamless pathways and to improve quality and outcomes.

6 Children's needs are paramount.

7 Reconfiguration of services is vital to ensure viable and safe services, and it is essential to engage with communities and to seek public opinion where potentially controversial changes are proposed.

The group identified the key themes for developing a pathway for mental health (see box below).

Key themes for developing a pathway for mental health

Get the core services right – ensure equitable, consistent, modern, comprehensive mental health services for people who need them.

Stop premature deaths – ensure high-quality, equitable physical health services for people with mental health problems, learning disabilities, substance-misuse problems and organic mental health problems.

Better support for carers – recognise the role of carers and do more work on identifying needs following assessments; provide more respite care.

Planned care

Planned care is care that can be scheduled in advance and involves patients and/or their family or carers in its organisation. It can take place in primary care, community settings or a hospital. The planned care pathway usually involves the scheduling of a range of interventions, including assessment, diagnostic testing, treatment and review. Common examples of planned care include hip-replacement operations, cataract removal and hernia treatment.

Our vision is that, in future, as much care as possible will be planned care – as opposed to urgent or emergency care when the problem has become critical. This will:

- follow agreed pathways that patients understand and that are based on clinical best practice
- be easy for patients to navigate – they will know where they are on the pathway and be aware of what happens next
- respect the diversity of patients and seek to respond appropriately to the full range of their needs
- be organised so it does not waste patient or clinical time or resources
- be provided as locally as possible – care closer to home.

For patients, the vision also means less time in hospital if they require surgery and faster recovery from less invasive surgery.

The proposed pathway for planned care is based on the major stages set out below and a set of principles that should apply to these stages.

Self-assessment and self-care

Support for patients in their decision to access planned care, with reliable, accessible advice on symptoms and condition management.

Primary assessment and treatment

Quick and convenient access to primary care, supported by diagnostics and electronic links for referral.

Specialist assessment and treatment

A range of routes for more specialist treatment. All should aim to be 'one stop' and delivered as locally as possible.

Supra-specialist assessment and treatment

Certain specialist treatments will be carried out at specialist centres – for example cancer surgery.

'A single point of access to acute care could potentially be an 888 number available around the clock'

Review and rehabilitation

Patients should be well prepared for discharge. A range of community services should be in place to support care closer to home.

Acute care

This clinical pathway group concentrated on urgent and emergency care in an acute setting. This is care that is not planned – for example, an accident, a suspected heart attack or the worsening of an existing condition. Often patients themselves will decide where to go in such a case and at present, that is generally a hospital's A&E department, or their GP – including out-of-hours services.

Our aim is for patients to get the right treatment in the right place without unnecessary delay. At the moment, people can be unsure what to do or where to go if they think they have an urgent health need – indeed, not all NHS staff are clear about which services should be used, when and how.

The vision is for a single point of access – potentially an 888 telephone number available around the clock. People calling this number would have their needs assessed (triaged). Although this single point of access would be widely promoted, there would also be other ways for people to enter the urgent and emergency care system, for example by going to an urgent care

'Vulnerable and hard-to-reach groups will be sought out to ensure they have equal access to high-quality care'

centre. However, the assessment would be common to wherever patients accessed the service and the system will be responsible for ensuring that the patient is seen and treated by the most appropriate professional in the most appropriate setting.

Better provision of information to the public, combined with education programmes and alternative support services in the community, could increase the number of people who have the ability and confidence to self-care.

Overall, the quality of care will be increased, along with patient and staff satisfaction, because of the streamlined access to appropriate urgent care services.

The pathway will increase the number of patients being assessed and receiving treatment in or close to their own homes. It will also increase the numbers receiving rapid diagnostics and given care plans.

The clinical pathway group made three key additional points (see box, below).

Long-term conditions

Long-term conditions are those that cannot, at present, be cured but can be controlled by medication and other therapies. At least 15 per cent of people in the West Midlands have a long-term condition, such as diabetes, asthma, hypertension, heart disease or chronic kidney disease.

The vision for people with long-term conditions combines much greater involvement by patients in their own care, which will be better co-ordinated and more personalised. People will be helped to take responsibility for their health, including how to prevent, detect and treat their illness. The vision demands an approach that seeks out vulnerable and hard-to-reach groups to ensure they have equal access to high-quality care.

There will be active care, finding a rapid diagnosis with early interventions, provided closer to home, with patients as lead partners in decisions. All interventions will be co-ordinated around patients, and accessible at their convenience.

Acute care: key points

- In the absence of demonstrable benefit to alternative urgent care provisions, there is a need to gear up A&E services to cope with the instinctive path that patients take – this will be influenced by local geography.
- All A&E departments should incorporate urgent care centres (UCCs) but not necessarily the other way round.
- In the West Midlands, some concentration of the most specialist emergency services into major emergency departments is necessary to achieve the best quality of care for patients with, for example, stroke, heart attacks and major trauma.

Healthcare professionals will work as a single team across traditional health boundaries, using use the best evidence to discuss a range of treatment options with their patients. Patients will benefit from greater involvement in their own care and from being able to better manage their conditions. Care will be personalised, tailored to individual needs and the approach will be one of treating the whole patient, not just the condition. Patients will be guided through the system by their own care co-ordinator.

The clinical pathway group identified a number of steps (see below) on the long-term conditions pathway and highlighted the actions that we need to take in the West Midlands to make our vision of an improved service a reality.

Prevention and early detection

This is about doing more to tackle many of the underlying causes of long-term conditions, such as smoking, poor diet or lack of physical activity, and identification of at-risk patients.

Self-care

We need to introduce more self-management programmes, which will result in increased well-being for patients.

Single-team approach

To provide proactive, responsive and integrated care, we need a system that will help us to know more about the population and the risks of people developing long-term conditions.

We need to identify patients who are being seen in hospital outpatient

departments who could be seen in the community. Good rehabilitation services need to be in place to help patients live independently.

We need a major programme of training to ensure a far greater proportion of the frontline workforce are able to support people with long-term conditions and understand key clinical alert signs. Staff also need the ability to develop individualised care plans with patients, to empower patients and to support them with behavioural change.

End-of-life care

End-of-life care has to be considered in relation to the care pathway for people with long-term conditions.

Dementia

Dementia is a neurological condition with symptoms of progressive decline of mental abilities, accompanied by personality and behaviour changes. There is usually a loss of memory and the ability to carry out everyday activities.

Our vision is that by 2012, all people with a suspected or confirmed diagnosis of dementia will access a locality-based service that is integrated, seamless, proactive and high quality, and that encompasses all the expertise necessary to meet their needs and those of their carers. The emphasis will be on personalisation and choice. Patients will also find that the staff they come into contact with will have much improved awareness of dementia and will be competent to address their physical and behavioural symptoms.

The group has identified the features of a good care pathway for dementia. These include respect for patients and their carers, services that maximise personal control and empowerment, and seamless transitions between organisations.

The pathway will start by raising public awareness and making information available on prevention activities. The second step will be early intervention, including GP screening and specialist memory assessment via a single access point. Pre-assessment counselling should take place at an early stage to enable people to make an informed decision about the future. Assessments will be carried out in the patient's own home if possible.

Once a person has been given a diagnosis, they will receive support from a co-ordinator for the rest of the dementia 'journey'.

The aim will be for ongoing treatment to take place closer to home, although there will still be a need for institution-based care, and respite care will be important. Residential care services should develop high-quality, affordable, person-centred care and promote well-being, recovery and independence.

A critical message from this clinical pathway group is the importance of better support for carers and of finding new approaches to caring as the population ages.

End-of-life care

When thinking about end-of-life care, we consider:

- living well at the end of life
- care in the last days of life
- support for carers after death.

'With the pathway in place, dying at home should become the norm if that is what people choose'

End-of-life care also involves taking account of the needs of the families of the dying.

When patients and those around them recognise that they are coming to the end of their lives, they want their communities and carers to talk to them about their wishes and choices. In the last year of life, most people become more dependent on others, so when help and support is needed, they want it to be provided promptly and to meet their needs. Patients also recognise that those close to them will have their own needs and want these to be met as well.

With the pathway in place, dying at home should become the norm if that is what people choose. Patients and carers will have more opportunity to be informed and involved in decisions about treatment and settings for their care.

Wherever someone chooses to die, that patient and their family will be treated with dignity by staff who are confident in their end-of-life skills. Overall, care will be co-ordinated, seamless and equitable, taking account of the needs of patients and the carers before and after death. Religious and cultural beliefs will be respected.

The report contains a proposed care pathway with a description of what 'excellent' looks like under each of the steps listed below.

'We need local models for each of the clinical pathways and specific plans for particular specialties'

Being informed
This will empower the public to make informed end-of-life choices.

Discussing wishes
Patients will be prepared for appropriate discussions with clinicians. Clinicians will use tools to identify when these discussions are needed and have the necessary communication skills.

Assessment and care planning
Active, repeated, and explicitly recorded and shared with other professionals, the patient and their carers.

Co-ordination of care
Health and social economies will have systems designed to deliver co-ordinated and proactive care, and also respond to crisis.

Integrated care
Round-the-clock care, including high-quality nursing and medical care, and also a range of supportive services, such as housekeeping and transport.

Last days of life
The use of established end-of-life tools will be recognised and death will occur, where possible, in the place of the patient's choice

Care after death
Respect for the beliefs and cultures of our communities, and care for the bereaved.

Implications for local services

While it is for NHS West Midlands to set the overall strategy and framework for the future of health services in the region, it is for local health service commissioners – the organisations who 'buy' services from a range of organisations, including hospitals – to develop plans to meet local needs.

All commissioners in the West Midlands are working on a vision for a local model of care that is:

- evidence based
- clinically owned
- clear about clinical and economical viability
- mapped onto local geography.

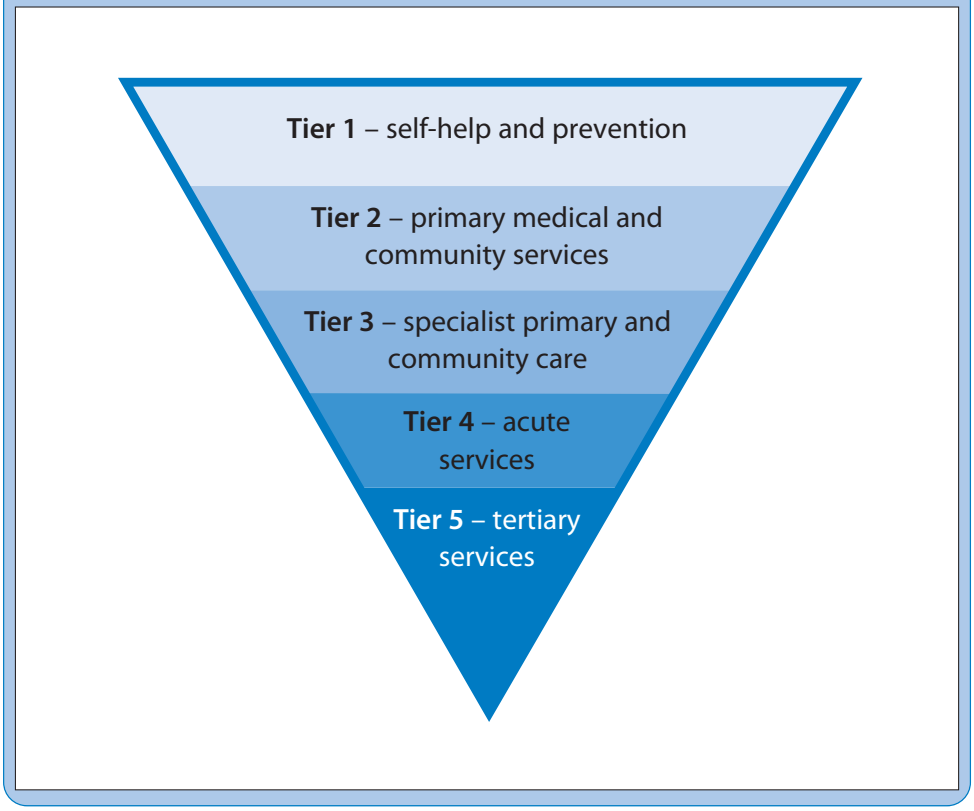
They need to set out a model of care for each of the clinical pathways, and a specific plan for particular specialties such as paediatrics, maternity and A&E.

They also need to show that their plans will work in practice, for example that the right facilities and services are in place to support a particular activity, and that the plans are financially sound.

The model of care that is emerging can best be visualised using a pyramid. The number of tiers and the description of them varies depending on local circumstances, but essentially the vision for future services is shown in the diagram below.

This model of care is then made specific in each local area for each

West Midlands model of care



of the nine clinical pathways. Primary care trusts (PCTs) are also being asked to identify 'neighbourhoods', or local areas within which services are clustered and interlinked.

Supporting these local models of care and plans are a set of health investment proposals that will lead to:

- increased investment in preventive and early-intervention services
- enhanced capacity and capability in primary care and systematic management of people with long-term conditions
- a shift from hospital to community for a great deal of care, diagnostics and assessment
- some patients who need the facilities of an acute hospital accessing more specialist sub-regional centres that are able to provide round-the-clock specialist care
- provision of the highest-quality care to patients throughout the system
- investment in specific areas of weakness.

Investment framework

The status quo is not viable from a financial point of view. Increases in costs associated with population change, the prevalence of disease, advances in medical technology and increases in patient expectations mean that the costs of running the NHS will quickly outstrip anticipated increases in funding.

However, our strategy should enable us to bring costs back within available resources and create a 'quality dividend', where we save money by:

- getting people more involved in improving their own health
- improving commissioning and service productivity
- avoiding preventable errors
- adopting new technologies.

We anticipate spending more on care closer to home, advances in medical technology, new IT, interventions designed to prevent illness, and increased responsiveness – such as shorter waiting times.

Implementation

Although the scale of change is significant, it does not involve dramatically new, untested ideas. It is about doing what we already know can work and doing that comprehensively, robustly and quickly.

Achievement of the aims of *Investing for Health* and the clinical pathway group reports relies on six important characteristics:

- the foundations of our plans need to be in the local community and must fit with the aspirations of the public and our partner organisations
- we will need to use all the 'levers' we have to achieve change
- the framework must lead to immediate action on the most important issues
- the opportunities presented by national NHS reforms must be seized to help us take forward our objectives

'It is about doing what we already know can work and doing it comprehensively, robustly and quickly'

- the framework should prompt joint working across our patch in areas where change is needed
- we must be able to measure success and be held accountable by our publics.

Investing for Health also involves ten collaborative projects that are being carried out with all the PCTs in the region. In addition, West Midlands SHA is working with partners in the region to establish Academic Health Science Centres to provide greater research and development capability.

Our vision requires a cultural and skills shift and will depend greatly on the quality of leadership. Clinical leaders are vital to the process. At a local level, the key to clinical engagement in commissioning will be through strengthening practice-based commissioning.

At a strategic level, NHS West Midlands has created a new structure to support clinical leadership and local commissioning across the region. This involves appointing up to 15 new clinical leads, who will concentrate on implementing the clinical pathway group recommendations and *Investing for Health*, working with PCTs and providers.

Effective implementation will also rely on:

- patient, carer, public and staff engagement in strategic planning

'We are getting on with the work that will turn our vision of a world-class health service into reality'

- greater collaborative commissioning across PCTs
- specific workforce actions such as training, reviewing and enhancing the skills we have, and retraining as necessary
- securing some 'quick wins' – that is, where things can be done now, we must do them
- being held to account – for example, we intend to hold an annual event where patients, carers, public and staff representatives who have contributed to the work are invited to review progress with us. We will also have an annual independent review of our progress, which will be made public.

Measuring success

We need to make sure that the changes are making a difference by delivering improved healthcare and improved outcomes for people in the West Midlands. We need to understand what works and what does not.

In *Investing for Health*, we published 33 core indicators that would help us see if we were meeting the seven big challenges and five strategies. To these we will add indicators that identify progress on implementing the clinical pathway group visions. We will also use national indicators and track PCTs' progress in meeting their local targets for improvement. All will be tested against the West Midlands Framework for Excellence.

Conclusion

This is an exciting time for the NHS in West Midlands. We are already getting on with some of the work that will turn our clinical vision for a world-class health service into reality. We are taking steps now to build the clinical leadership that will guide us through the next stages of that work.

We have a broad agreement from patients, carers, public, staff and partner organisations about the way forward for our health services. It is for NHS West Midlands to lead the work and we will report regularly and fully on what has been achieved. We will continue to work with all who have contributed so far to ensure that our plans remain fit for purpose to deliver *Investing for Health*.

More information

If you would like more information about *Investing for Health* – Step 2: Delivering our clinical vision for a world-class health service, or have comments on the proposals please visit www.westmidlands.nhs.uk

NHS West Midlands

This document is available in PDF format at www.westmidlands.nhs.uk

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NHS

The National Health Service

Constitution

A draft for consultation, July 2008

The NHS belongs to the people. It is there to improve our health, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.

The NHS is founded on a common set of principles, values and commitments that bind together the people who it serves – patients and public – and the staff who work for it.

This Constitution establishes the **principles** and **values** of the NHS in England. It sets out commitments to patients, public and staff in the form of **rights** to which they are entitled and **pledges** which the NHS will strive to deliver, together with **responsibilities** which the public, patients and staff owe to each other to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services will be required by law to take account of this Constitution in their decisions and actions.

The Constitution will be renewed every ten years, with the involvement of patients, public and staff. It will be accompanied by the *Handbook to the NHS Constitution*, to be renewed every three years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution. These requirements for renewal will be legally binding. They will guarantee that the principles and values which underpin the NHS are subject to regular review and recommitment; and that any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff.

1. Principles that guide the NHS

Seven key principles guide the NHS in all it does. They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public. These values are set out at the back of this document.

1. The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, religion or sexual orientation. It has a duty to each and every individual that it serves. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. Access to NHS services is based on clinical need, not an individual's ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. The NHS aspires to high standards of excellence and professionalism – in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.

4. NHS services must reflect the needs and preferences of patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.

5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles, values and commitments now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and wellbeing.

6. The NHS is committed to providing best value for taxpayers' money and the most effective and fair use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

7. The NHS is accountable to the public, communities and patients that it serves. The NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose. In addition, all NHS organisations will give patients and the public the opportunity to influence and scrutinise their performance and priorities; and patients, public and staff will be involved in relevant decisions about the NHS which affect them, either directly or through their representatives.

2a. Patients and the public – your rights and NHS pledges to you

Everyone who is entitled to use the NHS should understand what legal rights they have. For this reason, important rights are summarised in this Constitution and explained in more detail in the *Handbook to the NHS Constitution*, which also explains what you can do if you think you have not received what is rightfully yours. This summary does not alter the content of your legal rights.

This Constitution also contains **pledges** – those things the NHS strives to do above and beyond its legal requirements.

Access to health services:

You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.

You have the right to access local NHS services. You will not be refused access on unreasonable grounds.

You have the right to expect your local NHS to assess the health requirements of the local community and to put in place the services to meet those needs as considered necessary.

You have the right to seek treatment elsewhere in Europe if you are entitled to NHS treatment but you face undue delay in receiving that treatment.

You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion, sexual orientation, disability (including learning disability or mental illness).

The NHS will strive to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution. (pledge)

The NHS will strive to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered. (pledge)

The NHS will strive to make the transition as smooth as possible when you are referred between services, and to include you in relevant discussions. (pledge)

Quality of care and environment:

You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation.

You have the right to expect NHS organisations to monitor, and make efforts to improve the quality of healthcare they provide, taking account of the applicable standards.[1]

The NHS will strive to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice. (pledge)

The NHS will strive for continuous improvement in the quality of services you receive, identifying and sharing best practice in quality of care and treatments. (pledge)

Nationally approved treatments, drugs and programmes:

You have the right to drugs and treatments that have been recommended by NICE[2] for use in the NHS, if your doctor says they are clinically appropriate for you.

You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you

[1] The current standards are set out in the *Handbook to the NHS Constitution.*

[2] NICE (the National Institute for Health and Clinical Excellence) is an independent NHS organisation producing guidance on drugs and treatments. 'Recommended' means recommended by a NICE technology appraisal. Primary Care Trusts are normally obliged to fund NICE technology appraisals from a date no later than three months from the publication of the appraisal.

and your doctor feel would be right for you, they will explain that decision to you.

The NHS will strive always to provide vaccination and screening programmes as recommended by the appropriate national advisory bodies. (pledge)

Respect, consent and confidentiality:

You have the right to be treated with dignity and respect.

You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests.

You have the right to be given information about your proposed treatment in advance, including any significant risks and any alternative treatments which may be available, and the risks involved in doing nothing.

You have the right to privacy and confidentiality.

You have the right to access your own health records. These will always be used to manage your treatment in your best interests.

The NHS will strive to share with you any letters sent between clinicians about your care. (pledge)

Informed choice:

You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.

You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.

You have the right to make choices about your NHS care. The options available to you will develop over time and depend on your individual needs. Details are set out in the *Handbook to the NHS Constitution*.

The NHS will strive to inform you about what healthcare services are available to you, locally and nationally. (pledge)

The NHS will strive to offer you easily accessible information to enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available. (pledge)

Involvement in your healthcare and in the NHS:

You have the right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this.

You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

The NHS will strive to provide you with the information you need to participate effectively to influence the planning and delivery of NHS services. (pledge)

The NHS will strive to work in partnership with you, your family and carers. (pledge)

Complaint and redress:

You have the right to have any complaint you make about NHS services dealt with efficiently and to have it properly investigated.

You have the right to know the outcome of any investigation into your complaint.

You have the right to take your complaint to the Health Service Ombudsman where you have exhausted any other rights of appeal or review.

You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful NHS decision or action.

You have the right to compensation where you have been harmed by negligent treatment.

The NHS will strive to ensure that if you make a complaint, you will receive a timely and appropriate response, that any harm you suffered is corrected where possible, and that the organisation learns lessons and puts in place necessary improvements. (pledge)

The NHS will strive to ensure that you receive appropriate support and are treated with respect and courtesy throughout the handling of any complaint you make; and the fact that you have complained will not affect your future treatment. (pledge)

2b. Patients and the public – your responsibilities

The NHS belongs to all of us. There are things that we can all do to help it work effectively and to ensure resources are used responsibly:

You should recognise that you can make a significant contribution to your own, and your family's, good health, and take some personal responsibility for it.

You should register with a GP practice – the main point of access to NHS care.

You should treat NHS staff and other patients with respect and recognise that causing a nuisance or disturbance on NHS premises could result in prosecution.

You should provide relevant and accurate information about your health, condition and status.

You should keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.

You should follow the course of treatment which you have agreed with your clinician.

You should participate in important public health programmes such as vaccination.

You should ensure that those closest to you are aware of your wishes about organ donation.

You should give feedback – both positive and negative – about the treatment and care you have received, including any adverse reactions you may have had.

3a. Staff – your rights and NHS pledges to you

It is the commitment, professionalism and dedication of staff involved in working for the benefit of the people the NHS serves which really make the difference to patients' quality of care and experience.

All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and treated with respect at work; to have the tools, training and support to deliver care; and to have opportunities to develop and progress.

Staff have extensive **legal rights**, embodied in general employment and discrimination law. These are summarised in the *Handbook to the NHS Constitution*. In addition, individual contracts of employment contain terms and conditions giving staff further rights.

The rights are there to help ensure that staff:

- have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives;

- have a fair pay and contract framework;
- can be involved and represented in the workplace;
- have safe working conditions free from harassment, bullying and violence;
- are treated fairly, equally and free from discrimination; and
- can raise an internal grievance and if necessary seek redress, where it is felt that a right has not been upheld.

In addition to these legal rights, there are a number of **pledges** which the NHS will strive to deliver.

The NHS will strive to provide all staff with well-designed and rewarding jobs that make a difference to patients, their families and carers, and communities. (pledge)

The NHS will strive to provide all staff with personal development, access to appropriate training for their jobs, and line management support to succeed. (pledge)

The NHS will strive to provide support and opportunities for staff to keep themselves healthy and safe. (pledge)

The NHS will strive to engage staff in decisions that affect them and the services they provide, individually and through representatives. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families. (pledge)

3b. Staff – your responsibilities

All staff have responsibilities to the public, their patients and colleagues. Important legal duties are summarised below. The Constitution also includes expectations that reflect how staff should play their part in ensuring the success of the NHS.

You have a duty to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body, applicable to your profession or role.

You have a duty to take reasonable care of health and safety at work for you and others, and to co-operate with employers to ensure compliance with health and safety requirements.

You have a duty to act in accordance with the express and implied terms of your contract of employment.

You have a duty not to discriminate against patients or staff and to adhere to equal opportunities and diversity legislation.

You have a duty to protect the confidentiality of personal information that you hold.

You have a duty to be honest and truthful in applying for a job.

You should strive to maintain the highest standards of care and service, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole.

You should strive to take up training and development opportunities provided.

You should strive to play your part in improving services for patients, the public and communities.

You should strive to contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged.

You should strive to involve patients, their families and carers in the services you provide.

NHS values

The NHS values have been derived from extensive discussions with staff, patients and the public:

Respect and dignity. We value each person as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we can and cannot do.

Commitment to quality of care. We earn the trust placed in us by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. We welcome feedback, learn from our mistakes and build on our successes.

Compassion. We find the time to listen and talk when it is needed, make the effort to understand, and get on and do the small things that mean so much – not because we are asked to but because we care.

Improving lives. We strive to improve health and well-being and people's experiences of the NHS. We value excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation.

Working together for patients. We put patients first in everything we do, by reaching out to staff, patients, carers, families, communities, and professionals outside the NHS. We put the needs of patients and communities before organisational boundaries.

Everyone counts. We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste others' opportunities. We recognise that we all have a part to play in making ourselves and our communities healthier.

288970 1p 5k June 08 (CWP)
Produced by the Department of Health

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Sandwell and West Birmingham Hospitals NHS
NHS Trust

HIGH QUALITY CARE FOR ALL
DEVELOPMENTS IN REGIONAL AND NATIONAL POLICY

TRUST BOARD DISCUSSION PAPER

INTRODUCTION

"High Quality Care for All", the final report of the NHS Next Stage Review (NSR) led by Lord Darzi, was published in June 2008. The report, and its accompanying regional reports, set the strategic direction for the medium-term future of the NHS as well as announcing a series of specific policy developments that will affect the NHS in the short-term. In the West Midlands, the Strategic Health Authority (SHA) used the NSR to develop further the regional strategy set out in "Investing for Health" through the work of series of clinical pathway groups. Although much of the regional and national vision set out in these reports is consistent with our long-standing local vision developed through the Towards 2010 Programme, these reports set significant elements of our future strategic context. This paper is designed to enable the Trust Board to consider their implications, opportunities and threats as we develop our plans for NHS Foundation Trust (NHS FT) status.

BACKGROUND

The Trust's work to prepare an application for NHS Foundation Trust status included an assessment of national and regional policy and its affect on the strategic context in which we operate. This is set out in more detail in section 4.3 of our Integrated Business Plan (IBP), and also features in the PEST (section 4.5) and SWOT (section 5.3) analyses in the IBP.

This assessment was undertaken before the publication of the NHS NSR final report and included the following key elements of national and regional policy:

- Choosing Health (2004): focus on public health policy setting priorities for action including smoking, obesity, diet and nutrition, exercise, alcohol, sexual health and mental health.

- Our Health, Our Care, Our Say (2006): set policy in four areas: better prevention and earlier intervention, more choice and a louder voice; tackling inequalities and more support for people with long-term conditions.

- System reform changes including Payment by results, Practice-based commissioning, Patient choice, NHS Foundation Trusts and independent systems for external inspection and regulation (Monitor and Healthcare Commission / Care Quality Commission).

- Investing for Health (2007): the NHS West Midlands regional strategy identified seven major challenges facing the local NHS including widening inequalities, variability in quality and safety, services that are difficulty to navigate, low public confidence, too little prevention, low return on investment and cost pressures and opportunity costs.

From this assessment, the Trust's IBP identified five key themes in national and regional policy.

1. Focus on prevention, early intervention and tackling inequalities.

2. Patient choice, personalisation and responsiveness.

3. Clinical safety and quality.

4. Care closer to home.

5. Value for money.

The Trust's plans for NHS FT status, including our organisational vision and six strategic objectives (set out for ease of reference in Appendix 1) are designed to respond effectively to these five key themes.

RECENT POLICY DEVELOPMENTS

The NHS NSR resulted in the publication of a series of reports in June 2008. These comprised:

- High Quality Care for All. The Final Report of the NHS Next Stage Review;
- A Consultation on the NHS Constitution;
- NHS Next Stage Review. Our Vision for Primary and Community Care;
- NHS Next Stage review. A High Quality Workforce.

In addition to this set of reports, there have been a series of other developments in national policy since the Trust undertook our original assessment of national and regional policy to inform our plans. Many of these relate to the development of PCT commissioning and national competition policy. Some of the most significant include:

- World Class Commissioning: a national approach to developing PCT commissioning including an annual assurance process and the requirement for PCT's to produce Strategic Plans during the autumn of 2008;

- Care Quality Commission: creation of a single-integrated regulator for health and adult social care combining the functions of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission.

- Principles and Rules for Cooperation and Competition (Annex D Operating Framework 2008/9): sets ten principles and associated rules for the operation of cooperation and competition within an increasingly "rules-based NHS" (the principles are set out in Appendix 2).

- Cooperation and Competition Panel: to be established in October 2008 with an independent chair to ensure the application of the Principles and Rules for Cooperation and Competition.

- PCT Procurement Guide (May 2008): designed to support PCT commissioners in decisions about whether and how to procure health services through formal tendering and market-testing exercises.

- Changing for the Better (May 2008): provides guidance on undertaking major service changes, stresses that changes should clinically-driven and locally-led and introduces requirement for Office of Government Commerce gateway reviews for future major service change proposals.

Although the final report for the NHS HSR is the most far-reaching of these policy developments, the development of independent regulation and inspection and the development of PCT commissioning and competition policy of the NHS are also a significant part of our external strategic environment.

HIGH QUALITY CARE FOR ALL

The executive summary of Lord Darzi's report and the draft NHS Constitution accompany this report. This paper does not aim to provide an alternative executive summary of the main report but rather to provide some analysis to support the Board in considering the implications for the Trust of the content of the report.

Six Challenges

"High Quality Care for All" identifies six challenges facing the NHS:

1. Ever higher expectations;
2. Demand driven by demographics;
3. Health in an age of information and connectivity;
4. The changing nature of disease;
5. Advances in treatments;
6. A changing health workplace.

Not surprisingly, there is considerable overlap between these challenges, the regional challenges identified in "Investing for Health" and the five key policy themes identified by the Trust in preparing our IBP.

Five Main Themes

In setting out how the NHS should respond to these challenges, the vision and proposals in "High Quality Care for All" can be grouped into five main themes.

1. *Create an NHS that helps people stay healthy*. "The NHS has a responsibility to promote good health as well as tackle illness". This concentrates on the role of PCTs working with local authorities, private and third sector organisations to commission wellbeing and preventative services. Whilst this may not directly affect acute hospital trusts, these developments may over time affect demand for our services (possibly by identifying patients needing specialist input earlier) and given our local Towards 2010 vision may provide opportunities for us to support primary care in this work. The Trust also has responsibilities towards our workforce to ensure that they are supported in staying healthy.

2. *Patient Choice*. "We will give patients more rights and control over their own health and care". The NHS Constitution enshrines the right of patients to choose treatments and providers and to access to information on quality. Other proposals include extending choice of GP practice and piloting personal health budgets for "particular patients in certain circumstances". The further strengthening of patient choice is

critical to the future of acute trusts, particularly those operating in competitive urban environments such as ours especially when combined with the proposals in the next section.

3. *Quality at the heart of the NHS.* "High quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect". This includes a range of proposals designed to provide clear incentives to improve standards that will directly affect acute hospital trusts. These include the publication of annual "Quality Accounts" including patient views on the quality of their experience and the success of their treatment, linking hospital payment to patient views about their treatment through the tariff, tariff setting in some conditions based on best practice not average cost and changes to the Clinical Excellence Award scheme for doctors to reinforce quality improvement. Combined with the reinforced commitment to patient choice, the emphasis on quality and the linking of quality to payment through measures including patient-reported measures will provide strong incentives for trusts in competitive markets to respond to this agenda.

4. *Clinical leadership.* "Change is most likely to be effective if it is led by clinicians". This includes proposals to strengthen clinical leadership at national and regional level and to support innovation in clinical practice through incentive funds and partnerships with universities and industry. At organisational level, the work that the Trust is undertaking to develop service line management through clinical directors is one application of this approach.

5. *Working in partnership with staff.* "Where change is led by clinicians and based on evidence of improved quality of care staff . . . are energised by it and patients and the public more likely to support it". This includes proposals to reinvigorate practice-based commissioning and develop new organisations to provide community and primary care services including social enterprise organisations and opens the possibility of integrated care organisations spanning community and hospital heath services and social care. The new organisational structures suggested here may offer opportunities to work with our 2010 partners in a different way to deliver our new models of care. The report restates the national commitment to NHS Foundation Trusts and aims to accelerate the rate at which NHS Trusts achieve NHS FT status.

   "NHS staff make the difference where it matters most". The NHS Constitution includes commitments to staff on work and wellbeing, learning and development and involvement and partnership. The Trust's Listening into Action programme aims to address some of these issues but meeting what will become statutory duties through the Constitution will require further work by the Trust as a major employer.

Like the six challenges considered earlier, much of the vision set out by Lord Darzi in "High Quality Care for All", echoes the themes in national and regional policy identified previously by the Trust in developing our plans. However, this report places much greater emphasis on the importance of quality and includes a set of specific new proposals that make it of major significance to the Trust as a large provider of acute healthcare services.

INVESTING FOR HEALTH

The national NHS NSR final report is accompanied by ten regional reports. NHS West Midlands report - "Investing for Health. Delivering our Clinical Vision for a World Class Health Service" – is based on the original regional strategy set out "Investing for Health" in 2007 further developed in the light of the work of nine regional clinical pathway groups in

which SWBH clinicians were well represented. The executive summary of the report accompanies this paper.

The pathways developed by the nine regional clinical groups cover the following areas:

- Staying Healthy
- Maternity and Newborn
- Children's Services
- Mental Health
- Planned Care
- Acute Care
- Long-Term Conditions
- Dementia
- End of Life Care

The models proposed by the clinical pathway groups are in large part consistent with the models of care that our health economy has been developing locally through the Towards 2010 Programme.

The regional strategy also includes the "West Midlands Pledge for Excellence". This is intended to set out a framework that the SHA will use to test services and proposals for service development in the future. It includes pledges for patients, the public, staff and partner organisations.

IMPACT ON SWBH STRATEGY

The changes in national and regional policy set out in the earlier sections of this paper are highly significant for the environment in which the Trust operates. This section uses the five key themes identified originally identified by the Trust in preparing the IBP to consider the main areas of potential impact for the Trust arising from "High Quality Care for All" and other recent policy developments.

SWBH Key Theme	**Potential Impact of Recent Developments including NHS NSR.**
Focus on intervention, prevention and tackling inequalities	• Successful delivery of preventative services by our PCTs may change pattern of demand for our services (fewer patients arriving as emergencies; an increase in earlier referrals to support management of long-term conditions). • May be opportunities to support primary care in improved management of patients with long-term conditions. • Need to develop further approach to health of the workforce of the Trust.
Patient choice, personalisation and responsiveness.	• Reinforced right to choice will continue to raise patient expectations of choice of treatment and provider. • Challenge to the Trust's catchment / market share if other local Trust's provide more "customer-focussed" services than ours. • Opportunities for the Trust to increase catchment / market share through patient choice if able to provide highly "customer-focussed" services. • Reinforces need for work on "customer care" issues (e.g. through Listening into Action projects).

SWBH Key Theme	Potential Impact of Recent Developments including NHS NSR.
Clinical safety and quality.	• Places clinical quality and patient outcomes at the centre of the national policy agenda • PBR income dependent in future on patient view of service quality and outcome as well as just volume. • Publication of "Quality Accounts" and other quality information will highlight variations in quality and outcome within and between trusts. • Regulation and inspection regime will develop as Care Quality Commission replaces the Healthcare Commission. • Will need to respond to regional strategies for particular clinical services (e.g. trauma, stroke, heart attacks). • Will need to take account of "Changing for the Better" guidance in future plans for major service change.
Care closer to home.	• Clear reinforcement of Towards 2010 model through national and regional strategies. • Opportunities to work more closely with primary and community health services through new types of organisation (e.g integrated care organisations) to deliver 2010 models of care. • Challenge of greater competition for the provision of services outside of the acute hospital in the Towards 2010 model. • Need to develop relationships with local PCT provider arms as they move towards more autonomous organisations.
Value for money.	• Move to more "rules-based" system for competition in the NHS may result in greater use of market-testing and tenders by PCTs. • Will need to ensure that agreements reached with our PCTs on Towards 2010 transition plan are consistent with Principles and Rules for Cooperation and Competition. • "Best practice" tariffs may present opportunity or threat depending on how current costs, current tariff and new tariff compare. • DH commitment to NHS FT status as the model for the future for acute hospital trusts.

In the light of this assessment, to operate successfully in response to this national and regional policy agenda, acute trusts will need to:

- deliver and be able to demonstrate that they deliver consistently high clinical outcomes;
- deliver and be able to demonstrate that they deliver consistently high levels of patient satisfaction;
- have a robust understanding of income and expenditure at specialty level and operate highly productive services;

- have structures that support strong clinical leadership and staff engagement in delivering the objectives of the organisation.

These four areas (clinical quality, patient satisfaction, commercial focus and an engaged workforce) are therefore areas that the Trust needs to ensure are properly addressed in our plans for the future.

ISSUES FOR CONSIDERATION

This paper presents a number of issues for further consideration by the Trust Board as part of the process of further developing our organisational strategy.

1. Are there other potential opportunities and threats for the Trust arising from recent policy developments?

2. Do the vision for the future of the organisation and/or our six strategic objectives need further development in the light of recent policy developments?

3. Are there areas where our approach to the Towards 2010 Programme with our partners needs developing in the light of recent developments?

4. Do our current plans give sufficient focus to the two key issues arising for Trusts from the NHS NSR final report: clinical quality and patient choice?

5. What are the key issues arising from recent policy developments that the Trust needs to focus on in planning for 2009/10?

The outcome of the Trust Board discussion of these issues on 4th September 2008 will be used to support the ongoing development of our plans for 2009/10 and our longer-term strategy as set out in the IBP for NHS FT status.

CONCLUSION AND RECOMMENDATIONS

This paper has provided an overview of the work that the Trust has done to date to analyse national and regional policy as part of the development of our organisational strategy. It has also summarised a set of recent policy developments including most significantly the final report of the NHS NSR both regionally and nationally. It has identified a set of key issues for consideration by the Board to support the ongoing process of developing our strategy and plans in the light of recent policy changes.

The Trust Board is recommended to:

1. NOTE recent policy developments including the final report of the NHS Next Stage Review;

2. CONSIDER the impact of the key issues arising from recent developments on the Trust's service strategy and future plans.

Richard Kirby
26th August 2008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Interim Reconfiguration of Surgical Services. Business Case for Investment
SPONSORING DIRECTOR:	Director of Strategy
AUTHORS:	Deputy 2010 Implementation Director, 2010 Implementation Director, Director of Strategy
DATE OF MEETING:	4 September 2008

KEY POINTS:

The Trust Board approved the implementation plan for surgical interim reconfiguration in June 2008. The Board noted the need for investment to deliver the plan and that more detailed work was being undertaken on the business case. This paper presents the business case for approval by the Trust Board.

The business case considers options for investment to deliver our plans. The preferred option requires an investment of £837k of recurrent revenue and £534k of capital to support delivery of surgical reconfiguration. The impact of this option in 2008/9 is covered by reserves already agreed within the 2008/9 financial plan.

The investment will deliver the following key benefits:

- avoided future costs – the cost of bringing two services up to the same standard without reconfiguration is estimated at £1,377k. This is £540k more than the preferred option proposed in the business case;
- improved service quality – the preferred option will support improvements in service quality as a result of reconfiguration including reductions in delays for access to theatres for many emergency patients;
- potential future productivity – the preferred option will support the delivery of future productivity through further reductions in length of stay and improved emergency theatre utilisation.

PURPOSE OF THE REPORT:

✓ **For approval**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. APPROVE the additional revenue investment of £837,905

2. APPROVE the additional capital investment of £534,000

3. NOTE the additional revenue and capital investments required in 2008/09 can be covered within the Trust's financial plan for 2008/09 and that the balance to full year effect for 2009/10 will need to be addressed through the Trust's planning for 2009/10.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Approval of the business case supports delivery of the Trust's annual objective 2.5 Deliver service reconfiguration changes in neo-natal services, surgery and pathology.

IMPACT ASSESSMENT:

FINANCIAL	✓	Investment of £837k full year effect revenue and £534k capital in surgical reconfiguration.
ALE		
CLINICAL	✓	Delivers surgical reconfiguration changes supporting changes to the clinical pathway for surgery.
WORKFORCE	✓	Implementation of surgical reconfiguration will affect staff currently working in surgery.
LEGAL		
EQUALITY & DIVERSITY	✓	The Trust has developed an approach to equality impact assessment for surgical reconfiguration.
COMMUNICATIONS		
PPI		
RISKS		Four main risks to implementation are considered in the paper: • Sandwell bed capacity; • Delay to implementation; • Complexity of the project; • Income risks.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SHAPING HOSPITAL SERVICES FOR THE FUTURE

INTERIM RECONFIGURATION – SURGICAL SERVICES
BUSINESS CASE FOR INVESTMENT

1.0 Introduction

1.1 In December 2007 the Interim Reconfiguration Project Board requested that the Surgical Steering Group proceed with developing an implementation plan for the Trust's agreed surgical interim reconfiguration changes.

1.2 In June 2008 the Interim Reconfiguration Project Board recommended to the Trust Board the resulting implementation plan that had been agreed with clinicians. The Trust Board approved the implementation plan and noted the associated financial impact of up to £990,000. It was agreed that more detailed analysis of costs was required and that approval for additional investment should be in the form of a business case submitted initially through the Trust's Strategic Investment Review Group (SIRG) with final approval from Trust Board.

1.3 The Business Case has been completed, discussed at SIRG and is now being submitted to Trust Board. This paper presents the key issues arising from the business case for Trust Board approval. The full business case presented to SIRG is available for Trust Board members on request.

1.4 Note. This paper considers the case for investment to deliver surgical reconfiguration. It does not seek to repeat the case for reconfiguration itself as set out for the Trust Board at its meeting in May 2007.

2.0 Operational Requirements in Support of Surgical Interim Reconfiguration.

2.1 As part of developing the implementation plan for surgical interim reconfiguration, four key areas were identified as requiring additional capacity and investment. These were; medical staffing, ward capacity, theatre capacity and transport.

2.2 ***Medical Staffing***
A key driver for surgical interim reconfiguration was to avoid or minimise future medical staffing costs associated with the impact of the Working Time Directive (WTD) and Modernising Medical Careers (MMC). A case was submitted to SIRG outlining the issues and options associated with medical staffing in July 2008. This identified estimated additional medical staffing costs within surgery of £1,015,068 if surgical interim reconfiguration did not take place. The business case recommended an option linked to surgical interim reconfiguration that required an additional investment of £228,099 and this was approved by SIRG. For completeness these medical staffing costs are included in the total investment considered in this paper.

2.3 ***Ward Capacity***

As a result of surgical interim reconfiguration a total of 38 beds will be transferred to the Sandwell site with 2 surgical wards closing at City but an increase in Surgical Assessment Unit (SAU) capacity at City from 8 to 20 trolleys. This increase in SAU capacity is required to maintain local access for patients and to address clinical concerns with levels of current capacity. To accommodate this increased capacity the SAU needs to be relocated to another ward at City (D42) with some refurbishment and a capital cost of £364,000.

The transferred 38 beds cannot be accommodated within the current wards allocated to surgery on the Sandwell site and so require additional capacity to be made available for surgery at Sandwell.

2.4 ***Theatre Capacity***

Within the implementation plan 7 trauma theatre sessions per week will transfer from City to Sandwell and a number of elective theatre lists will transfer from Sandwell to City, these being 3 elective lists for Breast and Urology (2 have already transferred) and 12 orthopaedics lists (to move as part of the second phase of reconfiguration). There will be no general emergency theatre sessions transferred from City to Sandwell as these are still required for emergency cases in other specialities (including Gynaecology, Vascular Surgery and ENT) at City and for any general surgery emergency cases requiring immediate surgery at City. As a consequence Sandwell general emergency theatres which will be required to manage significantly increased theatre activity following transfer of surgical emergencies and trauma.

Currently a significant proportion of trauma activity on both sites takes place outside of planned trauma theatre lists. Across the Trust activity equates to 30 sessions worth of cases per week whilst only 12 planned trauma theatre lists are currently available. Therefore, there is already a heavy reliance on the general emergency theatres on both sites to accommodate this work. Consolidating all emergency and trauma operating to one site without any additional investment or ability to transfer the required resource will create unmanageable levels of demand, bottlenecks on SAU and Emergency Assessment Unit (EAU), delays in surgical intervention and the associated clinical risks, poor patient experience and increased overall length of stay for these patients.

In addition some investment into specialist theatre equipment and instrumentation is required with a capital cost of £160,000.

2.5 ***Transfer of Patients Cross Sites***

We estimate that up to 3,705 emergency and trauma inpatients a year will have their care transferred across sites from City to Sandwell. A large proportion of these will require ambulance transfer with appropriately trained paramedics and nurse escort. It was noted from the outset of our planning that investment into transport costs would be required. However, in developing the costs for this the capacity currently within the service, which was expanded to support paediatric reconfiguration, was included to keep investment to a minimum. The additional investment proposed is £157,418.

3.0 Consideration of Options

3.1 Three options surrounding ward configuration and three options surrounding theatre and supporting infrastructure requirements were considered and non-financial and financial assessments were undertaken. These options were:

- **Bed Configuration**
  Option 1 - Manage the increase of beds on the Sandwell site by managing within the existing 4 inpatient wards and the 4.5 day ward, changing the function of the latter
  Option 2 - Manage the increase in beds on Sandwell within the existing 4 inpatient wards, maintain the function of the 4.5 day ward and open a 16 bedded unit on Newton One
  Option 3 - Manage the increase in beds on Sandwell within the existing 4 inpatient wards, maintain the function of the 4.5 day ward and open 10 beds on Elisabeth Suite

- **Theatres**
  Option 1 - Do Minimum - transfer 7 trauma sessions from City to Sandwell
  Option 2 – Invest into the trauma and general surgery infrastructure and reconfigure theatres
  Option 3 – invest into 10 general emergency theatres only.

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3.2 *Ward Capacity and Configuration*

The outcome of the non-financial option appraisal presented to SIRG is set out in the table below.

Non financial option appraisal

Criteria	**Option Scores**		
	Option 1	Option 2	Option 3
Integrate speciality teams, services and practices	3	4	4
Minimise future costs (includes medical staffing- previous business case, and nursing)	1	4	2
Support reduction of pre-op LOS and LOS in general	1	4	3
Increase emergency/trauma day-case and minimal stay surgery	1	5	4
Consultant support for changes	2	3	4
Minimise impact on other specialities	1	5	3
Maintain/increase single sex wards	0	5	4
	9/35	30/35	24/35

The above assessment demonstrates that absorbing all transferred beds within the current surgical wards at Sandwell (Option 1) carries too many risks to the success of reconfiguration. Option 2, opening additional beds on Newton 1 and option 3, opening 10 additional beds on Elizabeth Suite are close in their scores with option 2 attaining the best by 6 points.

3.3 ***Management of Trauma and Emergency Theatres.***

The outcome of the non-financial option appraisal presented to SIRG is set out in the table below.

Non financial option appraisal

Criteria	**Option Scores**		
	Option 1	Option 2	Option 3
Integrate speciality teams, services and practices	3	5	3
Minimise future costs (includes medical staffing, nursing and technical advances)	3	5	2
Support reduction of pre-op LOS and LOS in general	3	4	3
Increase emergency/trauma day-case and minimal stay surgery	1	4	3
Improve utilisation of trauma and emergency theatres	1	4	3
Consultant support for changes	0	4	4
Minimise impact on other specialities	0	4	5
Deliver future savings	0	4	2
	11/40	34/40	25/40

Option 1 (transferring 7 trauma sessions from City to Sandwell) was considered unmanageable as it focuses all the existing problems with capacity in planned trauma lists onto one site without addressing the capacity challenges already present. Option 2 focuses on removing the trauma demand on the emergency theatre by creating additional planned trauma lists and more importantly introducing new ways of working by increasing anaesthetic input to theatre sessions to gain the most efficient use of resources for both general surgery and trauma. Option 3 replicates current practice but provides an additional 10 general emergency theatre lists per week in general surgery. This maintains access for orthopaedics but does not support new working practices in both specialities.

4.0 Financial Consequences

4.1 In order to undertake an assessment of the combined financial impact of reconfiguration, the options for theatres and beds were combined into a set of scenarios for financial modelling. A detailed financial analysis is included in section 10 and appendices 3 and 4 of the business case presented to SIRG. The tables below summarise the additional revenue costs associated with each option.

Representation of combined options to show financial scenarios.

	T&O and Surgical Theatre Infrastructure		
Ward Configuration ↓	**Option 1 -** Do Minimum - transfer 7 trauma sessions from City to Sandwell	**Option 2** – Invest into the trauma and general surgery infrastructure and reconfigure theatres	**Option 3** – invest into 10 general emergency theatres only.
Option 1 - Manage the increase of beds on the Sandwell site by managing within the 4 inpatient wards and the 4.5 day ward, changing the function of the latter	**Scenario 1** **£176,203**		
Option 2 - Manage the increase in beds on Sandwell within the 4 inpatient wards, maintain the function of the 4.5 day ward and open a 16 bedded unit on N1		**Scenario 2** **£609,807**	**Scenario 2A** **£678,108**
Option 3 - Manage the increase in beds on Sandwell within the 4 inpatient wards, maintain the function of the 4.5 day ward and open 10 beds on ES		**Scenario 3** **£764,244**	**Scenario 3A** **£832,545**

Comparison of Cost Drivers by Scenario and including all investments relating to Surgical Reconfiguration

Cost Driver	**Scenario 1**	**Scenario 2**	**Scenario 2A**	**Scenario 3**	**Scenario3 A**
Nursing	(£36,865)	£33,668	£33,668	£188,105	£188,105
Theatres	0	£363,071	£431,372	£363,071	£431,372
Transport	£157,418	£157,418	£157,418	£157,418	£157,418
Overheads	£55,650	£55,650	£55,650	£55,650	£55,650
Total	**£176,203**	**£609,807**	**£678,108**	**£764,244**	**£832,545**
Medical Staffing	£228,099	£228,099	£228,099	£228,099	£228,099
Grand Total	**£404,302**	**£837,905**	**£906,207**	**£992,343**	**£1,060,644**
Non recurrent and set up	£92,000	£92,000	£92,000	£92,000	£92,000
Additional Capital	£534,000	£534,000	£534,000	£534,000	£534,000

4.2 The financial and non-financial option appraisals have, therefore, identified the preferred options as being:

Ward Configuration
Option 2 – Manage the required increase in beds on Sandwell site within the 4 inpatient wards, maintain the function of the 4.5 day ward and open a 16 bedded unit on Newton 1. At City site relocate SAU and increase capacity. This option had the highest score on the non-financial appraisal and has lower nursing costs that scenarios including Option 3 for beds.

Management of Trauma and General Emergency Theatres
Option 2 - invest in additional planned trauma lists, other supporting trauma and general surgery infrastructure and reconfigure theatres. This option also had the highest score on the non-financial option appraisal and has lower theatre costs than the options including Option 3 for theatres.

These options combine into scenario two in the financial modelling table with a total recurrent revenue cost (including junior medical staff) of £837,905.

4.3 For these preferred options the additional costs phased over years in line with the timetable for implementation of the changes are:

	2008/09 part year effect	**2009/10 full year effect**
Revenue – recurrent	£250,839	£609 807
Revenue – non recurrent	£92 000	0
Medical Staffing	£152,066	£228,099
Totals	**£494,905**	**£837,905**
Capital	£424,000*	£110,000

*NB £100,000 has been committed to support cross site MDTs with investment into a second video conferencing room.

4.4 The Trust's financial plan for 2008/09 includes a reserve of £700,000 for the costs of reconfiguration and medical staffing issues associated with WTD and MMC. Some of this is required for other specialities but the reserve currently contains sufficient uncommitted resources to cover the impact of this investment in 2008/9. The Trust's capital programme for 2008/9 includes £500,000 allocated for surgical reconfiguration.

4.5 Approval of this business case, will however result in an additional commitment of £343,000 revenue as part of our planning for 2009/10. £110,000 capital would also be needed from the 2009/10 capital programme.

5.0 Risks

5.1 The Trust Board considered a range of risks and mitigation strategies associated with surgical reconfiguration as part of its decision making in May 2008. This included setting out how our plans addressed any clinical risks. This section summarises our approach to the main risks associated with the preferred option for implementation.

5.2 *Sandwell Bed Capacity*. As noted above reconfiguration creates an increased need for surgical bed capacity at Sandwell. As well as accommodating the additional surgical beds at Sandwell, the Trust is also developing plans to ensure that Sandwell has two wards available to accommodate seasonal fluctuations in activity and provide de-cant facilities for deep-cleaning or refurbishment of wards. This is particularly important as the Trust has plans to refurbish a number of wards at Sandwell to create additional

side-rooms to improve infection control. The preferred option for implementing surgical reconfiguration adds additional pressure to the planning of bed capacity at Sandwell. The timetable for reconfiguration means that Sandwell will be able to operate with two wards available during the winter of 2008/9 but without further measures this will drop to one ward available when the second phase of reconfiguration occurs in April 2009. Following a review with the Divisions involved there are plans being developed for 2009/10 to ensure that two wards can be available for flexible capacity as quickly as possible in 2009/10. The detail of these plans will be finalised by the end of December 2008.

5.3 *Delay to Implementation*. The timetable for surgical reconfiguration depends on a set of ward moves at City to vacate D42 for conversion to the new SAU. The timetable for the capital work on D42 does not allow for slippage in this stage of the process if the first stage (general surgery) of reconfiguration is to be delivered in early December 2008 and the second phase (trauma and orthopaedics) in early 2009/10. Robust project management is in place to minimise the risk of delay and the programme will be the subject of a formal stocktake at the end of September to provide assurance of progress.

5.4 *Complexity of the Project.* The successful delivery of surgical reconfiguration is a large and complex project. The Trust is minimising the risks associated with the scale of the change through robust project management structures similar to those used for paediatrics and neo-natal reconfigurations and additional senior management support within the Strategy Directorate to lead the detailed planning and implementation with Divisional managers.

5.5 *Income Risks.* The original consideration of options for the future of our surgical services considered the risk of potential income loss if our catchment reduced as a result of the changes. Income loss has not been factored into this business case because the model of care the Board approved for surgical reconfiguration (maintaining an SAU and emergency theatre cover at City) is designed to minimise the risk of income loss. The experience to date of paediatric reconfiguration does not suggest a reduction in our catchment in that specialty.

6.0 Conclusion

6.1 This paper has presented the business case for investment of a total of £837,905 recurrent revenue and £534,000 of capital in delivering surgical reconfiguration. This investment will deliver benefits in three major areas.

6.2 *Avoided Future Costs*. The costs of providing comparable levels of service provision on two sites without reconfiguration are significantly higher than the costs of reconfiguration. If the Trust were not to pursue reconfiguration there would be significant additional medical staffing costs and it would be necessary to address issues of emergency theatre capacity. The resulting comparison is set out in the table below.

Cost Driver	Without Reconfiguration	With Reconfiguration (Scenario Two)	Variance
Medical Staffing	£1,015,068	£228,099	+£786,969
Nursing	0	£33,668	-£33,638
Theatres	£363,071	£363,071	0
Transport	0	£157,418	-£157,418
Overheads	0	£55,650	-£55,650
Total	**£1,378,139**	**£837,905**	**+£540,263**
Non recurrent and set up	0	£92,000	
Capital	0	£534,000	

It is also possible that at some stage it would become necessary to separate the planned surgical admissions from the emergency surgical assessments at City leading to the need to create a new SAU even without reconfiguration and further increasing the £540,000 extra cost of not proceeding with reconfiguration.

6.3 *Improved Service Quality.* The full range of benefits expected from surgical reconfiguration were set out for the Trust Board in May 2007. The proposed level of investment, however, secures a number of important improvements in service quality including:

- improved facilities for assessment of surgical emergency patients at City separated from the facilities for planned surgical admissions;
- improved in-hours access to emergency theatre capacity for the Trust reducing competition between specialities for theatre space and reducing delays in access to theatre;
- supports the concentration of emergency surgical expertise within the Trust enabling improvements to the patient pathway;

6.4 *Potential for Future Productivity.* The investment proposed will facilitate the bringing together of the Trust's Trauma and Orthopaedic and General Surgical teams. Concentrating our expertise will support the Division's in delivering future productivity improvements through:

- further length of stay reductions and bed reductions being planned for 2009/10;
- further improvements in theatre utilisation.

The detail of these proposals is being developed as part of the Trust's planning for its 2009/10 Cost Improvement Programme.

7.0 Recommendations

The Trust Board is therefore recommended to:

1. APPROVE the additional revenue investment of £837,905 required for the recommended options for delivering surgical reconfiguration;

2. APPROVE the additional capital investment of £534,000 required for the recommended options for delivering surgical reconfiguration;

3. NOTE the additional revenue and capital investments required in 2008/09 can be covered within the Trust's financial plan for 2008/09 and that the balance to full year effect for 2009/10 will need to be addressed through the Trust's financial planning for 2009/10.

Angela Thomas
Jayne Dunn
Richard Kirby

27th August 2008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Trust Annual Plan 2009/10. Process and Timetable
SPONSORING DIRECTOR:	Director of Strategy
AUTHOR:	Head of Corporate Planning
DATE OF MEETING:	4 September 2008

KEY POINTS:

The paper presents the process and timetable for developing the Trust's Annual Plan for approval by the Trust Board. The process for 2009/10 is based on the largely successful approach adopted to the production of the plan for 2008/9.

The process will commence with a session for the Trust Board at the October away-day and the issuing of the Annual Planning Framework for 2009/10 to Divisions in mid-October. The final plan will be approved by the Trust Board at its meeting at the start of April 2009.

PURPOSE OF THE REPORT:

✓ **For Approval**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. APPROVE the process and timetable for the production of the Annual Plan 2009/10.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Achieving the Trust's strategic objective of becoming An Effective NHS FT depends in part upon an effective annual planning process. The planning process will set the Trust's objectives for 2009/10.

IMPACT ASSESSMENT:

FINANCIAL	✓	The planning process includes the annual financial planning process.
ALE	✓	An effective annual planning process is a key part of the ALE assessment.
CLINICAL	✓	The planning process will set the clinical priorities for 2009/10.
WORKFORCE	✓	The planning process includes the annual workforce planning process.
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST ANNUAL PLAN 2009/10
PROCESS AND TIMETABLE

INTRODUCTION

This paper presents the proposed timetable for developing the Trust's Annual Plan for 2009/10 for approval by the Trust Board.

PROCESS AND TIMETABLE

The proposed process and timetable for the production of the Trust's Annual Plan for 2009/10 by the beginning of April 2009 is set out below. This mirrors that for 2008/09 with minor variations. Detailed financial planning will proceed in parallel.

Stage	**Dates**
Annual Planning Process & Timetable report • to Operational Management Board (OMB) • to Trust Board	 28th Aug 08 4th Sept 08
Initial Cost Improvement Programme (CIP) proposals	End Sept 08
Annual Planning Framework to Trust Board 'Away Day'	3rd Oct 08
Issue Annual Planning Framework to Divisions	w/c 6th Oct 08
National Operating Framework issued	End Oct 08
Divisions engage with Clinical Directorates	Mid Oct – Mid Nov 08
Planning meetings with each Division to review plans	w/c 17th /24th Nov 08
First Cut Divisional Plans inc. CIP	28th Nov 08
Financial Plan – High level I&E assumptions 2009/10 • Finance and Performance Committee (F&PC) • Trust Board	 27th Nov 08 4th Dec 08
Review of Divisional submissions	Dec 08
Update of Planning Assumptions	Early Jan 09
Annual Plan Monthly updates to Trust Board	Jan-Mar 09
Financial Plan Update • F&PC • Trust Board	 29th Jan 09 5th Feb 09
Second Cut Divisional Plans	2nd Feb 09

Stage	Dates
Financial Plan Draft • F&PC • Trust Board	 26th Feb 09 5th Mar 09
Draft Trust Annual Plan issued	w/c 23rd Feb 09
Local Delivery Plan Sign Off (assumed date)	End Feb 09
Consultation on draft Trust Annual Plan /Updating	From issue to 12th Mar 09
Annual Plan to OMB	26th Mar 09
Financial Plan – Final Sign Off • F&PC • Trust Board	 26th Mar 09 2nd April 09
Annual Plan presented to Trust Board for approval	2nd April 09
Printed version of Annual Plan completed	Mid May 09
Divisional Annual Plans Signed	By end May 09

N.B. Meeting dates for the Trust Board and other Committees for 2009 are draft subject to agreement

The Trust Board will consider the initial Annual Planning Framework at the beginning of October. The Annual Planning Framework will then be issued to Divisions during the second week in October setting out the corporate assumptions relating to our objectives, targets, patient activity and financial position for 2009/10. Divisions will be expected to return their draft Divisional Plan proformas by 28th November 2008.

The national Operating Framework containing planning assumptions and guidance is expected to be issued at an earlier stage this year – by the end of October. However, the timetable allows for any update required to the Annual Planning Framework to be made and circulated in early January. The aim is to complete any adjustments to Divisional Plans and to produce the Trust's Annual Plan 2009/10 for Trust Board approval at the beginning of April 2009.

RECOMMENDATIONS

The Trust Board is recommended to:

1. APPROVE the process and timetable for the production of the Annual Plan 2009/10.

Ann Charlesworth
27th August 2008

SWBTB (9-08) 083

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Trust Board Development Plan
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	4 September 2008

KEY POINTS:

To ensure that the Trust Board perform its functions effectively and, is fit for purpose in respect of our application to be a Foundation Trust, Board Development activities have been taking place since October 2007.

The attached paper sets out the strengths highlighted through this work and the areas for development identified. The actions already taken in response to these are also reported together with the plans where additional effort needs to be made.

PURPOSE OF THE REPORT:

✓ **For approval**

ACTIONS REQUIRED, INCLUDING RECOMMENDATIONS:

To approve the proposed Board Development Plan

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

This report supports achievement of the following corporate objective:

6.2 Achieve NHS Foundation Trust status

IMPACT ASSESSMENT:

FINANCIAL		
ALE		
CLINICAL		
WORKFORCE		
LEGAL	✓	
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

Trust Board Development

Introduction

In line with the Trust's ambition to achieve Foundation Trust status next year, the Board needs to be able to demonstrate a compelling case for this change of status. Imperative to this is a realistic assessment of the current Board, as a team and as individuals, together with a clear and realistic plan that will promote the development of required skills, information and behaviours to support the modified demands on the Trust after authorisation.

While the Trust Board began a self assessment of its capability and processes, including governance, performance, and strategic operation some time ago, it was agreed that external validation of the work was needed from an experienced external organisation. KPMG LLP was therefore engaged in October 2007 to provide this perspective and contribute additional input to the work.

The key elements of the brief given to KPMG were:

- Evaluate the effectiveness of the Board and its key committees;
- Assist in the next phase of Board development; and
- Develop an appropriate appraisal process going forward that will continue to monitor Board performance both as individuals and as a whole

Work Undertaken

The work undertaken by KPMG has, to date, has taken the form of several distinct exercises:

1 Performance Evaluation of the Whole Board

One of the critical areas on which KPMG was asked to focus, was that of the performance of the Board as a whole. This initial work included an observation and analysis of a Trust Board meeting, a Finance and Performance Management Committee and an Audit Committee. A whole Board skills gaps was also performed to compare the skill level of the directors with those considered to be required by successful Foundation Trusts.

2 Performance Evaluation of Individual Board Members

A series of in-depth interviews was held with individual Board directors, with the intention of identifying key areas of development for the Executive members as a whole and each Non Executive on an individual basis.

Views were canvassed from both Executive and Non Executive Directors concerning the way the Board operated, specifically the dynamics of the team, and any improvements that had been identified.

3 Review of Trust Documentation

A review of some of the standard Board papers submitted to the Trust Board was undertaken, with particular attention to the finance and performance reports. The information was assessed to determine whether it fulfilled the criteria of 'intelligent' information, including whether it was clearly and simply presented, including an

appropriate mix of graphical information in addition to narrative; updated in a timely manner; directed the Board's attention to significant risks, issues and exceptions; provided a level of detail appropriate to the Board's role.

4 Review of the Effectiveness of the Governance Arrangements

The effectiveness of the Board's governance was gauged by the distribution of the minutes from the main committees to the Board and a review of the agendas considered by the committees. Evidence was sought that the arrangements supported the timely review of information from the committees by the Board, yet allowed sufficient time for reflection on issues.

5 Considering an Appropriate Director Appraisal Mechanism

Consideration was given to the development of an appraisal process, supportive of a self-assessment approach which is ongoing. The appraisal process is designed to cover Non Executive director appraisal; Executive director appraisal; whole Board appraisal; and a linkage to the Board Development Plan to support continuous improvement.

This programme of work has been supported by two, off-site, Board Development days in October 2007 and April 2008, which have provided a focussed environment for the consideration of Board Development issues. A number of feedback sessions have also been held to enable KPMG to present observations and associated recommendations against the various elements.

The table below summarises areas for development identified through this work and the high level actions completed by the Trust in response to these.

Areas for development	Action taken to date
1. Review Board and sub-committee agendas to ensure business is better prioritised for action and decision, standard categories are not used and agendas overall are more focused on the external and the future and less focused on the internal and historical. Also reduce overall volume of paperwork.	▪ Board Secretary appointed ▪ Board agenda no longer includes standard categories ▪ More items are external and future focused ▪ Summary papers now used more effectively with shorter reports overall
2. Enhance the reporting to the Board by providing a sharper more forward looking assessment based on the performance to date.	▪ Finance now provide an executive report to the Board highlighting the key movements and forecast position
3. Increase level of clinical expertise and workforce planning amongst the NEDs and level of strategic marketing and commercial knowledge and expertise amongst the EDs	▪ New NED appointed with a clinical background (academic appointment)
4. Undertake some team-building activities to encourage the Board to work more closely as a single team.	▪ Regular Board FT seminars help address being one team ▪ Team-building activities undertaken as part of Board development days
5. Increase Board involvement externally to the Trust and improve the reporting back to the	▪ More Board directors (NEDs and EDs) involved externally

Areas for development	Action taken to date
Board.	▪ Systems for reporting back for greatest effectiveness and to improve decision-making under review
6. The Trust should review its timing and flow of information to the Board in support of its performance and assurance framework.	▪ Analysis under review
7. Develop system for whole Board appraisal as required by Monitor after FT authorisation.	▪ Whole Board appraisal system under review for approval.
8. Draw up rolling Board Development Plan, with regular updates on progress and including new areas as they are identified.	▪ Under discussion
9. Strengthen appraisal for Board directors, including EDs in their Board roles, based on up to date and relevant job descriptions	▪ Appraisals this year carried out using information from the Board Development programme. ▪ Job descriptions for Chair, NEDs and EDs under review

While the work highlighted several areas where additional effort needs to be made, the work also identified several positive areas, mainly around the Board's skills and some of the standard reports received by the Board:

- The Executive Board members constitute a highly-performing team, which is committed and knowledgeable and works well with partners

- The Non Executive members have a good local knowledge, commitment and strong contact. A number of the members also have good commercial awareness and NHS experience in a clinical environment

- The level of detail in the finance and performance reports is conducive to identifying patterns and future issues from across different target areas, such as sickness, staffing and infections. The reports also largely adhere to the criteria set out for 'intelligent' information

Board Development Plan

An outline Board Development plan has been drafted to bring structure to the delivery of the outstanding recommendations arising from the Board Development work. The draft plan is attached as Appendix 1.

The plan is separated into four workstreams, addressing different development needs: review the role of the Board more explicitly; becoming more of a single Board; focus Board work around delivering the agreed role; statutory regulation.

Areas still to be completed include consideration of the most appropriate presentation of information to ensure that it is relevant and supports robust decision making; completion of service line reporting to develop a fuller understanding of key activities and their

financial impact for the future; recruitment of NED with workforce planning experience; improved skills in strategic marketing and commercial awareness; improved external involvement to support Board working and decision-making.

Next Steps

KPMG will continue to be engaged with the preparation of the Board for the FT application, including a series of readiness exercises for the Board to Board event with Monitor, expected in January 2009.

The Board development plan will be populated with Executive and Operational leads and delivery will be monitored through regular reports to the Trust Board.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

DRAFT BOARD DEVELOPMENT PLAN

Board development area	Key tasks	By end of:	Lead person	Progress to date	Status
1. Review role of Board more explicitly	1.1. Review how the Board adds value to the work of the Trust and how it differentiates its role from the senior management team				
	1.2. Actively review Board activities as a whole including sub-committees, seminars etc, to use NED and ED time most effectively				
	1.3. Be clear about business critical areas, risk and trends, including changing expectations of commissioners, and focus challenge and performance reporting in these areas				
2. Become more a single Board	2.1 Bring items to the Board at key decision points when all directors can input equally				
	2.2 Encourage NEDs to challenge more outside their own areas of professional expertise				

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

Board development area	Key tasks	By end of:	Lead person	Progress to date	Status
	2.3 Undertake some team building activities to give directors more experience of working as a single team				
3. Focus Board work around delivering the agreed role	3.1 Determine thresholds and filter what issues come to the Board and what does not				
	3.2 Structure agendas in priority order, with items requiring discussion and decision first. Review alternative ways of dealing with items for noting				
	3.3 Use commercially experienced NEDs to help develop more business-like ways of reporting – try different formats to see what works for this Board				
	3.4 Focus agendas more on the future and the external rather than the past and the internal				
4. Statutory regulation	4.1 Review need for updating or training in key statutory areas such as equality and diversity, health and safety etc				

September 2008

STATUS		Complete		On track		Some delay – expect to be completed as planned		Significant delay – unlikely to be completed as planned	1	Not yet commenced		Objective revised

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Single Tender Approval – A Clinician Resource Management System
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Management
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	4 September 2008

KEY POINTS:

Work has been undertaken within the Trust to look at increasing medical productivity and to maximise the benefits to the Trust of the 2003 Consultant Contract. A crucial factor is to ensure there is effective and robust management of the job planning process.

A software solution is proposed to enable a structured and consistent approach to consultant job planning and effective clinical resource management across the organisation.

Despite a clear need for job planning and enabling IT solutions, only one appropriate commercial solution has been identified. This software, though not part of the national IT programme, is recommended nationally for best practice management of the consultant contract.

Approval is therefore requested in relation to the purchase of the Clinician Resource Management System.

The value of this purchase is £63,000 per annum (excl. VAT)

PURPOSE OF THE REPORT:

✓ **For Approval**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is requested to approve the single tender action.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically, however, medical productivity is an enabling work stream supporting the 2008/09 CIP.

IMPACT ASSESSMENT:

FINANCIAL	✓	Total cost £63k per annum plus VAT
ALE		
CLINICAL		
WORKFORCE	✓	Supports improved implementation of the 2003 Consultant Contract
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Order for Sterile Service Provision to BBraun
SPONSORING DIRECTOR:	Graham Seager, Director of Estates & New Hospital Director
AUTHOR:	Corinne Bromley
DATE OF MEETING:	4 September 2008

KEY POINTS:

To request for authorisation of a requisition to place an order with BBraun. The value of the requisition is £933,671 for City site and £960,671 for Sandwell site, which includes Rowley Regis. The order will cover the service period April 2008 to 31st March 2009. The requisition excludes V.A.T. as it is reclaimable. Orders exceeding £1m require Trust Board approval.

The requisition takes into account 08/09 contract cost uplift and activity increase.

The order will cover year 2 of contract which is in place following full board approval of the full business case of the Pan Birmingham Decontamination Project, the contract being awarded to BBraun for the provision of sterile instrumentation and other supplementary items.

PURPOSE OF THE REPORT:

✓ **For Approval**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to approve the placing of the order with BBraun.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

1.2 Improve patient safety 6.1 Achieve Healthcare Commission Core Standards

IMPACT ASSESSMENT:

FINANCIAL	✓	Value at City Site £933,671; Value at Sandwell Site £960,671
ALE		
CLINICAL		
WORKFORCE		
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		This is the sole supplier of sterile services available to the Trust at this time. The Trust will be unable to fulfil core functions, should approval not given to this single tender action.

Report to the Trust Board - 17th August 2008

Order for Sterile Service Provision to BBRAUN

Introduction

This report is to support the request for authorisation of a requisition to place an order with BBraun. The value of the requisition is £933,671 for City site and £960,671 for Sandwell site, which includes Rowley Regis for the period April 2008 to 31st March 2009. The requisition excludes V.A.T. however as the V.A.T is reclaimable the service is actually V.A.T free.

The requisition takes into account 08/09 contract cost uplift and a 0.87% activity increase.
The Division does not expect the level of service failure deductions and cancellation payments attributed to the contractor in 07/08 to feature in 08/09.

The order will cover year 2 of a 20 year contract (subject to contractual terms and conditions)which is in place following full board approval of the full business case of the Pan Birmingham Decontamination Project, the contract being awarded to BBraun for the provision of sterile instrumentation and other supplementary items.

The service has been provided by BBraun for Sandwell site since the 23rd April 2007 and for City site since 5th June 2007.

Financial Assessment

Bbraun – Invoices 07-08

	City	SGH	Total
Apr-07	0	0	0
May-07	0	62,748	62,748
Jun-07	83,742	57,689	141,431
Jul-07	74,708	56,971	131,679
Aug-07	74,054	55,419	129,473
Sep-07	76,403	57,244	133,647
Oct-07	94,894	60,375	155,269
Nov-07	78,217	60,854	139,071
Dec-07	80,317	56,274	136,591
Jan-08	89,645	58,013	147,658
Feb-08	86,122	58,301	144,423
Mar-08	76,645	56,698	133,343
Total 07/08 actual cost	**814,747**	**640,586**	**1,455,333**
Projected Annual Cost 07/08	**785,712**	**902,534**	**1,688,446**
Average Monthly Expenditure 07/08	81,475	58,235	139,710
08/09 uplifted cost FY	**933,671**	**960,671**	**1,894,342**
Expected average monthly expenditure 08/09	77,805	80,021	1,894,342

The table above demonstrates the total service costs for 2007/08 (10months and 2weeks)
The cost variance for the period is largely a result of adjustments linked to service failures and patient cancellation however, as the service provided has improved these adjustments will be significantly reduced in 2008/09.

The activity level on both sites for the first three months of the financial year is in line with the expected monthly expenditure outlined above and reflected in the requisition value for this financial year.

Reconfiguration – It is expected that the total contract required by the Trust will remain unchanged in terms of the total number of trays required however, the City / Sandwell site order value split is likely to change. The full year effect of the Braun contract in relation to reconfiguration will demonstrated in the requisition for the service supply 2009/10

Failure to support this request will leave the Trust without a sterile service supply and will be contrary to the contract held with BBraun.

Sandwell General Hospital Projected Activity

Year	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**
Growth Assumptions		5%	5%	0.87%	0.87%
Factors		1.05	1.05	1.01	1.01
RPI Uplift		1.031556	1.0565832	1.105005	1.150163

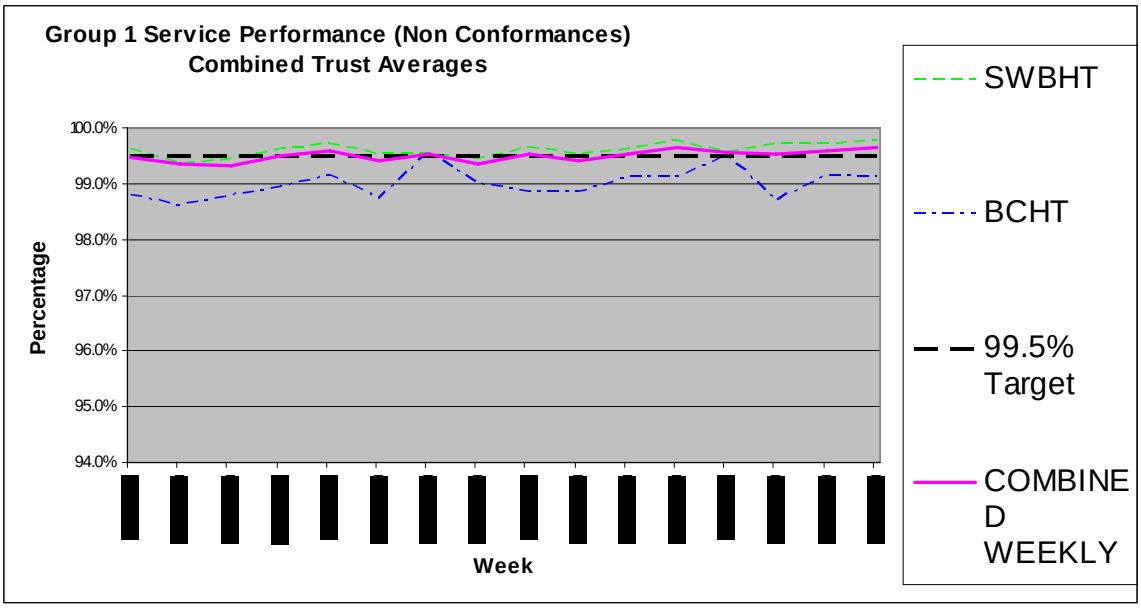
City Hospital Projected Activity

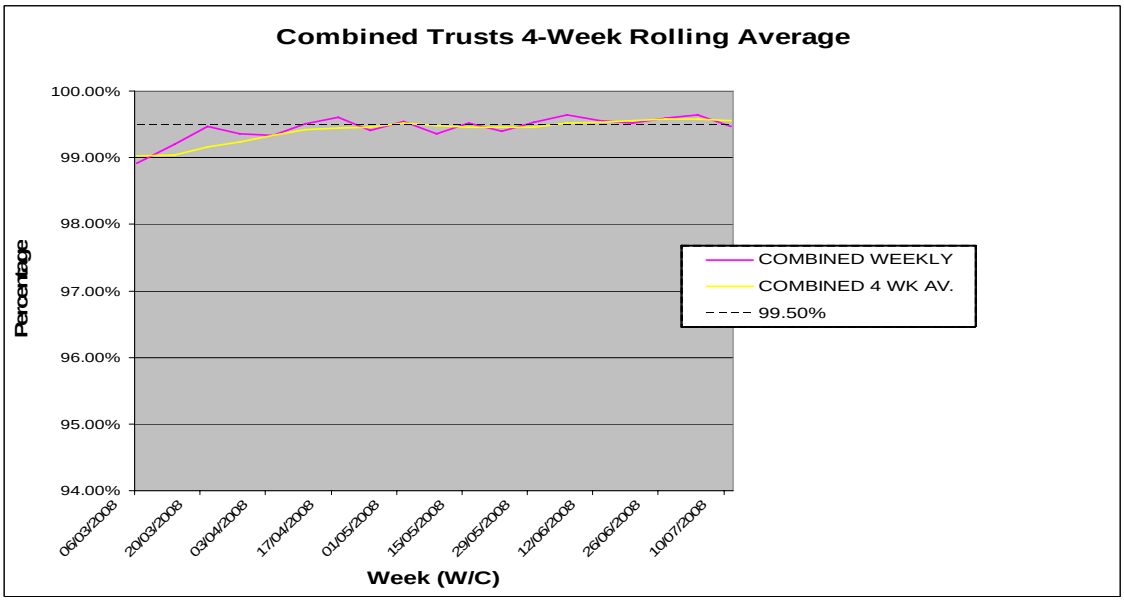
Year	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**
Growth Assumptions		5%	5%	0.87%	0.87%
Factors		1.05	1.05	1.01	1.01
RPI Uplift		1.031556	1.0565832	1.1050054	1.1501632

Performance

Over all provider service performance has shown a sustained improvement during the final quarter of 2007/08 and this improvement has been maintained this financial year. Performance is now consistently on or close to the performance target of 99.50% for both turnaround times and service defects.
There remain issues with missing and broken equipment, both of these issues are under review by both the National and Local project teams as well as provider and user groups.
Importantly there have been no operations cancelled attributable to the service provided by Bbraun since October 2007.

Performance Graphs





Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Towards 2010 Programme Progress Report – August 2008
SPONSORING DIRECTOR:	Director of Strategy
AUTHOR:	2010 Implementation Director
DATE OF MEETING:	4 September 2008

KEY POINTS:

The paper provides a progress report on the work of the Towards 2010 Programme as at the end of August 2008 and includes a copy of the 2010 Programme Director's report to the 2010 Partnership. It covers:

- The Programme's new approach to service redesign;
- Progress with developing workforce plans ;
- Establishment of the Finance Group.

PURPOSE OF THE REPORT:

✓ **For Noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

3.1 Deliver new models of care through the first wave 2010 exemplar projects and begin to deliver new models of care for community-based outpatients in the second wave 2010 exemplar specialties.

IMPACT ASSESSMENT:

FINANCIAL		
ALE		
CLINICAL	✓	The 2010 Programme sets the context for future clinical service models.
WORKFORCE	✓	
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TOWARDS 2010 PROGRAMME: PROGRESS REPORT
AUGUST 2008

INTRODUCTION

The Towards 2010 Programme is the partnership of S&WBH, HoB tPCT, Sandwell PCT and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. This brief paper provides a progress report for the Trust Board on the work of the Programme as at the end of August 2008.

This report is in two sections:

a) overview of the work of the Towards 2010 Programme;
b) Programme Director's report as presented to the 2010 Partnership and the Boards of Sandwell and HoB PCTs (appendix 1 – August report, appendix 2 – July report)

OVERVIEW

This section provides an overview of the work of the Towards 2010 Programme (as set out in more detail in the Programme Director's reports in Appendix 1 and Appendix 2). The most significant issues arising are as follows:

Taking Forward Service Redesign – The Partnership have agreed a new approach to service redesign within the Programme. This involves establishing nine Strategic Model of Care Steering groups (SMOCS) to deliver the agreed strategic, planning and engagement objectives and reporting to the 2010 Clinical Group. The SMOCs cover the national Darzi Review descriptions of care/service with some local additions. Each SMOC will have a clinical lead and a project management lead (from the PCTs). The Clinical Group is currently agreeing clinical leads and the aim is for the SMOCs to start meeting in September.

Project Targets - The Programme Director is undertaking a review of progress with each of the exemplar and second stage transition projects. A report of his findings will be presented to the 2010 Partnership in September but initial findings show that in some projects there are issues with availability of information, reporting, equipment and facilities. The new 2010 Programme Manager will be working with the partner organisations to resolve these.

SHA External Review – 19th June 2008 – A draft report has been received from the SHA and a response is being drafted through the 2010 Strategy Group.

Workforce Group - The Programme Director's report for July outlines progress with a number of workforce issues. In particular the following should be noted:

- submission of a workforce plan to the SHA,
- appointment of three workforce planners to work across the health economy,
- a qualifications audit across the health economy will commence in August,
- the Programme's involvement in 'Collaborations for Leadership in Applied Health Research and Care' which will assist in evaluation of the Programme.

Finance Group - The Programme has established a Finance Group that has now met several times. The group is developing an Activity and Capacity Model for primary care. It has also agreed some principles for local unbundling of national tariff and is considering this with

regard to the three areas of, intermediate care, x-ray and urgent care. In addition the group is starting to define the transitional funding required by the Trust and PCTs to support implementing the new models of care.

RECOMMENDATIONS

The Trust Board is recommended to:

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

Jayne Dunn
27th August 2008

APPENDIX 1

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, 18th August 2008**

1. Summary and Recommendation

This paper summarises the main issues and developments in the Programme since the previous report, apart from those which are the subject of separate papers on the agenda.

The Partnership Board is recommended to note the contents of this report.

2. General Updates

2.1 Taking Forward Service Redesign

Members of the Partnership Board will recall that this was discussed at some length at last month's meeting. It was agreed that I would make amendments and then re-issue the paper to Partnership Board for information. The amended paper is attached at Appendix 1. The amendments include:

- Revision of table on page 5 to reflect full involvement of Heart of Birmingham tPCT
- Para 4.5 responds to the request to ensure that the needs of all patient and client groups are taken into account by the work of the SMOCS Groups
- Further clarification of the responsibilities of partner organisations in para 4.6

This paper has been discussed and agreed by the Strategy Group.

The Clinical Group at its meeting on 6th August agreed an approach to identifying the chairs of the SMOCS Groups and a full list will be provided to Partnership Board members at the next meeting.

2.2 Project Targets 2008/09

I have not yet completed the review of project targets for 2008/09 but these will be available for the September meeting.

I attach at Appendix 2 a summary of the activity undertaken to date in each project, as submitted by project leads for activity to the end of July. This demonstrates that there are inadequate systems in place in some areas for the provision of reports and data on a routine basis, and this will be addressed comprehensively now that Angela Poulton, the Programme Manager, has taken up post.

In some projects, there remain issues which are hindering progress, particularly the issues of accommodation availability and provision of equipment in community facilities. This latter issue is being addressed by the Finance Group (see below). In addition, I am now meeting regularly with Jon Dicken, Deputy Director of Commissioning, Sandwell PCT and Sohaib Khalid, Associate Director of Commissioning, Strategy and Redesign, Heart of Birmingham tPCT, to ensure more effective co-ordination of Programme issues and reporting.

2.3 SHA External Review – 19th June 2008

Following the external review on 19th June, 2008, the draft report from the SHA has been received. The Programme's response to this is being developed through the Strategy Group.
A detailed response will be made and then the SHA will issue the final report for our formal response. This will be brought to the Partnership Board meeting in September.

3. Updates from Programme Groups

3.1 Communications and Engagement Group

The Communications and Engagement Group has established sub groups to deliver the detail of the Implementation Plan previously agreed by the Partnership Board. These will deliver detailed, timed plans to the Group at its next meeting in September, and these will then form a more detailed implementation plan.

This will be presented to the September Partnership Board, along with an update on progress.

3.2 Finance Group

The Finance Group terms of reference were agreed by the Partnership Board on 23rdJune 2008. The Group has met on three occasions and has made the following progress:

- **Development of activity and capacity model for primary care and community services**

  This is being developed to ensure that activity and capacity issues for the new configuration are modelled, so that more accurate forecasting and planning can be undertaken. This will enable assessment of the feasibility of placing activity in centres in the community, and will allow the income and expenditure impacts of these to be assessed on the basis of viability and VFM. This model has been populated with high level data and this is currently being validated with PCTs. This will need to be adjusted to take account of the full Workforce Plan when this is completed in November.

  The activity and financial model will be presented in detail to the Finance Group meeting on 23rd September 2008.

- **Cost effectiveness of service redesign**

  Following the Partnership's addition to the terms of reference of the Group, to ensure that service redesign is cost effective, a small group is being establishing to develop a methodology for this with the Ophthalmology Project.

- **Unbundling of Tariff**

  The Group has agreed a set of principles to govern unbundling of the national tariff, and these are:

  - Unbundling should be related to identified and agreed pathway changes
  - Changes to tariff should reflect the reduced costs to the acute provider of these
  - Reimbursement to alternative providers should reflect the cost of providing the service
  - Unbundling reductions should be based on average lengths of stay
  - Unbundling should only be applied where there is an agreed change to pathways
  - There needs to be agreement between PCTs and the Provider before the application of unbundled tariffs
  - HRG V4 unbundled tariffs which are nationally mandated will be introduced

  Three areas for consideration of local unbundling have been agreed and work is progressing in these:

  - Intermediate care
  - X-ray
  - Urgent Care Centre

- **Transitional Costs**

  The Group is defining the transitional funds which will be required in SWBH and in the PCTs to enable significant changes in the style and locations of services. SWBH is currently producing a schedule of its expected need for transitional costs, as are the PCTs. These will then be brought together and reviewed in the light of the funding available.

- **Change Management Support**

  There are several issues, as referred to in para 2.2 above, which are hindering progress in projects delivering new patterns of services in the community. I have previously suggested that these need ‘supporting financial frameworks’ put in place to achieve a resolution. The Group believes that these should be termed ‘change management support’ approaches to avoid confusion with other financial frameworks. The Group is awaiting the provision of an econometric model from HoBtPCT which will allow agreement to be made on how accommodation and the provision of equipment in community premises is handled.

- **Shared Programme Costs**

  The Group has almost concluded an agreement on the basis on which Programme costs, including the costs of the new acute hospital project and the Programme Team, will be met. This will be concluded at the meeting on 23rd September and reported to the Partnership Board in October 2008.

- **PCT Consideration/Approval of SWBH Outline Business Case**

  The Group has agreed the process and timeframe for the PCT Executive Teams and Boards to receive, consider and approve the Outline Business Case submission from SWBH for the new acute hospital by December 2008.

4. Recommendation

The Partnership Board is recommended to note the contents of this report.

Les Williams
Programme Director

APPENDIX 2

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, 21st July 2008**

5. Summary and Recommendation

This paper summarises the main issues and developments in the Programme since the previous report, apart from those which are the subject of separate papers on the agenda.

The Partnership Board is recommended to note the content of the report and to make a decision on whether or not the time of the meeting should be moved from 10am to 11.30am. Please see item 2.10.

6. General Updates

6.1 Project Targets 2008/09

I reported last month that I was meeting each of the Project Leads to confirm targets and capacity for 2008/09 and to ensure that we are recording activity at the appropriate stage of service redesign. These meetings have completed last week and I am now compiling the analysis. This will be available at the August meeting, along with activity data against the targets for the year to date.

6.2 SHA External Review

Following the external review on 19th June, 2008, I reported the informal feedback given. At the time of preparing this report, no further feedback had been received. This has been requested from the SHA and an update will be given at the meeting.

6.3 SHA Feedback on Overarching Plans

While detailed feedback has not yet been received, the SHA have sent to us the analysis on the control charts undertaken on their behalf by Teamwork Management Services. This indicates that this LHE is far ahead of others in the West Midlands in the scope of our ambition in developing services in the community setting, and shows several variations between HoBtPCT and Sandwell PCT assumptions. To ensure that we achieve a thorough understanding of these issues and differences, I am arranging for Teamwork to come to a joint meeting of the Clinical and Strategy groups in August. A copy of the summary of the main points of the feedback is attached for information. A full copy of the analysis is available on request.

6.4 Communications and Engagement Facilitator

Successful interviews were held on 17th June 2008 and Abigail Clinton has been appointed. Abigail has previous experience working for the Commission for Public and Patient Involvement in Health. She takes up her duties on 21st July 2008.

6.5 Workforce Plan submitted to SHA

The SHA required the submission of workforce plans, including templates, from all NHS organisations by 11th July 2008. This generated some debate with the SHA, given the recent submission of workforce planning numbers to the SHA as part of the Overarching Plans submission in May 2008 and our agreement through the SLA route to provide the SHA with a more detailed plan by November 2008.

On discussion it appears that the primary reason for requesting plans was to inform decisions on commissioning education and training places by the SHA and a specific commentary has been added to our plan on this issue. In essence, it indicates that in our context, the development of workforce planning has not progressed sufficiently to result in our being able to project these requirements with confidence. We have therefore indicated no change. We may be criticised by the SHA for adopting this approach in their analysis of the plans.

The full Workforce Plan submission will be presented to the Partnership Board meeting in August, by Karen Scott.

6.6 Workforce Planners

Following interviews on 11th July 2008, the three posts, funded from the SHA allocation for Workforce, have been appointed.

These posts will be managed by Karen Scott, Workforce Lead, and one each will be placed in Sandwell PCT, HoBtPCT and SWBH , to provide support and development for workforce planning. This will increase capacity to deliver workforce plans, and importantly, help to build sustainable capability within each of these organisations.

The appointees are:

- Helena Chappell, currently at Sandwell PCT
- Brenda Jumi, currently at SWBH
- Sarah Race, currently at HoBtPCT

It is probable that each will be assigned to an organisation different to the one in which they have recently worked, to help spread expertise and offer different perspectives. This will be agreed during August.

2.7 Other Workforce Issues

The Qualifications Audit preparation is progressing rapidly and emails will be sent out to the workforce in SWBH, Sandwell PCT and HoBtPCT in August. An internal set of communications messages have been developed so that staff are made aware of the purpose of the audit and the security and confidentiality of the data collected.

Karen Scott will be contacting other partners to see if they would also like to undertake the profiling of their staff.

Work on developing the Change Management Framework for the whole Programme is progressing and there will be a stakeholder event to check its impact and application on 29th July 2008. This is timed to take place before the draft Framework is brought to the Partnership Board in August.

2.8 Collaborations for Leadership in Applied Health Research and Care

There have been two meetings in preparation for establishing the CLAHRC, the first a briefing for all Chief Executives and the second a more detailed discussion about the extent of the involvement of the LHE in Research Theme 1: 'From structure to function: Health service redesign'.

These have confirmed that the research to be undertaken will be beneficial to the Programme on an immediate practical basis as it can be used to help form part of the overall evaluation of the Programme, as discussed elsewhere on this agenda in the paper on the Programme Framework. In addition, it was noted that there would be no requirement for further investment from the LHE in the CLAHRC process, beyond the funds already identified as part of the bidding process. There may possibly be some resource provided to allow us to respond effectively. However, it will require time from colleagues to participate as the researchers undertake analyses and observations and the discussion of findings. The approach will be to identify a small number of services or specialties and to study the process, impact and outcomes of service redesign on those in some detail.

I am the principal point of contact, so all such contributions can be managed and arranged through the Programme Team.

It is also worth noting that while Research Theme 1 relates to changes made in acute hospitals and their impact, the research activity will cover the impact on the two PCTs in our LHE, given the strong partnership approach which exists.

A launch event, to which it is intended to invite clinicians and professionals working in the organisations which are subject to the research, is being planned for the afternoon of 23rd September, 2008.

2.9 Sandwell Overview and Scrutiny Committee – Health Working Group

Doug Round, the Chair of the Partnership Board, Jon Dicken, Deputy Director of Commissioning and I presented to this group on Tuesday, 15th July 2008.

The main points raised were:

- Provision of bone densitometry service for osteoporosis patients
- The basis of maternity services provision
- Confirmation that the commitment to a Neighbourhood Centre in Great Barr remains, along with a subsidiary centre in Hamstead
- Clarification on the meaning of 'bed equivalents' for community provision
- Given the scale of change expected, the level of confidence we have in delivering
- Appraisal of the plans in the light of the Darzi Final Report
- Level of confidence in achieving fully integrated plans across health and social care
- Services which will be provided seven days per week
- Requirement for consultation/engagement with the public on transport issues

It was agreed that we would return to the Health Working Group or full Overview and Scrutiny Committee later in the year.

2.10 Change in time for Partnership Board meetings from September 2008

It has been suggested that we should move the time of the meeting from 10am to 11.30am, as this may allow more people to attend, avoiding issues of lack of quoracy. The length of the meeting would remain at a maximum of two hours, ending at 1.30 pm with a sandwich lunch.

The Partnership Board is asked to comment on this proposal and if agreed, to begin this from the September meeting.

Les Williams
Programme Director

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	2010 New Acute Hospital Project
SPONSORING DIRECTOR:	Graham Seager, New Hospital Project Director
AUTHOR:	Andrea Bigmore, New Hospital Project Manager
DATE OF MEETING:	4th August 2008

KEY POINTS:

This report is provided to update the Trust Board on key issues and progress relating to the development of the 2010 Acute Hospital Project

✓ **For noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to note the progress with the project and discuss any items.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Submission of OBC for 2010 Acute Hospital Project is a Trust Strategic Objective

Sandwell and West Birmingham Hospitals NHS
NHS Trust

IMPACT ASSESSMENT:

FINANCIAL		
ALE		
CLINICAL		
WORKFORCE		
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

1.0 Engagement and Communications

Delivery of engagement and communications activities continues as planned.

The focus groups are now considering the design of the new hospital atrium. Useful suggestions have been made for ways of making the atrium more welcoming for patients and visitors. Early results show that staff and community groups feel that way finding and access to information points are of high priority. The report on the outcome of this work will be presented to the Project Board in October and will inform the development of the new hospital. The Project Team will ensure that participants will also receive copies of the report.

The 2010 Acute Hospital Project website is now ready to go live pending final review. The website will be launched within the next two weeks.

2.0 Design / Public Sector Comparator

Work on the set of design and policy documents that form the Public Sector Comparator (PSC) is now complete to Version 7. The PSC is used to specify the Trust's construction requirements for the PFI and will be used in the Outline Business Case to demonstrate that the design works and is affordable.

Development of the PSC has taken a great deal of time and commitment from the Project Team and has involved many of our clinical staff.

The technical advisors to the project are currently reviewing the PSC in preparation for the procurement phase of the project.

3.0 Outline Business Case (OBC) and Estates Annex

Draft two of the OBC has been completed to timetable and has been presented to the Project Board for review of the strategic case for the new hospital. This version does not include the financial and economic appraisal, which will follow in draft three.

The draft OBC main body document, appendices and Estates Annex have also been submitted to the SHA for their first review. This collaborative approach will help the Trust to develop a robust business case and ensure ongoing support for the project. The Project Team will receive written feedback on 08.09.08 and will meet SHA colleagues on 15.09.08 to discuss next steps. The outcome of the first review will be presented to the next Project Board. Several more drafts will be required before the OBC is ready for formal approval.

4.0 Financial Update

Since the Board's last meeting, further progress has been made with the financial and economic analysis of the project in preparation for inclusion in the Outline Business Case. Progress is in line with agreed timetable.

The work needed to finalise the capital and revenue cost projections and to complete the financial and economic appraisal of the options for the OBC is now underway. The results will then be documented for inclusion in the next draft OBC version.

The Project Team continues to ensure that the financial projections on which the OBC is based are consistent with the Trust's internal financial plans and the long-term financial model (LTFM) which will be submitted as part of the Trust's Foundation Trust application.

5.0 Planning

To allow time to address issues raised by the Environment Agency, at the request of the Trust, consideration of the Outline Planning Application for the new hospital has been differed with the aim to have it considered at the October 2008 planning committee.

Graham Seager
Project Director

SWBTB (9/08) 064

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance
AUTHOR:	Mike Harding, Head of Planning and Performance Management
DATE OF MEETING:	4 September 2008

KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – July 2008

PURPOSE OF THE REPORT:

✓ **For noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically. Satisfies compliance with NHS Plan and other locally agreed targets.

IMPACT ASSESSMENT:

FINANCIAL	✓	
ALE		
CLINICAL	✓	
WORKFORCE	✓	
LEGAL	✓	
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI	✓	
RISKS		

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - JULY 2008

SWBTB (9-08) 064 (a)

EXECUTIVE SUMMARY

<table>
<tr><th>Note</th><th>Comments</th></tr>
<tr><td>a</td><td>The overall percentage of cancelled operations reduced during July to 1.0% at City Hospital and 0.7% Trust wide, although numerically they increased slightly from 38 in June to 43 in July, with cancellations in Ophthalmology accounting for greater than 50% of cancellations in both months. A costed proposal to reduce cancellations in Ophthalmology will be presented to the September meeting of SIRG.</td></tr>
<tr><td>b</td><td>Delayed Transfers of Care reduced on both sites during the month to 3.0% overall. Of the 16 delays recorded on the census date, they were equally split between those attributable to Social Care and those attributable to the NHS.</td></tr>
<tr><td rowspan="2">c</td><td>One patient was eligible for thrombolysis during April (although month not shown in performance report), but did not receive thrombolytic treatment within the 60 minute call to needle time. The patient was however treated within the 30 minute door to needle time. No patients were eligible for treatment during May.</td></tr>
<tr><td>Primary Angioplasty performance data now features within the report, with performance expressed as the percentage of eligible patients receiving primary angioplasty within 90 minutes 'call to balloon' time. The performance of the Trust during 07/08 was 63%, which has increased to 79% for the first 2 months of this year. The national average during 07/08 was 79%.</td></tr>
<tr><td>d</td><td>Most recent data for June indicates that 22.2% of patients admitted with a Stroke spent more than 90% of their time in hospital on a Stroke Unit. As part of an on-going more detailed examination of the data, 50% of patients do spend more than 50% of their stay on a Stroke Unit. A number of patient records will be examined as part of the data validation process.</td></tr>
<tr><td>e</td><td>GU Medicine performance further improved during July with 85.1% of patients being seen within 48 hours of contacting the service, increasing the year to date performance to 72.1%. Patients offered an appointment was 100% for the second consecutive month.</td></tr>
<tr><td>f</td><td>Infection Control - C. Diff and MRSA Bacteraemia trajectories continue to be met. One case of MRSA Bacteraemia was reported during the month of July, which brings the year to date total to 3.</td></tr>
<tr><td>g</td><td>Referral to Treatment Time - Milestones for both the Admitted and Non-Admitted components were met during July. The range (by specialty) for Admitted patients was 90.2% - 100% and the range (by specialty) for Non-Admitted patients was 91.9% - 98.8%. There were 10 Diagnostic waits reported in excess of 6 weeks, 5 in Audiology and 5 in Imaging.</td></tr>
<tr><td>h</td><td>
Activity to date is compared with the contracted activity plan for 2008 / 2009.
<table>
<tr><th></th><th>Sandwell</th><th>City</th><th>Trust</th></tr>
<tr><td>IP Elective</td><td>12.0%</td><td>-3.8%</td><td>1.9%</td></tr>
<tr><td>Day case</td><td>1.4%</td><td>1.9%</td><td>1.7%</td></tr>
<tr><td>IPE plus DC</td><td>3.3%</td><td>0.5%</td><td>1.7%</td></tr>
<tr><td>IP Non-Elective</td><td>0.3%</td><td>0.3%</td><td>0.3%</td></tr>
<tr><td>OP New</td><td>4.4%</td><td>15.4%</td><td>11.1%</td></tr>
<tr><td>OP Review</td><td>-1.4%</td><td>-2.5%</td><td>-2.0%</td></tr>
</table>
A much higher level of Elective, Non-Elective and Outpatient activity was undertaken during the month of July, than in previous months, which has improved the performance against contract to date as indicated in the table opposite.

When activity to date is compared with 2007 / 08 for the corresponding period
<table>
<tr><th></th><th>Sandwell</th><th>City</th><th>Trust</th></tr>
<tr><td>IP Elective</td><td>14.8%</td><td>9.8%</td><td>11.8%</td></tr>
<tr><td>Day case</td><td>5.1%</td><td>10.5%</td><td>7.9%</td></tr>
<tr><td>IPE plus DC</td><td>6.8%</td><td>10.4%</td><td>8.8%</td></tr>
<tr><td>IP Non-Elective</td><td>0.8%</td><td>3.4%</td><td>2.3%</td></tr>
<tr><td>OP New</td><td>10.9%</td><td>18.3%</td><td>15.4%</td></tr>
<tr><td>OP Review</td><td>3.7%</td><td>0.0%</td><td>2.0%</td></tr>
</table>
The impact of activity undertaken within July has further increased the Trust's performance to date when compared with the corresponding period last year.
</td></tr>
<tr><td rowspan="2">i</td><td>Elective Access Contact Centre performance is now assessed against an in-year trajectory and end of year target, with ultimately the aim to answer more than 90% of calls within 15 seconds. Plans to improve performance are being formulated, which are likely to include investment in additional staff and proposals to maximise OP capacity.</td></tr>
<tr><td>Choose and Book performance continues to improve, such that the Trust's ranking nationally is 3rd (1st Regionally)</td></tr>
<tr><td>j</td><td>The ability to extract performance data from the Telephone System has proved to be more problematic than envisaged, predominantly as a result of recent upgrades to the system, and the corresponding need to revise data extract queries. This is being addressed. Data which was available prior to the upgrade, such as volume of calls and those answered within specific time periods will soon be available.</td></tr>
<tr><td>k</td><td>The turnaround of Ambulances within the WMAS target time of 15 minutes improved at both sites during July, similarly delays in excess of 30 minutes and 60 minutes reduced. WMAS have confirmed that there were no delays in excess of 90 minutes attributable to the Trust during the month.</td></tr>
<tr><td>l</td><td>Income per spell during July was 1.2% higher than cost per spell. Although this is a less favourable differential than the previous month (+2.5%), the year to date differential for the first 4 months of the year is 1.1%</td></tr>
<tr><td>m</td><td>Overall agency spend expressed as a percentage increased to 2.79% during July, influenced by non-nursing costs. Higher than target expenditure was also seen in Nurse Bank and Medical Locum areas. It should be noted that almost 500 additional activity spells (+4.4%) were delivered during the same period.</td></tr>
<tr><td>n</td><td>Sickness Absence increased slightly to 4.27% during July. No Division reported sickness absence at greater than 6%.</td></tr>
<tr><td>o</td><td>PDRs reported to Learning and Development increased dramatically during July to 891. Adjustment has been made to the corporate target to recognise the average number of staff on maternity leave at any given time. Junior doctor numbers now also feature in the target and actual. The percentage of staff receiving a PDR since April 2007 has now increased to 69%. Divisional performance ranges from 42% - 100%.</td></tr>
</table>

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - JULY 2008

Exec Lead	NATIONAL INDICATORS			May-08			Jun-08			Jul-08			To Date	TARGET		Exec Summary Note	THRESHOLDS			06/07 Outturn	07/08 Outturn	08/09 Projected
				S'well	City	Trust	S'well	City	Trust	S'well	City	Trust		YTD	08/09							
RW	Net Income & Expenditure (Surplus / Deficit (-))		£000s	→		359 ▲	→		325 ▼	→		351 ▲	1254	920	2500		0%	0 - 1%	>1%	3399	6547	
RK	Cancer	2 weeks	%	→		100 ■	→		100 ■	→			99.1	>99	>99		No variation		Any variation	100	97.1	
		31 Days	%	→		100 ■	→		100 ■	→			100	>98	>98		No variation		Any variation	99.9	99.9	
		62 Days	%	→		100 ■	→		100 ■	→			99.6	>98	>98		No variation		Any variation	99.3	99.7	
TA / MD	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.6 ■	0.9 ■	0.7 ■	0.3 ▲	1.2 ■	0.8 ■	0.3 ■	1.0 ■	0.7 ■	0.9	<0.8	<0.8	a	<0.8	0.8 - 1.0	>1.0	0.9	0.9	
		28 day breaches	No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0	0	0		3 or less	4 - 6	>6	4	0	
	Delayed Transfers of Care	Total	%	3.2 ▲	4.3 ▲	3.8 ■	3.8 ▼	4.7 ▼	4.3 ■	2.1 ■	3.7 ■	3.0 ■	3.8	<3.0	<3.0	b	<3.0	3.0 - 4.0	>4.0	4.0	2.7	
	Coronary Heart Disease	Thrombolysis (60 minutes)	%	no pts	no pts	no pts							0	80	80	c	>80	75-80	<75	56.8	50.0	
		Primary Angioplasty (<90 mins)	%	80 ▼	50 ■	67 ■							79	80	80		>80	75-80	<75	n/a	63.0	
		Rapid Access Chest Pain	%	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■			100	100	100		>99	98 - 99	<98	99.7	99.6	
DO'D	Stroke Care	>90% stay on Stroke Unit	%	→		20.3 ▼	→		22.2 ▲	→			22.4	45+	65+	d	55 - 65+	45 - 54	<45	n/a	n/a	
		TIAs (Higher Risk) treated within 24 hours	%	Being Developed										25+	25+		20 - 25+	15 - 19	<15	n/a	n/a	
TA / MD	A/E 4 Hour Waits		%	98.8 ■	98.4 ▼	98.6 ■	97.6 ■	98.4 ■	98.1 ▼	98.0 ■	99.0 ▲	98.8 ▲	98.47	=>98	=>98		=>98		<98	98.20	98.28	
	GUM 48 Hours	Patients seen within 48 hours	%	→		55.4 ▼	→		79.7 ▲	→		85.1 ▲	72.1	95	95	e	No variation	0 - 10% variation	>10% variation	n/a	n/a	
		Patients offered appointment within 48 hours	%	→		88.8 ▼	→		100 ■	→		100 ■	95.9	100	100		No variation	0 - 10% variation	>10% variation	35.8	80.7	
RS	Infection Control	C. Diff (aged 2+) - EXTERNAL TARGET	No.	7 ■	10 ▲	17 ▲	7 ■	3 ▲	10 ▲	4 ▲	6 ▼	10 ■	55	108	317	f	No variation		Any variation	n/a	360	
		C. Diff (aged 2+) - EXTERNAL TARGET	per 1000 adm.	2.61 ▲	2.63 ▲	2.62 ▲	2.56 ▲	0.78 ▲	1.52 ▲	1.42 ▲	1.51 ▼	1.47 ▲	2.1	4.28	4.19		No variation		Any variation	n/a	4.76	
		C. Diff (aged 2+) - INTERNAL TARGET	No.	7 ■	10 ▲	17 ▲	7 ■	3 ▲	10 ▲	4 ▲	6 ▼	10 ■	55	104	301		No variation		Any variation	n/a	261	
		C. Diff (aged 2+) - INTERNAL TARGET	per 1000 adm.	2.61 ▲	2.63 ▲	2.62 ▲	2.56 ▲	0.78 ▲	1.52 ▲	1.42 ▲	1.51 ▼	1.47 ▲	2.1	4.13	3.98		No variation		Any variation	n/a	3.34	
		MRSA Bacteraemias	No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1 ▼	1 ▼	3	12	33		No variation		Any variation	61	43	
		MRSA Bacteraemias	per 1000 bed days	0.00 ■	0.00 ■	0.00 ■	0.00 ■	0.00 ■	0.00 ■	0.00 ■	0.07 ▼	0.04 ▼	0.03	0.10	0.10		No variation		Any variation	0.16	0.14	
TA	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	→		84 ■	→		83 ▼	→			84	90	90		>/=90	89.0-89.9	<89	90.0	89.0	
DO'D / RS	Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	→			100 ■	99.9 ■	99.9 ■	→			99.9	100	100		>99	98 - 99	<98	99.9	99.5	
		Breast Feeding Status Data Complete	%	→			100 ■	97.9 ■	98.9 ■	→			98.9	100	100		>99	98 - 99	<98	98.3	99.8	
		Maternal Smoking Rates	%	→			22.7	7.9	14.4	→			14.4	No. Only	No. Only					13.2	13.1	
		Breast Feeding Initiation Rates	%	→			40.5	62.0	52.5	→			52.5	No. Only	No. Only					52.5	55.0	
TA / MD	RTT Milestones	Admitted Care (RTT <18 weeks)	%	→		93.4 ▲	→		94.6 ▲	→		95.0 ▲	95.0	90	90	g	< YTD target		> YTD target	52.0	90.6	
		Non-Admitted Care (RTT <18 weeks)	%	→		90.0 ■	→		93.3 ▲	→		95.2 ■	95.2	95	100		< YTD target		> YTD target	n/a	95.5	
	Diagnostic Waits	Number greater than 6 weeks	No.	→		13 ▲	→		1 ▲	→		10 ▼	10	0	0		0-10% variation	10 - 20% variation	>20% variation	996	25	

Exec Lead	ACTIVITY			S'well	City	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	08/09	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Projected
TA	Spells	Elective IP	No.	451	665	1116	461	667	1128	508	742	1250	4618	4541	13669	h	No Variation	0 - 2% Variation	>2% Variation	13887	13395	
		Elective DC	No.	1891	2139	4030	1867	2286	4153	1918	2469	4387	16988	16595	48285		No Variation	0 - 2% Variation	>2% Variation	45831	46304	
		Total Elective	No.	2342	2804	5146	2328	2953	5281	2426	3211	5637	21606	21136	61954		No Variation	0 - 2% Variation	>2% Variation	59718	59699	
		Non-Elective - Short Stay	No.	450	372	822	460	466	926	480	453	933	3958	3951	11949		No Variation	0 - 2% Variation	>2% Variation	12414	11575	
		Non-Elective - Other	No.	1924	2874	4798	1932	2758	4690	1903	2900	4803	18482	18371	55538		No Variation	0 - 2% Variation	>2% Variation	52662	55163	
		Total Non-Elective	No.	2374	3246	5620	2392	3224	5616	2383	3353	5736	22440	22322	67487		No Variation	0 - 2% Variation	>2% Variation	65076	66738	
	Outpatients	New	No.	4286	7206	11492	4755	8031	12786	4827	8742	13569	50231	45335	131870		No Variation	0 - 2% Variation	>2% Variation	127449	131941	
		Review	No.	11340	17608	28948	11532	19409	30941	12401	20579	32980	124799	127217	369288		No Variation	0 - 2% Variation	>2% Variation	370970	361113	
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	7888	9411	17299	7503	9532	17035	7113	9253	16366	66753	66711	193188		No Variation	0 - 2% Variation	>2% Variation	200561	195093	
	A/E Attendances	Type II (BMEC)	No.	→	2416	2416	→	2714	2714	→	2624	2624	10257	11591	32743		No Variation	0 - 2% Variation	>2% Variation	31373	29803	
	CLINICAL QUALITY																					
TA	Readmission Rates	(Within 28 days of discharge)	%	10.0	10.7	10.4	12.4	11.7	12.0				10.9	No. Only	No. Only					10.1	n/a	
RS	Infection Control	Savings Lives Compliance	%	→		97.0	→		98.0	→		98.0	98.0	>95	>95		< YTD target		> YTD target	n/a	n/a	
		Phlebitis Rate	%	0.9	0.0		0.5	0.4		0.6	0.4			<5	<5		< YTD target		> YTD target	n/a	1.77	
		Phlebitis Compliance	%	81	76		84	86		87	81			>95	>95		>95%	75-95%	<75%	n/a	78	
KD	Incident Reporting	Internally Reported Clinical Red Incidents	No.	→		13	→		6	→		11	39	No. Only	No. Only					37	137	
		Internally Reported Non-Clinical Red Incidents	No.	→		3	→		1	→		1	10	No. Only	No. Only					53	34	
RS	Hip Fracture	Operations within 48 hours of admission	%	90.9	83.3	89.3	81.3	85.7	82.6	66.7	78.9	73.0	80.3	73	77		No variation	0 - 10% variation	>10% variation	63.6	70.1	
DO'D	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	→ (February 2008)		100.8	→ (March 2008)		87.9	→ (April 2008)		92.4	92.4	Rate Only	Rate Only					101.1	97.5	
		Peer (SHA) HSMR	HSMR	→ (February 2008)		100.8	→ (March 2008)		99.5	→ (April 2008)		96.7	96.7	Rate Only	Rate Only					110.7	101.8	
	PATIENT EXPERIENCE																					
KD	Complaints	Number Received	No.	→						→				No. Only	No. Only					673	697	
		Response within 25 days	%	→						→				85	85		80%+	70 - 79%	<70%	77.4	81.2	
		Thank You Letters	No.	→						→				No. Only	No. Only					6026	3491	
TA	Elective Access Contact Centre	Number of Calls Received	No.	8105	8449	16554	→		19686	→		17881	17881	No. Only	No. Only	j				n/a	n/a	
		Average Length of Queue	mins	2.38	3.17		→		3.27	→		3.28	3.28	2.5	0.5		No variation	0 - 10% variation	>10% variation	n/a	n/a	
		Maximum Length of Queue	mins	25.6	38.2		→		25.1	→		34.5	34.5	10.0	6.0		No variation	0 - 10% variation	>10% variation	n/a	n/a	
TA	Choose & Book	Prop'n of Referals via. CAB (inc DBS)	%	→		62	→		61	→			61	No. Only	No. Only					n/a	n/a	
		Prop'n of Refs via. Directly Bookable Service	%	→		20	→		26	→			26	No. Only	No. Only					n/a	n/a	
		Ranking (Nationally / Regionally)	No.	→		5th / 1st	→		3rd / 1st	→			3rd / 1st	No. Only	No. Only					n/a	n/a	
TA	Telephone Exchange			→		n/a	→		n/a	→		n/a	n/a	No. Only	No. Only	j				n/a	n/a	

Exec Lead	PATIENT ACCESS & EFFICIENCY			S'well	City	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	08/09	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Projected
TA	Admitted Care	RTT maximum IP wait	Weeks	→		17 ▲	→		16 ▲	→		15 ▲	15	13	8		< YTD target		> YTD target	18 weeks max	17 weeks max	
		RTT (IP Waits greater than 8 weeks)	No.	→		147 ■	→		124 ▲	→		94 ▲	94	100	0		< YTD target		> YTD target	n/a	191	
		Inpatients >26 weeks	No.	→		0 ■	→		0 ■	→		0 ■	0	0	0		0		>0	1	0	
		Revascularisation >13 weeks	No.	→		0 ■	→		0 ■	→		0 ■	0	0	0		0		>0	0	0	
	Length of Stay	Average Length of Stay	Days	5.6 ■	5.0 ■	5.3 ■	5.4 ▲	4.6 ▲	5.0 ■				5.2	5.0	5.0		No Variation	0 - 5% Variation	>5% Variation	5.7	5.0	
		All Patients with LOS > 14 days	No.	173	168	341	142	185	327	127	160	287	287	No. Only	No. Only					n/a	345	
		All Patients with LOS > 28 days	No.	83	82	165	77	96	173	60	69	129	129	No. Only	No. Only					190	174	
		Minimal Stay Rate (Electives (IP/DC) <2 days	%	91.3 ▼	90.1 ■	90.7 ▼	90.9 ▼	90.8 ■	90.8 ▲	90.1 ■	91.8 ▲	91.1 ▲	91.2	91.0	92.0		No Variation	0 - 5% Variation	>5% Variation	88.3	90.5	
	Admissions	Day of Surgery (IP Elective Surgery)	%	75.8 ■	77.9 ■	76.9 ■	76.7 ▲	80.8 ■	78.8 ▲	76.8 ▲	82.0 ▲	79.7 ■	78.6	79.3	82		No Variation	0 - 5% Variation	>5% Variation	63.2	76.5	
		Day of Surgery (IP Non-Elective Surgery)	%	61.0	64.5	63.0	65.3	69.4	67.8	67.7	68.4	68.1	68.0	No. Only	No. Only					n/a	68.3	
		With no Procedure (Elective Surgery)	%	10.5	11.1	10.9	9.7	11.7	10.9				10.5	No. Only	No. Only					10.6	n/a	
		Per Bed (Elective)	No.	4.93 ▲	5.07 ■	5.00 ■	5.98 ■	6.38 ▲	6.19 ▲	4.85 ■	5.33 ▼	5.11 ▼	5.30	5.10	5.90		No Variation	0 - 5% Variation	>5% Variation	4.66	4.87	
	Discharges	Pt's Social Care Delay	No.	16 ▼	9 ■	25 ▼	7 ■	15 ■	22 ▲	4 ▲	4 ■	8 ■	8	<18	<18	b	No Variation	0 - 10% Variation	>10% Variation			
		Pt.'s NHS & NHS plus S.C. Delay	No.	1 ■	10 ▲	11 ▲	2 ▼	12 ▼	14 ▼	2 ■	6 ■	8 ■	8	<10	<10		No Variation	0 - 10% Variation	>10% Variation			
	Beds	Occupied Bed Days	No.	13522 ■	15957 ▲	29479 ▲	12329 ■	15327 ▼	27656 ■	12665 ▲	15323 ▲	27988 ▲	113631	112976	338000		No Variation	0 - 5% Variation	>5% Variation	378060	348676	
		Occupancy Rate	%	92.0 ■	93.3 ▼	92.7 ▼	89.2 ■	91.9 ▲	90.6 ▲	88.3 ■	88.0 ■	88.1 ■	90.6	86.5 - 89.5	86.5 - 89.5		86.5 - 89.5	85.5-86.4 or 89.6-90.5	<85.5 or >90.5	88.6	90.8	
		Open at month end (total)	No.	467	575	1042 ▼	465	567	1032 ▲	460	564	1024 ▲	1024	1033	1017		No Variation	0 - 2% Variation	>2% Variation	1097	1065	
		Open at month end (exc Obstetrics)	No.	446	538	984 ▼	444	530	974 ▲	439	527	966 ▲	966	975	975		No Variation	0 - 2% Variation	>2% Variation	1039	1007	
	Day Case Rates	All Procedures	%	80.2 ▼	75.6 ▼	77.7 ▼	79.9 ▼	76.7 ▲	78.1 ▲	78.6 ▼	76.3 ▼	77.3 ■	78.1	77.9	80.0		No Variation	0 - 5% Variation	>5% Variation	76.0	76.9	
		BMEC Procedures	%	→	78.9 ▲	78.9 ▲	→	81.3 ▲	81.3 ▲	→	80.6 ▼	80.6 ▼	80.0	78.6	80.0		No Variation	0 - 5% Variation	>5% Variation	71.5	77.2	
		Basket of 25 procedures	%	75.5 ■	80.0 ▲	78.1 ▼	76.1 ▼	79.4 ▼	77.7 ▼	68.8 ■	79.9 ▲	75.5 ■	78.0	77.9	80		No Variation	0 - 5% Variation	>5% Variation	75.2	78.0	
		Quality Metrics (Specified Procedures)	%	58.8 ■	68.6 ▲	63.6 ▼	54.3 ▼	71.0 ▲	61.0 ■	49.2 ▼	74.6 ▲	61.4 ▲	62.3	64.00	69.08		No Variation	0 - 5% Variation	>5% Variation	n/a	61.29	
	Non-Admitted Care	RTT maximum OP wait	Weeks	→		10 ■	→		10 ■	→		12 ▼	12	5	5		< YTD target		> YTD target	9 weeks max	10 weeks max	
		RTT (OP Waits greater than 5 weeks)	No.			2042 ▼			1793 ▲			2091 ▼	2091	0	0		< YTD target		> YTD target	n/a	1409	
		New : Review Rate	Ratio	2.65 ▲	2.46 ■	2.53 ■	2.43 ■	2.42 ▲	2.42 ▲	2.56 ■	2.35 ▲	2.43 ▼	2.48	2.52	2.30		No Variation	0 - 5% Variation	>5% Variation	2.91	2.74	
		DNA Rate - New Referrals	%	9.8 ▲	10.9 ■	10.5 ■	9.4 ▲	10.6 ▲	10.1 ▲	10.8 ■	11.9 ■	11.5 ■	10.9	10.6	9.0		No Variation	0 - 5% Variation	>5% Variation	10.8	10.9	
		DNA Rate - Reviews	%	12.7 ■	14.1 ■	13.5 ▲	12.3 ▲	13.7 ▲	13.2 ▲	12.0 ▼	14.5 ▼	13.6 ▼	13.6	12.3	9.0		No Variation	0 - 5% Variation	>5% Variation	12.8	13.5	
		Outpatients >13 weeks	No.	→		0 ■	→		0 ■	→		0 ■	0	0	0		0		>0	4	0	
	Diagnostics	Imaging Waits >6 weeks	No.	→		10 ▲	→		0 ■	→		5 ■	5	0	0	g	0 - 10%	10 - 15%	>15%	185	18	
		Pathology >6 weeks	No.	→		0 ■	→		0 ■	→		0 ■	0	0	0		0 - 10%	10 - 15%	>15%	n/a	0	
		Audiology Waits >6 weeks	No.	→		2 ▲	→		1 ▲	→		5 ▼	5	0	0		0 - 10%	10 - 15%	>15%	60	3	
		Cardiology Waits >6 weeks	No.	→		0 ■	→		0 ■	→		0 ■	0	0	0		0 - 10%	10 - 15%	>15%	137	0	
		Neurophysiology Waits >6 weeks	No.	→		0 ■	→		0 ■	→		0 ■	0	0	0		0 - 10%	10 - 15%	>15%	218	0	
		Respiratory Physiology Waits >6 weeks	No.	→		0 ■	→		0 ■	→		0 ■	0	0	0		0 - 10%	10 - 15%	>15%	12	4	
		Endoscopy Waits >6 weeks	No.	→		0 ■	→		0 ■	→		0 ■	0	0	0		0 - 10%	10 - 15%	>15%	106	0	
		Ophthalmic Science Waits >6 weeks	No.	→		0 ■	→		0 ■	→		0 ■	0	0	0		0 - 10%	10 - 15%	>15%	278	0	
		Urodynamics Waits >6 weeks	No.	→		0 ■	→		0 ■	→		0 ■	0	0	0		0 - 10%	10 - 15%	>15%	0	0	
		Orthotics Waits >6 weeks	No.	→		n/a	→		12 ■	→			12	75	0		0 - 10%	10 - 15%	>15%	1854	67	
	Pathology	Cervical Cytology Turnaround	Weeks	2.0 ▲	1.9 ▲		2.3 ▼	1.9 ■					1.9 - 2.3	<4.0	<4.0		<4.0	4.0-6.0	>6.0	1.7 - 4.0	1.5 - 2.9	
	Ambulance Turnaround	Within 15 minute WMAS target	%	19	17	18	14	18	16	17	22	20	20	No. Only	No. Only	k				n/a	n/a	
		(West Midlands average)	%	→		20	→		20	→		23	23	No. Only	No. Only					n/a	n/a	
		In Excess of 30 minutes	%	7	12	10	14	11	12	13	10	11	11	No. Only	No. Only					n/a	29.1	
		(West Midlands average)	%	→		11	→		12	→		11	11	No. Only	No. Only					n/a	31.1	
		In Excess of 60 minutes	%	0.4	0.3	0.3	0.7	0.2	0.4	0.0	0.2	0.1	0.1	No. Only	No. Only					n/a	n/a	
		(West Midlands average)	%	→		0.6	→		0.6	→		0.5	0..5	No. Only	No. Only					n/a	n/a	

Exec Lead	FINANCE & FINANCIAL EFFICIENCY			S'well	City	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	08/09	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Projected
RW	Gross Margin		£000s	→		2357 ■	→		2421 ▼	→		2361 ▲	9361	9142	27137		0%	0 - 1%	>1%		26429	33250	
RW	CIP		£000s	→		647 ■	→		861 ▼	→		696 ▼	4697	4697	11030		0 - 2.5%	2.5 - 7.5%	>7.5%		19679	14027	
	In Year Monthly Run Rate		%	→		41.9 ▲	→		47.7 ▲	→		50.0 ▲	36.30	0	0		NO or a + variation	0 - 5% variation	>5% variation		329	45	
TA	Income / WTE		£s	→		4965 ■	→		4978 ▲	→		5062 ▲	4959	4861	4861	l	No variation	0 - 5% variation	>5% variation		5460	4924	
TA	Income / Open Bed		£s	→		29908 ▲	→		30364 ■	→		31085 ▲	30141	30158	30158		No variation	0 - 5% variation	>5% variation		24774	29065	
TA	Income per Spell	Total Income	£s	→		2722 ■	→		2714 ▼	→		2640 ■	2673	2808	2808		No Variation	0 - 4% Variation	>4% Variation		2635	2740	
TA	Income per Spell	Clinical Income	£s	→		2420 ■	→		2399 ▼	→		2332 ■	2377	2510	2510		No Variation	0 - 4% Variation	>4% Variation		2317	2449	
TA	Income per Spell	Non-Clinical Income	£s	→		302 ■	→		315 ▲	→		308 ▼	296	298	298		No Variation	0 - 4% Variation	>4% Variation		318	291	
TA	Cost per Spell	Total Cost	£s	→		2688 ▼	→		2648 ▲	→		2609 ▲	2644	2709	2709		No Variation	0 - 4% Variation	>4% Variation		n/a	2643	
TA	Cost per Spell	Total Pay Cost	£s	→		1749 ■	→		1750 ▼	→		1714 ■	1728	1737	1737		No Variation	0 - 4% Variation	>4% Variation		1772	1737	
TA	Cost per Spell	Medical Pay Cost	£s	→		541 ■	→		531 ■	→		507 ■	522	517	517		No Variation	0 - 4% Variation	>4% Variation		543	517	
TA	Cost per Spell	Nursing Pay Cost (including Bank)	£s	→		600 ▲	→		610 ▼	→		592 ▲	600	615	615		No Variation	0 - 4% Variation	>4% Variation		609	615	
TA	Cost per Spell	Non-Pay Cost	£s	→		939 ■	→		933 ▲	→		895 ■	917	929	929		No Variation	0 - 4% Variation	>4% Variation		n/a	906	
TA	Cost per Spell	Mean Drug Cost / IP Spell	£s	→		108 ▼	→		102 ▲	→		102 ■	105	97	97		No Variation	0 - 4% Variation	>4% Variation		n/a	95	
TA	Cost per Spell	Mean Drug Cost / Occupied Bed Day	£s	→		38 ▲	→		40 ▼	→		41 ▼	41	35	35		No Variation	0 - 4% Variation	>4% Variation		n/a	35	
	WORKFORCE																					
TA	WTE in Post	Total	No.	→		5927 ▲	→		5940 ▼	→		5932 ▲	5932	6119	6082		No Variation	0 - 1% Variation	>1% Variation		6000	5875	
TA	WTE in Post	Medical and Dental	No.	→		748 ▲	→		751 ▼	→		745 ▲	745	769	761		No Variation	0 - 1% Variation	>1% Variation		822	736	
TA	WTE in Post	M'ment, Admin. & HCAs	No.	→		1797 ▲	→		1795 ▲	→		1795 ▲	1795	1884	1867		No Variation	0 - 1% Variation	>1% Variation		1806	1765	
TA	WTE in Post	Nursing & Midwifery (excluding Bank)	No.	→		2236 ▲	→		2240 ▼	→		2243 ▼	2243	2527	2528		No Variation	0 - 1% Variation	>1% Variation		2481	2255	
TA	WTE in Post	Scientific and Technical	No.	→		890 ▼	→		894 ▼	→		897 ▼	897	938	926		No Variation	0 - 1% Variation	>1% Variation		891	869	
TA	WTE in Post	Bank Staff	No.	→		256	→		260	→		252	252	No. Only	No. Only						n/a	250	
TA	WTE in Post	Gross Salary Bill	£000s	→		18917 ▼	→		19078 ▼	→		19495 ▼	76093	76544	231000		No Variation	0 - 1% Variation	>1% Variation		220244	219667	
TA	Bank & Agency	Nurse Bank Fill Rate	%	→		86.3	→		87.0	→		84.9	85.8	No. Only	No. Only	m					n/a	87.6	
TA	Bank & Agency	Nurse Bank Shifts covered	No.	→		5703 ▲	→		5299 ■	→		5624 ■	22402	20612	61836		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation		67330	68707	
TA	Bank & Agency	Nurse Agency Shifts covered	No.	→		510 ▲	→		411 ■	→		387 ▲	1829	1657	4972		0 - 5% Variation	5 - 10% Variation	>10% Variation		2879	5524	
TA	Bank & Agency	Nurse Bank AND Agency Shifts covered	No.	→		6213 ▲	→		5710 ■	→		6011 ■	24231	22269	66808		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation		70209	74231	
TA	Bank & Agency	Nurse Bank Costs	£000s	→		535 ■	→		588 ■	→		583 ▲	2249	2094	6282		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation		6883	6980	
TA	Bank & Agency	Nurse Agency Costs	£000s	→		68 ▼	→		57 ▲	→		55 ▲	237	323	970		0 - 5% Variation	5 - 10% Variation	>10% Variation		474	1078	
KD	Bank & Agency	Medical Agency Costs	£000s	→		112 ■	→		106 ▲	→		166 ▼	482	389	1166		0 - 5% Variation	5 - 10% Variation	>10% Variation		693	1296	
TA	Bank & Agency	Other Agency Costs	£000s	→		233 ■	→		199 ▲	→		321 ▼	851	460	1379		0 - 5% Variation	5 - 10% Variation	>10% Variation		1661	2223	
KD	Bank & Agency	Medical Locum Costs	£000s	→		262 ▼	→		265 ▼	→		260 ▲	1013	733	2200		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation		2566	2445	
TA/KD	Bank & Agency	Agency Spend cf. Total Pay Spend	%	→		2.18 ■	→		1.90 ■	→		2.79 ■	2.07	<2	<2		<2	2 - 2.5	>2.5		1.50	2.15	
CH	Sickness Absence	Long Term	%	→		3.12 ■	→		3.19 ▼	→			3.10	<3.00	<3.00	n	<3.0	3.0-3.35	>3.35		2.50	3.52	
CH	Sickness Absence	Short Term	%	→		0.99 ■	→		1.08 ▼	→			1.11	<1.25	<1.25		<1.25	1.25-1.40	>1.40		2.17	1.26	
CH	Sickness Absence	Total	%	→		4.11 ■	→		4.27 ■	→			4.21	<4.25	<4.25		<4.25	4.25-4.75	>4.75		4.67	4.78	
CH	Recruitment & Retention	Permission to Recruit	wte	→		119	→		87	→		56	375	No. Only	No. Only						n/a	1143	
CH	Recruitment & Retention	New Starters	wte	→		52	→		59	→		39	246	No. Only	No. Only						n/a	855	
CH	Recruitment & Retention	Leavers	wte	→		59	→		60	→		62	246	No. Only	No. Only						n/a	1004	
CH	Recruitment & Retention	Inductions	No.	→		61			89			75	316	No. Only	No. Only						n/a	442	
CH	Learning & Development	PDRs (includes Junior Med staff)	No.	→		292 ▼	→		377 ▲	→		891 ■	1932	1791	5372	o	0-5% variation	5 - 15% variation	>15% variation		n/a	1912	
CH	Learning & Development	Mandatory Training	No.	→		285 ▲	→		343 ▲	→		265 ▼	1145	1721	5163		0-5% variation	5 - 15% variation	>15% variation		4313	2770	
CH	Learning & Development	Conflict Resolution Training	No.	→		61 ▼	→		89 ▲	→		73 ▼	307	667	2000		0-5% variation	5 - 15% variation	>15% variation		1441	1712	

Exec Lead	STRATEGY			S'well	City	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	08/09	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Projected
RK	Referral Rates (Target for 08/09 derived from 07/08 actuals profiled by month, according to 'working' days within period)	Total By Site	No.	→		13789 ▼	→		14900 ▲	→			44142	37522	147784		No Variation	0 - 2% Variation	>2% Variation	138580	151755	
		Total GP Referrals	No.	→		7499 ■	→		7938 ■	→			24121	24278	95622		No Variation	0 - 2% Variation	>2% Variation	98476	95857	
		Total Other Referrals	No.	→		6290 ▼	→		6962 ▲	→			20021	13244	52162		No Variation	0 - 2% Variation	>2% Variation	40104	55898	
		By PCT - Heart of B'ham	No.	→		3771 ▼	→		4251 ▲	→			12201	10336	40708		No Variation	0 - 2% Variation	>2% Variation	40394	41628	
		By PCT - Sandwell	No.	→		6825 ▼	→		7244 ▲	→			21648	18997	74820		No Variation	0 - 2% Variation	>2% Variation	72580	77592	
		By PCT - Other	No.	→		3193 ▼	→		3405 ▲	→			10293	8190	32256		No Variation	0 - 2% Variation	>2% Variation	25606	32535	
		Conversion (all referrals) to New OP Att'd	%	→		83.3	→		85.8	→			83.1	No. Only	No. Only					91.5	87.0	
	THEATRE UTILISATION																					
TA	Sitrep Declared Late **Cancellations** by Specialty	General Surgery	No.	1	4	5	0	4	4	3	2	5	37	No. Only	No. Only	a				n/a	75	
		Urology	No.	0	0	0	0	2	2	0	3	3	19	No. Only	No. Only					n/a	67	
		Vascular Surgery	No.	0	0	0	0	0	0	0	0	0	0	No. Only	No. Only					n/a	1	
		Trauma & Orthopaedics	No.	2	6	8	3	0	3	0	1	1	17	No. Only	No. Only					n/a	100	
		ENT	No.	0	5	5	0	1	1	0	2	2	9	No. Only	No. Only					n/a	19	
		Ophthalmology	No.	3	5	8	2	19	21	6	18	24	66	No. Only	No. Only					n/a	139	
		Oral Surgery	No.	0	0	0	0	2	2	0	0	0	4	No. Only	No. Only					n/a	10	
		Cardiology	No.	0	0	0	2	0	2	0	0	0	3	No. Only	No. Only					n/a	28	
		Gynaecology	No.	4	2	6	0	1	1	1	5	6	21	No. Only	No. Only					n/a	69	
		Plastic Surgery	No.	1	4	5	0	2	2	0	2	2	9	No. Only	No. Only					n/a	17	
		TOTAL	No.	11	26	37	7	31	38	10	33	43	185	No. Only	No. Only					n/a	525	

Theatre Location	Late Starts (%)	Early Finishes (%)	Session Util'on (%)	No. of Patients	Pts / Session	Late Starts (%)	Early Finishes (%)	Session Util'on (%)	No. of Patients	Pts / Session	Late Starts (%)	Early Finishes (%)	Session Util'on (%)	No. of Patients	Pts / Session			07/08 Outturn (Nov - March data only)				
																		Late Starts (%)	Early Finishes (%)	Session Utilisation (%)	No. of Patients	Patients / Session
Theatre Sessions																						
City (Main Spine)	43	42	91	322	1.5	41	51	165	338	1.5	37	47	87	306	1.4	No. Only	No. Only	41	53	83	1518	1.5
City (BTC)	34	62	77	516	3.4	37	56	83	550	3.5	42	60	80	699	3.3	No. Only	No. Only	41	59	85	2763	3.4
City (BMEC)	37	44	89	524	3.4	42	51	84	574	3.6	36	54	85	580	3.3	No. Only	No. Only	42	51	82	2539	3.2
Sandwell (Main Theatres)	46	45	93	374	2.3	45	43	97	415	2.3	52	40	90	457	2.4	No. Only	No. Only	42	47	93	1309	2.2
Sandwell (SDU)	34	61	120	494	4.4	37	71	76	482	4.4	49	64	77	485	4.4	No. Only	No. Only	44	69	78	1710	4.3
TRUST	39	51	92	2230	2.8	41	53	107	2359	2.8	43	53	85	2527	2.8	No. Only	No. Only	42	55	84	9839	2.7

KEY TO PERFORMANCE ASSESSMENT SYMBOLS

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Financial Performance – Month 4
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Management
AUTHOR:	Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	4 September 2008

KEY POINTS:

The report is provided to update the Board on financial performance for the period to 31st July 2008.

In-month surplus is £351k against a target of £234k; £117k ahead of plan.

Year to date surplus is £1,254k, £334k ahead of plan.

In-month WTEs are 230 below plan.

Cash balance is £1.4m below plan at 31st July.

PURPOSE OF THE REPORT:

✓ **For Noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To receive and note the monthly finance report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

4.1- Deliver the financial plan including achieving a financial surplus of at least £2.5m and a CIP of £11m.

IMPACT ASSESSMENT:

FINANCIAL	✓	Trust has a target surplus for the year of £2.5m in line with requirement to repay the residue of its working capital loan.
ALE		
CLINICAL		
WORKFORCE		
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – July 2008

EXECUTIVE SUMMARY

• At the end of July, the Trust had an actual surplus of £1,254k, £334k ahead of plan.

• In month surplus is £351k against a target of £234k, £117k ahead of plan.

• In-month WTE's 230 below plan.

•Cash balance is £1.4m below plan at 31st July.

•With some minor exceptions, operational divisions are delivering year to date budget surpluses. Corporate divisions have also delivered a year to date surplus of £440k. Reserves and miscellaneous divisions continue to show an adverse position due to provisions for data challenges and other cost uncertainties.

•Overall admitted patient care activity (based on data to 30th June) is broadly in line with plan with over performance on day cases and non electives and under performance on elective in-patients. New out-patients are significantly above plan as offset by review attendances which are below plan.

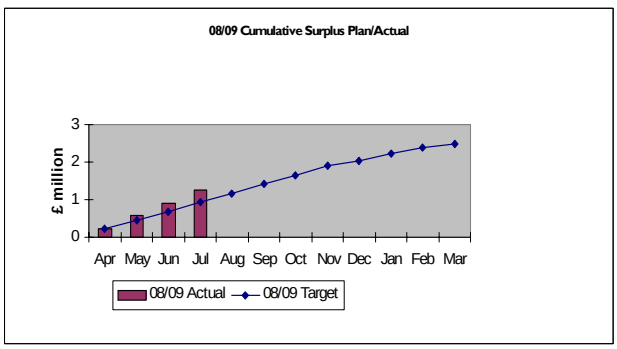
• Patient related income reflects activity against contract targets as adjusted for data challenges

• CIP performance remains broadly in line with planned levels.

Key Financial Performance Indicators

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	117	334	> Plan	>= 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	92	219	> Plan	>= 99% of plan	< 99% of plan
Pay Actual v Plan £000	80	451	< Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	-292	-628	< Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	230	187	< Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	-1,425	-1,425	>= Plan	>= 95% of plan	< 95% of plan
CIP Actual v Plan £000	0	0	> 97/3% of Plan	>= 92/3% of plan	< 92/3% of plan

Note: positive variances are favourable, negative variances unfavourable



2008/2009 Summary Income & Expenditure Performance at July 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	312,926	26,199	26,533	334	104,277	104,686	409	313,676
Other Income	37,967	3,524	3,495	(29)	13,055	13,043	(13)	37,967
Operating Expenses	(323,848)	(27,454)	(27,667)	(213)	(108,191)	(108,369)	(178)	(324,598)
EBITDA	27,045	2,269	2,361	92	9,141	9,360	219	27,045
Interest Receivable	1,164	110	135	25	359	474	115	1,164
Depreciation & Amortisation	(16,343)	(1,362)	(1,362)	0	(5,448)	(5,448)	0	(16,343)
PDC Dividend	(9,258)	(771)	(771)	0	(3,086)	(3,086)	0	(9,258)
Interest Payable	(108)	(12)	(12)	0	(47)	(47)	0	(108)
Net Surplus/(Deficit)	**2,500**	**234**	**351**	**117**	**920**	**1,254**	**334**	**2,500**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2008

External Perspective

• Both Sandwell and Heart of Birmingham PCT's continue to forecast surplus positions with no significant changes to previously reported performance.

•Overall, the NHS is forecasting a national surplus for the year of between £1.58 and £1.87 billion. At Q1, the West Midlands StHA is forecasting an overall surplus of £155m.

•Headline growth for 2009/2010 is 6.3% although in practice this will be lower due to central top slicing of resources. An efficiency gain of 3% is expected to be delivered. Net tariff uplift is expected to be around 2.3%.

•For years beyond 2009/2010, the gross uplift could be as low as 3% which, after assumed efficiency gains, suggests minimal growth. This is, of course, dependent upon general price behaviour closer to 2010/2011.

Performance of Major Commissioners

• Fully coded activity data is available up to 30th June and this, and its related income, is incorporated into the financial position reported this month.

•Over performance has continued in month but this mainly relates to high cost drugs and A&E activity. Limited over performance on admitted patient care (there is a far greater number of daycase elective procedures to inpatient elective procedures undertaken) is largely offset by under performance on follow up out-patients as the ratio of new/follow up attendances is improved.

•Although the improved financial position of the PCTs will improve relationships, the prospect of data challenges remains strong and the Trust has taken and will need to continue to take this into account when assessing its income position.

•Major variations from SLA activity targets are shown in the adjacent table.

Year to Date Key Activity Performance
Performance Against SLA

	Sandwell PCT	Heart of Birmingham PCT	Overall
Admitted Care			
Elective	-0.1%	-6.5%	-4.2%
Non Elective	-1.1%	2.9%	0.4%
Day Case	4.3%	-3.6%	1.5%
Out-Patients			
New	8.0%	0.9%	8.1%
Follow Ups	-3.9%	-9.7%	-4.3%

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2008

Divisional Performance

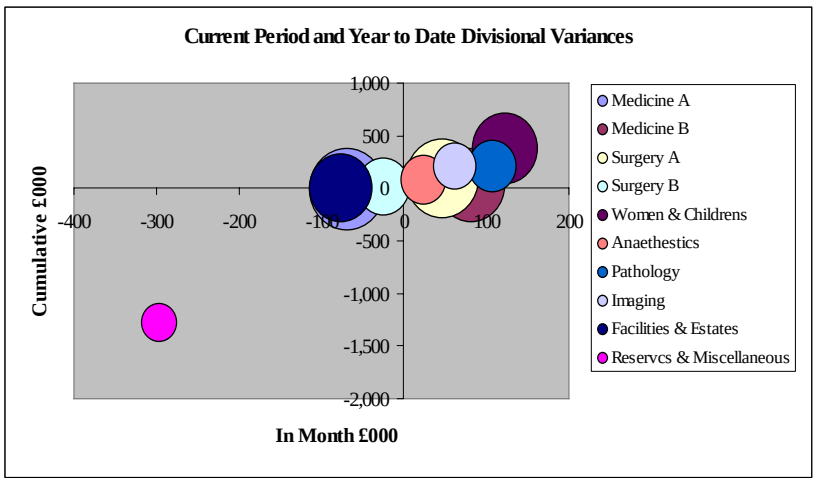
• Although overall operational divisions have delivered a bottom line surplus in month, there has been more variation in July than previous periods with deficits being recorded for Medicine A, Surgery B, Facilities and Estates. These are balanced by significant surpluses particularly for Pathology, Medicine B, Women & Childrens and Corporate Divisions. Divisional net surpluses are offset by a deficit in Reserves and Miscellaneous which is primarily the result of a cautious approach being taken on income and particularly data challenges from PCTs.

•For the year to date, the only operational divisions in deficit are Medicine A and Estates although in both cases the deficits are minimal. The adverse position reported within Reserves and Miscellaneous reflects a prudent position on income as well as some provision for uncertain expenditure items.

•For all major under spending divisions, including corporate services, the majority of the surplus continues to be accounted for by pay items. This is reflected in wte numbers which also remain lower than budget. Much of the under spend on nursing is covered by additional spend particularly on bank and, to a lesser degree, agency staff. The benefits of pay under spending must be regarded as non recurrent and therefore utilised only on a non recurrent basis.

•The outcome of the review of nursing services which will be delivered later in the year will also need to be reflected in budgets and the financial position generally. This may result in a review of the way in which the Trust plans for bank and agency staff.

•The performance of Medicine A, which is the only bed holding division with a year to date deficit, albeit a very small one, is driven primarily by a downturn in income in June. To date, income across both medical divisions has varied from one month to another and it may be that recovery will take place in subsequent months. Nevertheless, performance will need to be monitored and corrective action taken if improvements do not materialise.



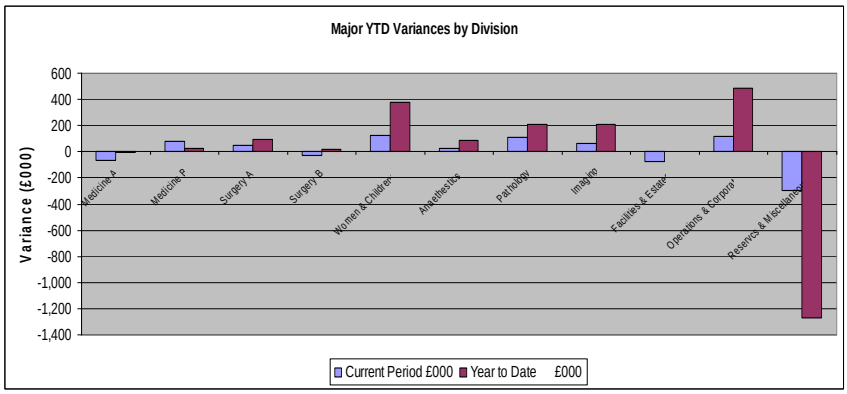
The tables adjacent and overleaf demonstrate Reserves and Miscellaneous as an outlier with deficits for both current period and year to date. Most other divisions are clustered fairly close together generally with small current period and year to date surpluses. Women & Childrens has the largest year to date surplus primarily driven by ongoing lower than planned pay expenditure across most pay groups.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2008

Divisional Variances from Plan

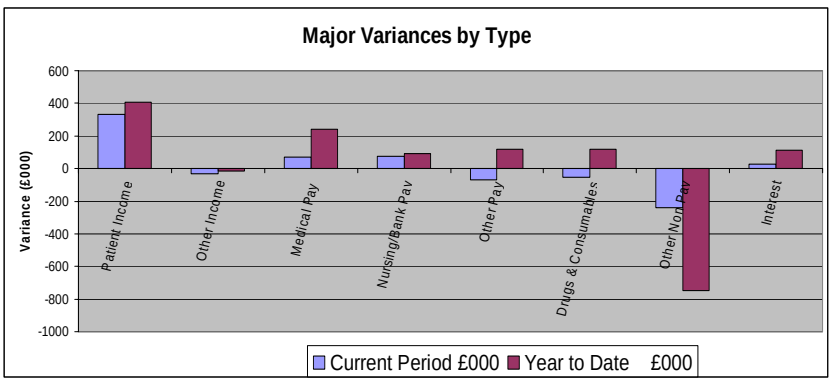
	Current Period £000	Year to Date £000
Medicine A	-69	-4
Medicine B	81	26
Surgery A	46	95
Surgery B	-25	17
Women & Childrens	122	374
Anaethestics	24	88
Pathology	107	207
Imaging	62	206
Facilities & Estates	-77	0
Operations & Corporate	119	484
Reservcs & Miscellaneous	-297	-1,273



The tables below illustrate that, income, pay and interest are all are performing better than plan. The only area where actual performance is worse than plan is other non pay. Most of this relates to Reserves and Miscellaneous where provisions are being made for uncertain expenditure as well as challenges to patient related income.

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	334	409
Other Income	-30	-13
Medical Pay	71	241
Nursing/Bank Pay	78	92
Other Pay	-69	118
Drugs & Consumables	-53	120
Other Non Pay	-239	-748
Interest	25	115

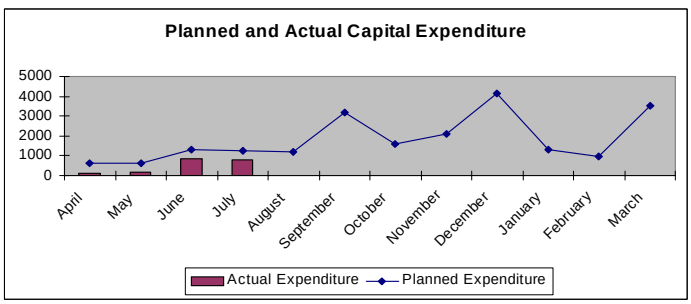


Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Year to date expenditure by July has risen to £1,975k, an increase in month of £776k.

•The majority of year to date expenditure relates to pathology reconfiguration, the City neo natal unit, statutory standards and the transfer of the breast screening service.

•Significant further expenditure in relation to pathology reconfiguration and the neo natal unit has been processed by the Capital Projects office and this will be manifested in the August expenditure position.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2008

Paybill & Workforce

• Overall workforce numbers (wte's) are around 230 below plan for July, primarily continuing to be within administration & estates, scientific & therapeutic and management.

•Paybill (including agency staff) is £80k below budgeted levels for the month, again mainly in the areas identified above although there is some degree of offsetting with agency staff.

•Excluding the cost of agency staff, the paybill would be £451k below budget in month and £1,631k year to date.

•Agency spend in month was £543k with the monthly average for the year reaching £343k. The biggest users of agency staff to date are Surgery A (mainly in theatres), Medicine B (primarily within A&E) and Finance (Internal Audit).

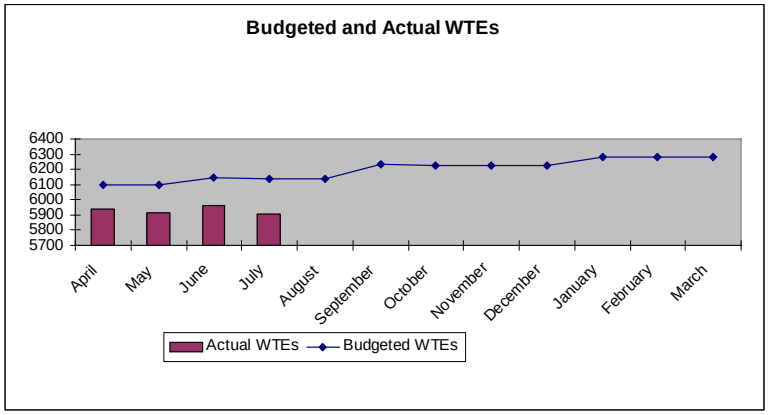
•In terms of divisional performance, the most significant contributors to the wte shortfall are:

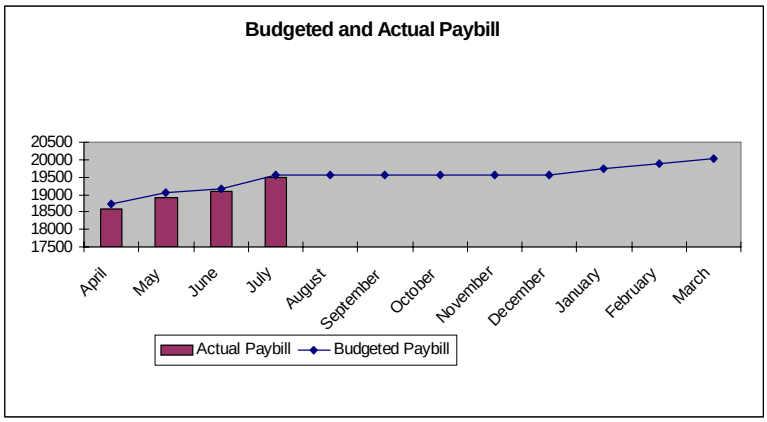
▪Women & Children's (most pay groups)

▪Pathology (scientific staff)

▪Finance

▪Surgery A (mainly nursing)





Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – July 2008

Balance Sheet

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

•Changes in fixed asset values are largely a consequence of the estimated value of indexation of existing assets at 1st April 2008 along with depreciation charged between April and July. New capital expenditure in 2008/2009 remains fairly low although it has accelerated over the last two months.

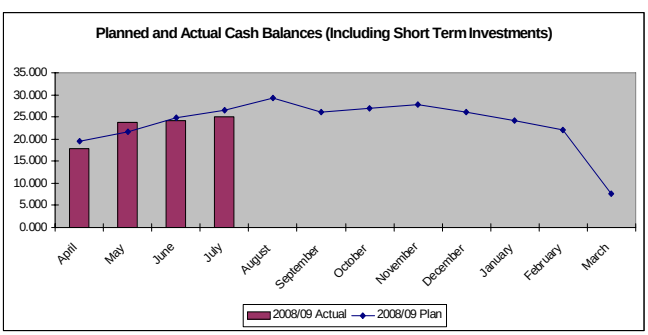
•Although cash balances have risen slightly in July, they remain below plan by approximately £1.4m. At present, there are no indications that this slight shortfall represents a change in trend and it is expected that cash will remain broadly in line with plan for the coming months.

•Debtor and accrued income balances have risen in month although this rise relates primarily to prepayments and accrued income rather than delayed receipts on raised invoices. DoH have indicated that the circular flow in relation to impairment funding will take place on 1st October. Although this will not result in any overall change in the cash position it will clear a debtor of around £2.3m with Sandwell PCT from the Trust's accounts.

•The debtor position with other NHS Bodies (non PCT) improved significantly in July.

Sandwell & West Birmingham Hospitals NHS Trust
BALANCE SHEET

		Opening Balance as at March 2008 £000	Balance as at July 2008 £000	Forecast at March 2009 £000
Fixed Assets	Intangible Assets	373	320	325
	Tangible Assets	274,392	281,551	285,524
	Investments	0	0	0
Current Assets	Stocks and Work in Progress	3,649	3,553	3,250
	Debtors and Accrued Income	19,508	20,111	13,750
	Investments	0	0	0
	Cash	8,285	24,232	7,614
Current Liabilities	Creditors and Accrued Expenditure Falling Due In Less Than 1 Year	(27,172)	(39,443)	(22,349)
	Loan Repayments Due in Less Than 1 Year	(2,500)	(2,500)	0
Long Term Liabilities	Creditors Falling Due in More Than 1 Year	0	0	0
Provisions for Liabilities and Charges		(5,571)	(4,974)	(3,750)
		270,964	282,850	284,364
Financed By				
Taxpayers Equity	Public Dividend Capital	162,296	162,296	163,396
	Revaluation Reserve	83,147	93,779	93,779
	Donated Asset Reserve	2,669	2,669	2,500
	Government Grant Reserve	2,163	2,163	1,500
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	11,631	12,885	14,131
		270,964	282,850	284,364



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2008

Forecast Outturn

•The forecast outturn position for the Trust currently remains at £2.5m which is in line with its target required to repay the residue of the working capital loan.

•Assuming patient related income continues to over perform at around the levels experienced over the first four months of the year then this, along with year to date pay under spending, could be expected to generate a higher than planned surplus at the year end. However, offsetting this are assumptions of some targeted non-recurrent spend, primarily non pay, thus limiting the bottom line surplus to the planned £2.5m. It is anticipated that any excess surplus will be used primarily to invest in non capital furniture and equipment and enhance the environmental improvements already included within the base position. Plans are being developed to scope and prioritise this expenditure.

•As reported last month, the dramatic increase in energy costs, particularly for gas, are expected to have a very significant effect on Trust expenditure, potentially up to £1.2m. At the moment, provision is being held within trust reserves to cover this expenditure and this will be released into operational budgets as the year progresses and the expected impact materialises. There is already some limited over spending on energy budgets and it is expected that this will worsen significantly in the autumn and winter.

Conclusions

Overall, the Trust has delivered a bottom line year to date surplus of £1,254,000 which is £334,000 ahead of plan for the 4 months to 31st July.

The better than planned performance is largely the result of an improvement in the income position as well as ongoing under spending against pay budgets. Non pay expenditure continues to reflect a prudent approach to potential cost pressures.

Although capital expenditure continues to be lower than plan, higher levels of expenditure were incurred in July particularly in respect of pathology reconfiguration and the City neo natal unit.

Cash balances remain slightly lower than planned but generally, although there are likely to be variances between months, expectations are that cash flow will continue to be in line with plan.

Both pay costs and wte's remain below plan although much of this financial benefit can only be considered as non recurrent. It is expected that as the year progresses monthly pay under spending will diminish.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report; and

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Corporate Objectives 2008/9. Quarter One Progress Report
SPONSORING DIRECTOR:	Director of Strategy
AUTHOR:	Head of Corporate Planning
DATE OF MEETING:	4 September 2008

KEY POINTS:

The Trust Board gave approval to the Corporate Objectives for 2008/09 in January 2008 and they form the central focus of the Annual Plan 2008/09. This is the first quarterly report on progress.

Note: this report was presented to July Operational Management Board (OMB) and was originally scheduled to be presented to the August Trust Board which was cancelled. It therefore reflects the position on these objectives as at end of July 2008.

The first Progress Report for 2008/09 showing the position at the end of June 2008 is attached. It should be noted that this is intended to offer a broad overview rather than to repeat the level of detail which is contained in separate reports on specific topics.

Of the 25 corporate objectives for 2008/9 set against our six strategic objectives at the end of Q1, 16 (64%) were rated "Green", 9 (36%) were rated "Amber" and 0 (0%) were rated "Red".

PURPOSE OF THE REPORT:

✓ **Noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. NOTE the progress with the Corporate Objectives as at the end of Quarter 1.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

The progress report demonstrates progress with the Trust's objectives for 2008/9.

IMPACT ASSESSMENT:

FINANCIAL		
ALE		
CLINICAL		
WORKFORCE		
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

SWBTB (9/08) 075 (a)

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

CORPORATE OBJECTIVES 2008/09: QUARTER 1 PROGRESS REPORT

INTRODUCTION

The Trust Board gave approval to the Corporate Objectives for 2008/09 in January 2008 and they form the central focus of the Annual Plan 2008/09. This is the first quarterly report on progress.

Note: this report was presented to July Operational Management Board (OMB) and was originally scheduled to be presented to the August Trust Board which was cancelled. It therefore reflects the position on these objectives as at end of July 2008.

OVERVIEW

The first Progress Report for 2008/09 showing the position at the end of June 2008 is attached. It should be noted that this is intended to offer a broad overview rather than to repeat the level of detail which is contained in separate reports on specific topics.

Of the 25 corporate objectives for 2008/9 set against our six strategic objectives at the end of Q1, 16 (64%) were rated “Green”, 9 (36%) were rated “Amber” and 0 (0%) were rated “Red”.

The objectives rated amber are as follows. The current position and action being taken on each of these objectives is set out in the table that follows.

2.3 Develop and begin to deliver Maternity Development Plan in the light of local reviews and national guidance.

2.7 Deliver improvements in national clinical priorities of cancer (Cancer Reform Strategy) and stroke (Stroke Strategy).

3.1 Deliver new models of care through the first wave 2010 exemplar projects (urgent care, intermediate care, dermatology and diabetes) and begin to deliver new models of care for community-based outpatients in the second wave 2010 exemplar specialties (cardiology, orthopaedics, rheumatology, ophthalmology, respiratory, gynaecology).

3.2 Successfully deliver a community-based dermatology service for Birmingham North and East PCT.

5.1 Agree and begin to implement land acquisition for the new hospital.

5.2 Produce and secure agreement to the Outline Business Case for the new acute hospital.

6.2 Ensure that all staff received appropriate mandatory training and receive an annual appraisal.

6.3 Develop further our approach to marketing and business development activity.

6.5 Achieve NHS Foundation Trust status

CONCLUSION AND RECOMMENDATIONS

This paper and the attached table present an overview of progress with the corporate objectives as at the end of Quarter 1. OMB is recommended to:

1. NOTE the progress with the Corporate Objectives as at the end of Quarter 1.

Ann Charlesworth
July 2008

TRUST OBJECTIVES 2008/9: QUARTER ONE PROGRESS REPORT

PROGRESS REPORTING

Progress with many of the corporate objectives will be reported to the Board monthly through for example the monthly performance and finance reports (e.g. progress with 2008/9 financial plan and progress with national access targets) or through specific monthly reports (e.g. 'Towards 2010' programme reports). In addition to this and in order to ensure that the Board has a clear view of progress across the corporate objectives as a whole it is intended to report progress quarterly, as we have throughout the last year, using a traffic-light based system at the following Board meetings:

- Q1 position reported to September Board meeting;
- Q2 position reported to November Board meeting;
- Q3 position reported to February Board meeting;
- Q4 position reported to May Board meeting.

CATEGORISATION

Progress with the actions in the plan has been assessed on the scale set out in the table below.

Status	
3	Progressing as planned or completed
2	Some delay but expect to be completed as planned
1	Significant delay – unlikely to be completed as planned

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter One (June 2008)**	**Red / Amber / Green Assessment**
1.	***Accessible and Responsive Care***				
1.1	Continue to achieve national and local access targets (18 weeks, cancer, A&E and GUM) TA	• 18 week referral to treatment target achieved by December 2008 • Cancer targets (2 week, 31 day and 62 day) achieved by March 2009 • A&E 4 hour wait target achieved by March 2009 • GUM target (48 hours) achieved by March 2009 • Accelerated waiting times agreed in the LDP delivered by March 2009. 75% of IP waits within 6 weeks and 90% within 8, 75% of OP waits within 4 weeks and 90% within 5; 75% of diagnostic waits within 4 weeks and 90% within 6.	March 2009	18-week on track, exceeding the 85%/90% admitted/non-admitted target. June position was 94%/93%. Component waiting times reducing A&E on track 98.4% YTD Cancer on target. MDT support team expansion agreed at SIRG to meet new targets Recruitment of additional staff commenced. Procurement of Somerset IT system. Definitions for new Cancer waits are awaited. GUM is a concern. Short term improvement plans in place however long term delivery of service under review	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter One (June 2008)**	**Red / Amber / Green Assessment**
1.2	Successfully deliver our Patient Experience Action Plan in response to patient survey results. RS/JK	• Patient Experience Action Plan agreed for 2008/9 • Actions delivered as set out in plan • Improvement in key areas of 2008 patient survey results	By September 2008 In line with plan.	Plan agreed at TB and is now being implemented via the newly formed patient experience group.	**3**
1.3	Develop and begin to deliver a Single Equality Scheme for the Trust. RS	• Single Equality Scheme agreed • Actions delivered as set out in plan.	By June Trust Board By March 2009	SES approved at June Trust Board. Structure established for the implementation of action plan.	**3**
2.	***High Quality Care***				
2.1	Continue to reduce hospital infection rates achieving national and local targets for MRSA and *clostridium difficile* including introducing MRSA screening in line with national guidance. RS	• Achievement of targets for MRSA and clostridium difficile by March 2009 • Introduction of MRSA screening for electives from April 2008	By March 2009	No MRSA bacteraemias for past 3 months. CDiff rates continue in a downward trend.	**3**
2.2	Develop and begin delivery of a plan to enhance the safety culture and systems of the Trust KD	• Patient Safety Plan agreed • Actions delivered as set out in plan	By July 2008 By March 2009	Achieved – plan approved at May Governance and Risk Management Committee and July Trust Board Actions progressing in line with plan. Quarterly progress updates to Governance Board and Governance and Risk Management Committee. Trust to sign up for national Patient	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter One (June 2008)**	**Red / Amber / Green Assessment**
				Safety First campaign	
2.3	Develop and begin to deliver Maternity Development Plan in the light of local reviews and national guidance. DOD	• Development Plan agreed for 2008/9 • Actions delivered as set out in plan • Improvements on measures used in Healthcare Commission assessment by March 2009	As set out in the plan.	The integrated development plan has been prepared and will shortly incorporate actions arising from LIA events. 4 Staff conversations complete. New CD appointed as per RCOG recommendations and due to commence 1/9/08	2
2.4	Deliver plans to improve the quality and consistency of nursing care RS	• Implementation of the Nursing Workforce Strategy • Implementation of the Ward Performance Review and Accreditation systems • Improved performance on key indicators for quality of nursing care	By March 2009 By March 2009 By March 2009	Ward reviews complete which have identified areas for corporate attention and also well performing wards and wards that require support.	**3**
2.5	Deliver service reconfiguration changes in neo-natal services, surgery and pathology. RK	• Neo-Natal reconfiguration completed by Autumn 2008 • Pathology reconfiguration completed by Winter 20008 • Surgery implementation plan agreed by June 2008 • Surgical reconfiguration implemented in line with plan	• Neonatal – Sept 08 • Pathology – Dec 08 • Emergency General Surgery – Dec 08 • T&O – April 09	- Neonates on track – capital scheme will be completed Jul-08. - Pathology on track – capital scheme on tract to complete Dec-o8. - Surgery on track – implementation plan approved by TB, SHA & PCTs June 08.	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter One (June 2008)**	**Red / Amber / Green Assessment**
2.6	Take on the Walsall and Sandwell breast screening service as part of a larger Walsall / Sandwell / City breast screening service. TA	• Service operational from April 2008 • Service maintains high performance on QA performance indicators		Service live at planned from April 1st	**3**
2.7	Deliver improvements in national clinical priorities of cancer (Cancer Reform Strategy) and stroke (Stroke Strategy). Cancer: RK Stroke: DOD	• Cancer: agreement of Trust Cancer Strategy and delivery of actions in line with plan • Stroke: agreement and delivery of plan to implement national stroke strategy	Trust Cancer Strategy document – Nov 2008 Timetable for stroke plan to be confirmed.	Consultation commenced at CLEG line with consultation plan. The stroke project is now underway. A sponsor group has been convened using the LIA methodology and a plan is expected to be developed through September and October 2008	**2**
2.8	Agree a clear plan to ensure EWTD (48 hr) compliance by August 2009, including continued development of Hospital at Night. DOD / KD	• EWTD plan agreed. • Actions delivered in line with plan.	To have at least 50% of all junior doctors EWTD compliant by 6 August 2008. To have at least 75% of all junior doctors EWTD compliant by 6 February 2009. To have all junior doctors EWTD compliant by 1 August 2009.	Current position statement and action plan drawn up. Plans in place for most specialties to achieve EWTD 2009 compliance. In areas where detailed plans are not yet in place meetings are taking place between the Head of Medical Staffing and Divisional Directors and Lead Clinicians to develop plans.	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter One (June 2008)**	**Red / Amber / Green Assessment**
3.	***Care Closer to Home***				
3.1	Deliver new models of care through the first wave 2010 exemplar projects (urgent care, intermediate care, dermatology and diabetes) and begin to deliver new models of care for community-based outpatients in the second wave 2010 exemplar specialties (cardiology, orthopaedics, rheumatology, ophthalmology, respiratory, gynaecology). TA / RK	• Significant volumes of outpatient activity delivered in line with new models of care in exemplar specialities • Clear plans agreed for next stages of community development • Increased numbers of patients treated through UCCs at City and Sandwell in 2008/9 compared with 2007/8 • Agreed models of care successfully implemented at Rowley and Sheldon.	• Second wave 2010 exemplar projects targets for 2008/09 as per Towards 2010 Programme • Speciality review of Towards 2010 outpatient assumptions to be complete by Oct 08	Ongoing work with 2010 Programme to agree activity that can be counted – to be complete Sept 08 Outpatient activity transferred to community locations in Gynaecology. Paediatric clinics started in Aston. Outstanding issues regarding availability of diagnostic and specialist equipment in community locations. City UCC on track – 25% of all AE/UCC attenders seen by the UCC team. SGH UCC service has had a review with revised plans to increase the current level of activity (10% of all AE/UCC attenders) to the planned 20% level. Rowley service in place. From September expanded Sheldon model (increase of 28 to 56 beds) in place plus new HoB intermediate care centre opens (increases beds by 18)	**2**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter One (June 2008)**	**Red / Amber / Green Assessment**
3.2	Successfully deliver a community-based dermatology service for Birmingham North and East PCT. RK	• BEN service launched and achieving expected levels of activity • BEN PCT and GPs satisfied with service	May 2008 Review October 2008	Activity levels lower than expected and some difficulties with medical staffing following departures of key staff.	**2**
4	***Good Use of Resources***				
4.1	Deliver the financial plan including achieving a financial surplus of at least £2.5m and a CIP of £11m. RW	• Financial plan delivered • £2.5m surplus by March 2009 • £11m CIP delivered by March 2009	Monitored monthly, final assessment at yearend	On track (on forecast basis) to achieve both targets. Ahead of target (favourably) as at Q1	**3**
4.2	Further improve productivity by improving day case rates and reducing average hospital; length of stay. TA	• Day case rate higher than 2007/8 outturn aiming for 80% by March 2009 • LDP day case incentive scheme targets achieved • Average hospital LOS lower than 2007/8 outturn aiming for 4.5 days by March 2009	Targets hit by March 2009	Schemes progressing to plan. SGH/Rowley has reduced beds by 30 as per plan. Investments agreed for additional acute physicians (+2 at SGH, + 1 at City). Issues with increase delayed discharges for Sandwell residents have been resolved	**3**
4.3	Deliver the next stages of the Trust's Service Improvement Programme. RK	• Service improvement priorities for 2008/9 agreed • Demonstrable improvements in areas prioritised	By July 2008 By March 2009.	SI Priorities agreed in July. Work in progress on early projects including supporting surgical reconfiguration and developing nrueo-physiology.	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter One (June 2008)**	**Red / Amber / Green Assessment**
5	***21st Century Facilities***				
5.1	Produce and secure agreement to the Outline Business Case for the new acute hospital. GS	• New hospital OBC approved by Trust Board • New hospital OBC approved by SHA and DoH	December 2008 March 2009	Overall on track, some non critical path items off track	**2**
5.2	Agree and begin to implement land acquisition for the new hospital. GS	• Land acquisition strategy agreed by Trust Board • Strategy delivered in line with plan	Start procurement October 2008	On Track, in discussions with SHA and DH regarding procurement route	**2**
6	***An Effective NHS FT***				
6.1	Continue to achieve Healthcare Commission Healthcheck standards. KD	• Maintain and if possible improve the Trust's ratings in the Annual Healthcheck	Achieve compliance with core standards declared as non-compliant – C7e by July 2008 and C8b by August 2008. Review evidence to support continued compliance with the core standards in November.	Actions identified to achieve compliance are being implemented. An electronic portfolio of evidence is under development.	**3**
6.2	Ensure that all staff received appropriate mandatory training and receive an annual appraisal. CH	• Significant increase in staff undertaking mandatory training and receiving annual appraisals.	By March 2009	Current figures show a significant increase in appraisals. Mandatory training remains problematic. Plans being developed for a LEARNING PASSPORT which	**2**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter One (June 2008)**	**Red / Amber / Green Assessment**
				will deal with MT , PDRs and the KSF and will guarantee protected learning time.	
6.3	Achieve NHS Foundation Trust status. RK	• FT application approved by Trust Board • Secretary of State approves Trust to apply to Monitor for FT status • Authorised as an FT	By October 2008 By January 2009 By April 2009 (earliest)	Final draft IBP presented to July Trust board for approval. Final amendments and associated appendices being prepared for October submission to SHA.	**2**
6.4	Using the Trust's new patient information systems improve clinical administration and clinical communications. TA	• Agree plan to improve clinical administration and communication • Improvement in processes leading to reduced OP DNAs and cancellations and quicker communication with GPs		Expansion of new functionality continues to plan. Q2 will see maternity go live and order comms go live at SGH. Initial focus is on improving the OP booking processes and first set of changes introduced in June	**3**
6.5	Develop further our approach to marketing and business development activity. RK / JK	• Marketing Strategy approved by Trust Board • Programme of business development and marketing activity delivered as agreed • Trust at least retains market share for main commissioners	Marketing strategy revised by end August To be included in Marketing Strategy Data reported monthly to OMB	Work in progress to revise marketing strategy including detailed plan for 2008/9. To date the Trust's market share has been stable for most commissioners although there has been some drop in outpatient share in Sandwell.	**2**
6.6	Improve staff engagement through implementation of the "Listening into Action" programme CH	• Staff engagement process successfully delivered • Improved staff engagement demonstrated through staff survey results		All LiA plans on target and progressing as planned. Staff survey planned for later this year .Will include specific LiA questions.	**3**

Trust Objectives 2008/09					
Ref.	**Objective**	**Success Factors**	**Measure/ Timescale**	**Summary Position as at end of Quarter One (June 2008)**	**Red / Amber / Green Assessment**
6.7	Ensure effective emergency preparedness. TA	• Emergency response plans agreed and tested as appropriate		New Emergency Planning Officer in post. Review of current systems started with aim to meet the ISO standard	**3**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Assurance Framework 2008/09: Quarter 1 Update
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	4 September 2008

KEY POINTS:

This report is provided to update the Trust Board on progress with actions undertaken to address the gaps in control and assurance against corporate objectives, which were identified in the Assurance Framework approved by the Trust Board at the July meeting.

Progress with plans to address the gaps is on track for the majority of actions.

Progress is amber (some delay, but expected to be completed as planned) with actions planned to address gaps identified against the achievement of objective 3.2, delivery of a community based dermatology service for Birmingham North East PCT, 5.1, produce and secure agreement to the Outline Business Case for the new acute hospital and 5.2, agree and begin to implement land acquisition for the new hospital.

PURPOSE OF THE REPORT:

✓ **Noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to note the progress with actions to address the gaps in assurance and control.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Relevant to all corporate objectives.

IMPACT ASSESSMENT:

FINANCIAL	✓	
ALE	✓	
CLINICAL	✓	
WORKFORCE	✓	
LEGAL	✓	
EQUALITY & DIVERSITY	✓	
COMMUNICATIONS	✓	
PPI	☐	
RISKS		None identified.

Sandwell and West Birmingham Hospitals NHS Trust

ASSURANCE FRAMEWORK 2008/09: Q1 UPDATE

September 2008

PROGRESS REPORTING

Reference is made within the Assurance Framework to the action plans that are in place to address the identified gaps in control and/or assurance in relation to the principal risks that threaten the achievement of the Trust's objectives for 2007/08. Regular reports are presented to the Board to update members on the progress made in implementing the plans e.g. the monthly performance report, the monthly Interim Reconfiguration update etc. In addition, this report captures within one document all the identified gaps in controls and assurance and provides a brief summary of the progress made to date.

CATEGORISATION

Progress with the actions in the plan has been assessed on the scale set out in the table below.

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

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
1	**Accessible and Responsive Care**					
1.1	Chief Operating Officer	Continue to achieve national targets (18 weeks, cancer, A & E and GUM)	**Gap in control** Need to improve the data reporting systems to support meeting the new cancer targets. This will be aided by a new IT system that is being procured. **Gap in assurance** None identified	Improvements to the 18-week reporting systems to be identified and actioned Additional staffing required to meet new December cancer targets	Improvements to 18-week system in place and further developments underway. Additional staffing agreed at SIRG and majority of new staff now in post. New cancer waiting times IT system commissioned.	**4**
1.2	Chief Nurse/Head of Communications	Successfully deliver our Patient Experience Action Plan in response to patient survey results	**Gap in control** Patient Experience Group not yet established **Gap in assurance** Patient surveys are not routinely carried out at a local level	Arrange schedule of meetings for Patient Experience Group Establish a mechanism for routinely carrying out patient surveys	Patient Experience Group met in June and a forward schedule for the remainder of the year has been set. Action plan has been written and actions are being progressed. Timescales against each have been agreed.	**4**
1.3	Chief Nurse	Develop and begin to deliver a Single Equality Scheme for the Trust	**Gap in control** SES steering group not yet met	Arrange schedule of meetings for Equality and Diversity Steering Group	Equality and Diversity Steering Group met on 20 June 08. Terms of	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
			Staff not yet recruited **Gap in assurance** Systems for training managers not yet in place	Recruit a Trust lead for Equality and Diversity Source firm to deliver equality impact assessment training to key managers across the Trust	reference for subgroups have been agreed and inaugural meetings have been arranged. Initial EIA training session conducted by ASTAR on 14 August. Further training sessions planned.	
2	**High Quality Care**					
2.1	Chief Nurse	Continue to reduce hospital infection rates achieving national and local targets for MRSA and clostridium difficile, including introducing MRSA screening in line with national guidance	**Gap in control** None identified **Gap in assurance** Audit returns not always completed	Instil more rigour and discipline into completion of audits. Revise infection control policies to reinforce requirement to complete audits	Audits now routinely completed to a high standard. MRSA and C diff policies revised and approved by OMB/Gov Board	**4**
2.2	Director of Governance	Develop and begin delivery of a plan to enhance the safety culture and systems of the Trust	**Gaps in control** Gaps in systems around training (NHLSA assessment action plan) and divisional/directorate governance structures **Gaps in assurance** None identified	Patient Safety Development Plan approved by Trust Board and monitored quarterly at Governance Board.	Plan continues to be implemented and reviewed on quarterly basis at Governance Board. Gap analysis of structures underway. Training provision has been reviewed. The Trust has signed up to the national	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
					Patient Safety First campaign.	
2.3	Medical Director	Develop and begin to deliver the Maternity Development Plan in light of local reviews and national guidance	**Gaps in control** Infra structure improvements not yet delivered **Gaps in assurance** None identified	Develop an integrated maternity services development plan.	Steady progress in respect of infrastructure and investment. Integrated development plan now at version 0.7 and feedback received from Commissioners Plan is to be presented to the September Maternity Taskforce and October Trust Board. The plan is a live document which will need constant review and development.	**4**
2.4	Chief Nurse	Deliver plans to improve the quality and consistency of nursing	**Gaps in control** None identified **Gaps in assurance** Some quality data not currently available. Ward review process only just commencing. LiA project only just commencing.	Establish and embed ward review process and optimal ward initiative	First round of Ward reviews completed 2 July. Outcome presented at divisional performance review meetings. Summary of corporate action to be taken to Sept SNF Accreditation	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
					system to be confirmed and implemented for next round. Wards failing to meet standard will work with the nursing turnaround team to improve. Next round commence Oct 08.Plan to review twice a year by Chief Nurse and ADNs.	
2.5	Director of Strategy	Deliver service reconfiguration changes in neo-natal services, surgery and pathology	**Gaps in control** None identified **Gaps in assurance** Process for formal review after implementation yet to be agreed by project board	Agree and implement process for formal review of impact of changes 12 months after implementation	The project board has approved a process for external review of changes in paediatrics. This is being commissioned in line with the agreed timetable.	**4**
2.6	Chief Operating Officer	Take on Walsall and Sandwell breast screening service as part of a larger Walsall/Sandwell/City breast screening service	**Gaps in control** None identified **Gaps in assurance** None identified		Service went live as planned on 1 April 2008	**5**
2.7	Director of Strategy/Medical Director	Deliver improvements in national clinical priorities of cancer (Cancer Reform Strategy) and stroke (Stroke Strategy)	**Gaps in control (cancer)** None identified once the planned changes to the structure of the MDT management arrangements have	Implement changes to MDT management structure by the end of September 2008	The changes to the structure for managing the Trust's MDTs are underway and will be complete by the end of	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
			been delivered **Gaps in assurance (cancer)** None identified **Gaps in control (stroke)** Appropriate long term performance management and control systems have not yet been established Stroke sponsor group is not yet in place Stroke action plan is not yet developed **Gaps in assurance (stroke)** Not applicable until further progress is made in the project	Establish robust performance management and control systems. Establish mechanism for wider engagement of plans.	September Stroke sponsor group is now in place and action plan is expected to be developed through September and October 08.	
2.8	Medical Director/Director of Governance	Agree a clear plan to ensure EWTD (48 hr) compliance by August 2009, including continued development of Hospital at Night	**Gaps in control** More structured reporting required withy greater Divisional level input **Gaps in assurance** None identified	Position statement of 2009 EWTD Compliance as at 6 August 2008 circulated to Divisional Directors and Divisional General Managers by mid September 2008. Meetings to be organised with Divisional Directors and Clinical Directors in	Some meetings with Divisional Directors and Clinical Directors have taken place to develop action plans in specialties not yet compliant with the August 2009 targets.	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
				specialties where 2009 compliance not yet achieved to be completed by mid October 2008.	Further meeting have been set up in September 2008.	
3	**Care Closer to Home**					
3.1	Chief Operating Officer/Director of Strategy	Deliver new models of care through the first wave 2010 exemplar projects (urgent care, intermediate care, dermatology and diabetes) and begin to deliver new models of care for community-based outpatients in the second wave 2010 exemplar specialities (cardiology, orthopaedics, rheumatology, ophthalmology, respiratory and gynaecology)	**Gaps in control** Lack of consistency in project management approach across the projects. This is being developed by the Programme following the SHA review **Gaps in assurance** None identified	With 2010 programme, agree framework to ensure future consistency	A framework for the management of projects across the Towards 2010 programme has been developed by the Programme Directors and will be adopted in the autumn of 2008	**4**
3.2	Director of Strategy	Successfully deliver a community-based dermatology service for Birmingham North East PCT	**Gaps in control** None identified **Gaps in assurance** The Trust needs to develop systems for capturing patient and GTP satisfaction with the service	Establish appropriate internal arrangements for ensuring successful delivery of the service from June 2008. Ensure that commissioners, GPs and patients are satisfied with the service by March 2009	A monthly project team has been established to ensure that the service is being delivered in line with the specification. This group will develop arrangements for ensuring reporting on GP and patient satisfaction by March 2009.	**3**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
4	**Good Use of Resources**					
4.1	Director of Finance	Deliver the financial plan including achieving a financial surplus of at least £2.5m and a CIP of £11m	**Gaps in control** None identified **Gaps in assurance** None identified			
4.2	Chief Operating Officer	Further improve productivity by improving day case rates and reducing average hospital length of stay	**Gaps in Control** Need to improve the Theatre Management reporting to demonstrate improvements. New reports are in place from April and these will be developed further **Gaps in assurance** None identified	Complete implementation of Theatre System by April 08 New Theatre utilisation reports in the monthly performance pack by June 08	Complete Complete. Further detailed reporting being developed.	**4**
4.3	Director of Strategy	Deliver the next stages of the Trust's Service Improvement Programme	**Gaps in control** None identified **Gaps in assurance** Do not currently have a formal process for post-project evaluation. Will see to introduce this during 2008/09.	Develop formal process for post-project evaluation by January 2009. Have used the process by March 2009.	Development of the process will take place during autumn of 2008.	**4**
5	**21st Century Facilities**					
5.1	New Hospital Project Director	Produce and secure agreement to the Outline Business Case for the new acute hospital	**Gaps in control** None identified **Gaps in assurance** Monthly progress reports are based on self assessment against plan. Trust Board may	Internal audit attend monthly Project Board meetings. This group will review OBC drafts at key stages prior to and including final submission to the DOH	OBC Second draft completed to plan and will be considered at Project board on 20.08.08	**3**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
			wish to consider requesting a more objective view (e.g. from internal audit) as work progresses in addition to the regular PFU reviews			
5.2	New Hospital Project Director	Agree and begin to implement land acquisition for the new hospital	**Gaps in control** None identified **Gaps in assurance** Monthly progress reports are based on self assessment against plan. Trust Board may wish to consider requesting a more objective view (e.g. from internal audit) as work progresses in addition to the regular PFU reviews	Internal audit attend Land Acquisition Group on biweekly basis	Land business case on track. Approval outside control of Trust.	**3**
6	**An effective NHS FT**					
6.1	Director of Governance	Continue to achieve Healthcare Commission Health Check Standards	**Gaps in control** None identified **Gaps in assurance** Electronic system to centrally capture evidence to support compliance	Establish a mechanism for electronically capturing all evidence to support the annual core standards declaration	Shared folder set up on S drive, structured in line with the annual heathcheck core standards. Executive and operational leads assigned to each core standards to ensure clarity of responsibility for providing	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
					supporting evidence. Collection of information is currently underway.	
6.2	Director of Strategy	Achieve NHS Foundation Trust status	**Gaps in control** None identified **Gaps in assurance** None identified			
6.3	Chief Operating Officer	Using the Trust's new patient information systems, improve clinical administration and clinical communications	**Gaps in control** None identified **Gaps in assurance** None identified			
6.4	Director of Strategy/Head of Communications	Develop further our approach to marketing and business development activity	**Gaps in control** None identified **Gaps in assurance** Business development group only reports to executive committees i.e. no structure for NED oversight of this activity. Will need to agree how this can best be delivered (e.g. through Trust Board or sub-committee, such as F & PMC)	Agree how to ensure appropriate level of NED input to and oversight of this agenda	Discussions taken place at FT seminars with the whole Board. Draft marketing and business development strategy to be presented to the October seminar for further consideration	**4**
6.5	Director of Workforce	Improve staff engagement through implementation of the 'Listening into Action' programme	**Gaps in control** None identified **Gaps in assurance** None identified			

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
6.6	Chief Operating Officer	Ensure effective emergency preparedness	**Gaps in control** Robust monitoring of emergency preparedness training in all areas More exercises required around the CBRN decontamination facilities **Gaps in assurance** This is being identified as part of the self audit against BSI 25999	Exercises on emergency preparedness to be undertaken. CBRN processes at City Hospital to be reviewed and training needs addressed. Major incident plan to be developed and training provided to staff. BSI 25999 to be undertaken.	A training exercise was undertaken at City Hospital in April 08 to investigate emergency preparedness and response. Training has been taking place at the City Hospital site on CBRN – ED staff have been training in putting into use the suits and erecting the tent. Revised MIP due to be presented to OMB in September 08 – training to follow as part of the implementation plan. BSI audits due to start in the Autumn.	**4**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Quarterly Infection Prevention and Control Report April – June 2008
SPONSORING DIRECTOR:	Director of Infection Prevention and Control
AUTHOR:	Dr Beryl Oppenheim
DATE OF MEETING:	4 September 2008

KEY POINTS:

- **The new structures are working well and links with the wider healthcare economy continue to be strengthened.**
- **Numbers of cases of MRSA bacteraemia and Clostridium difficile infections have reduced significantly compared to the previous year and new policies and initiatives should assist in allowing sustainability over time.**
- **A continuous programme of audit will allow the organisation to focus on those areas requiring improvement or attention.**

PURPOSE OF THE REPORT:

✓ **For Approval**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive and note the Quarterly Report for April to June 2008

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

IMPACT ASSESSMENT:

FINANCIAL		
ALE		
CLINICAL		
WORKFORCE		
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quarterly Infection Prevention and Control Report
April – June 2008

Executive Summary

The new structures are working well and links with the wider healthcare economy continue to be strengthened.

Numbers of cases of MRSA bacteraemia and Clostridium difficile infections have reduced significantly compared to the previous year and new policies and initiatives should assist in allowing sustainability over time.

A continuous programme of audit will allow the organisation to focus on those areas requiring improvement or attention.

Management and Organisation

The new structures are now becoming well-embedded within the organisation, with the Infection Control Operational Committee being a useful forum particularly for picking up on issues of clinical practice and cleaning and decontamination. Working across the healthcare economy is also being strengthened and the existing forum is proving valuable for discussing issues affecting the primary/secondary care interface such as the community arrangements for management of patients who have been found to be colonised with MRSA as part of the new screening regimens which are being developed. An infection control programme has been developed to detail the work to be carried out by the Infection Control Team during 2008/09, and we will provide regular reports about progress towards, and any barriers to, delivery of the programme.

Policy Development

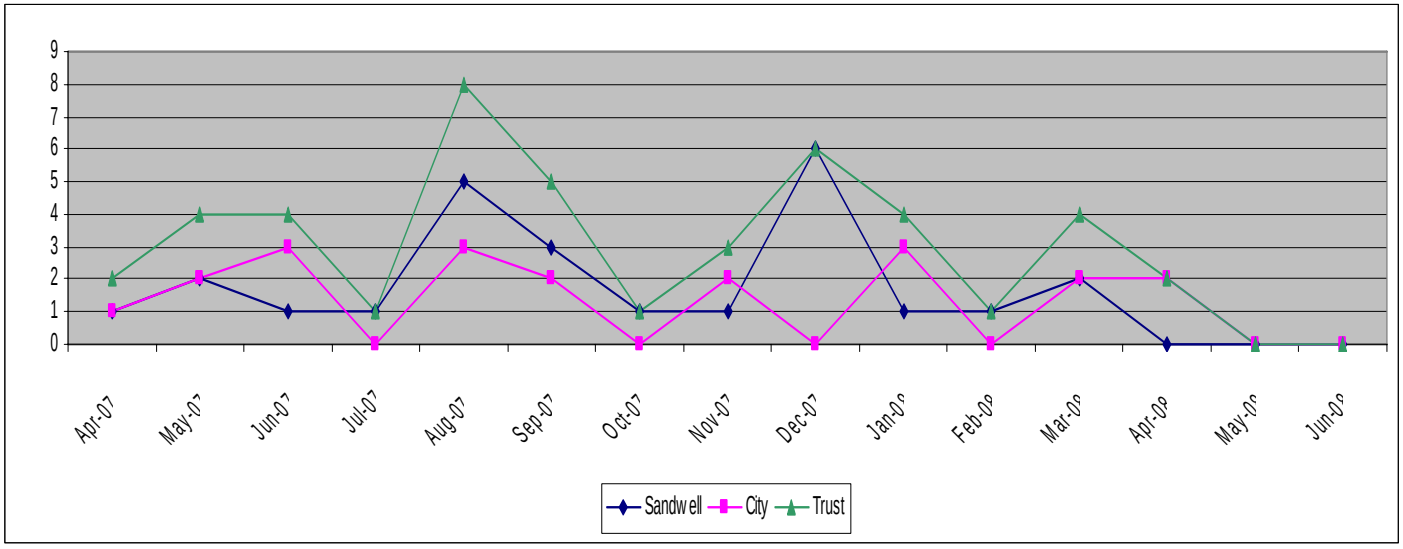
The past few months have seen significant activity in review or development of a number of policies which are key to development of the programme or have required adjustment following new national guidance. Policies for the prevention and management of MRSA and *C. difficile* have been approved and launched following wide consultation. A group within the Trust have carefully considered the most appropriate use of isolation facilities in conjunction with the development of a simple risk assessment for all patients with suspected or proven communicable infection, and the new policy developed to embrace these changes will be launched Trust-wide over the next weeks. This is happening in tandem with a project to improve the overall isolation facilities within the Trust, particularly focussing on medical and surgical wards on the Sandwell site and the Medical Assessment Unit on the City site.

MRSA

Mandatory Reporting of MRSA Bacteraemia

For the quarter April to June 2008 there were 2 new MRSA bacteraemias, one of which was a pre-48 hour bacteraemia. (Figure 1). This compares to 10 bacteraemias in the equivalent period in 2007. We continue to focus our efforts on the key themes which we believe will contribute to overall reduction in MRSA bacteraemia and other infection rates.

Figure 1. No. of cases of MRSA bacteraemia



Improving Quality of Blood Cultures

The new closed system for taking of blood cultures has been introduced and this has been accompanied by intensive training programmes for all staff involved in the procedure. A DVD demonstrating the process and giving other useful information on indications and limitations has been made and will be available on the Trust intranet.

MRSA Screening and Decolonisation Therapy

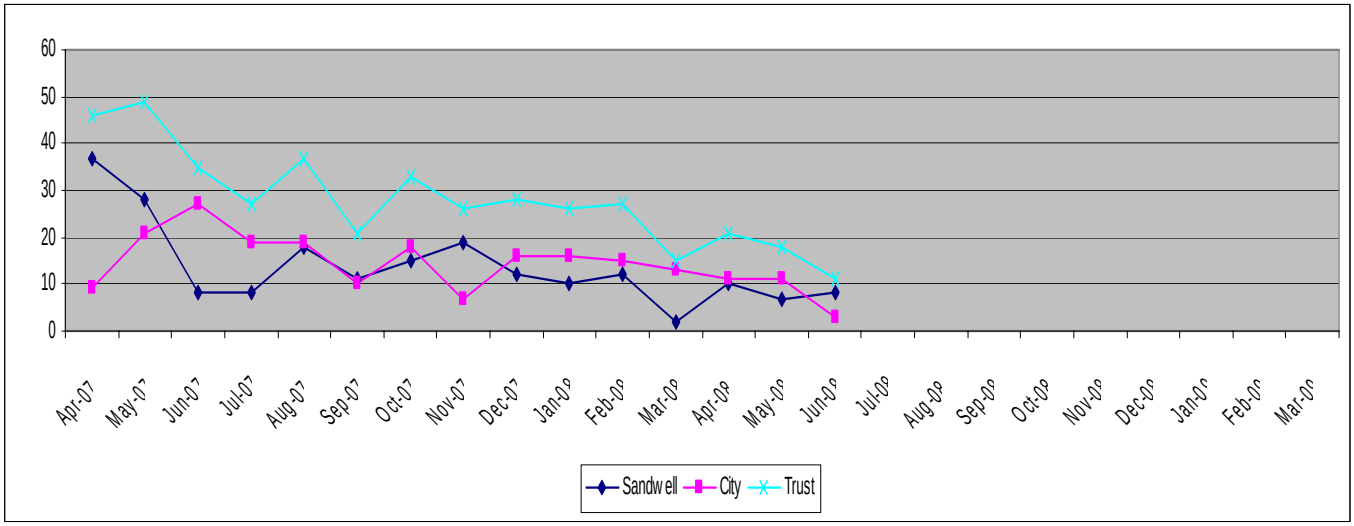
Screening of non-day case elective surgical patients is now in place. All patients being screened for these procedures will be offered an antiseptic body wash as this may prevent other and more commonly encountered surgical site infections.

The pilot study on rapid MRSA screening at the point of care was completed and a report prepared which highlighted the high degree of accuracy obtained when testing was undertaken in this way. These results were presented at a national meeting about MRSA screening organised by DH, and the study has also been accepted for presentation at an international congress to be held in Washington DC later this year. Rapid MRSA screening at the point of care is now routine in both critical care units and will be rolled out to the assessment units over the coming weeks.

Clostridium difficile infections (CDI)

There were 50 cases of CDI in patients admitted to the Trust in the quarter April to June 2008, which compares to 130 cases in the equivalent quarter of 2007. (Figure 2) Forty-five of these occurred more than 48 hours after admission and are attributable to the Trust trajectory. Table 1 shows recently published provisional data giving comparisons of CDI rates for similar Trusts across the Region.

Figure 2. Total Number of CDI Cases (including those diagnosed within 48 hours of admission)



New Policy for CDI

As mentioned above, the new policy for CDI has been launched, to take into account issues raised as a result of new draft national guidelines. The guidelines particularly highlight the importance of recognition of CDI as a disease in its own right and we have introduced a number of measures to strengthen the management of cases within our organisation. These include a review of all new cases by a gastroenterologist, and regular reviews of all ongoing cases within the hospitals by teams including microbiology and infection control, gastroenterologists and antibiotic pharmacists.

Other important issues are also addressed in the new policy. Lists of cases are carefully reviewed to attempt to identify any clusters of possibly related cases and where these are noted there is careful review of both antibiotic prescribing and whether there is a requirement for additional decontamination of the area. Arrangements are also detailed for the investigation of mortality in association with CDI. All cases where death certification indicated that death was as a direct result of CDI are classified as red incidents and a full table-top review undertaken. Cases where the patient has died within 30 days of a diagnosis of CDI have a root cause analysis performed by a senior member of the medical or nursing staff. Detailed analyses of data from these sources will be presented to the Trust Governance Board at regular intervals.

Table 1. Example of comparative data for CDI rates with similar large and medium acute Trusts within the Region (recently published provisional data from HPA for May 2008)

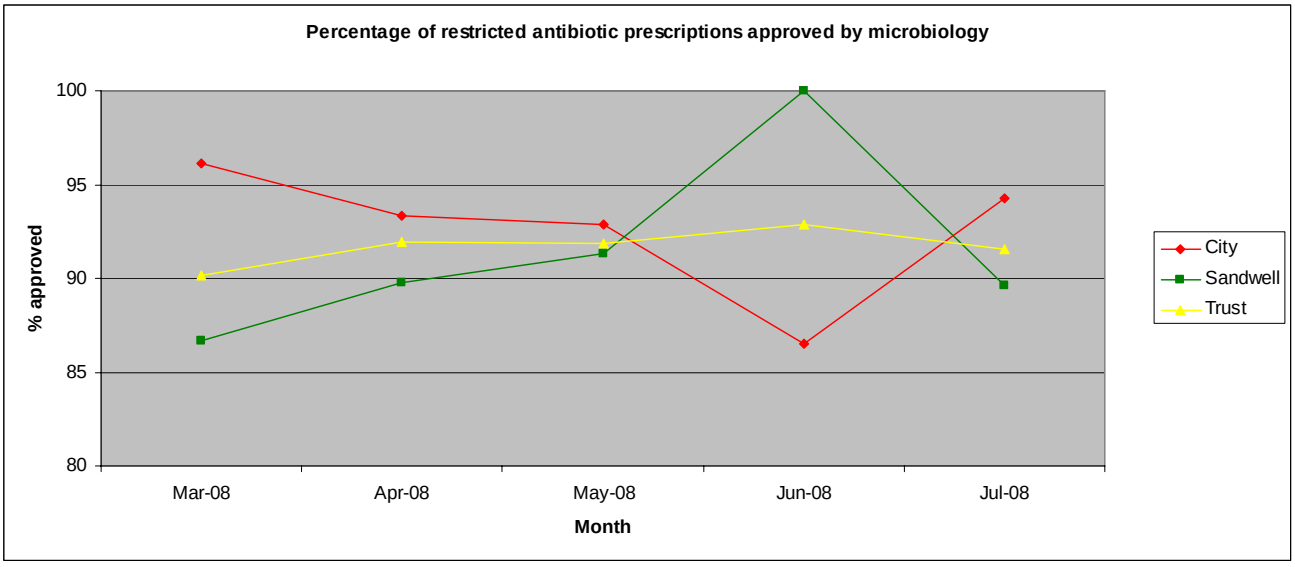
	Total cases (all ages)	Rate per 1000 bed days (≥2 years)
Royal Wolverhampton	14	0.43
Sandwell & West Birmingham	21	0.60
Worcestershire Acute	27	0.62
Shrewsbury & Telford	25	0.72
Heart of England	68	1.10
Walsall	19	1.15
Dudley Group	40	1.29
University Hospital N. Staffs	47	1.39

Audit

Hand hygiene and 'Saving Lives' audits are now well established as a routine for all clinical areas and there is a wealth of information available from these. The 'Saving Lives' audits focus mainly on general clinical care and overall results show very good compliance with the majority of the standards. Hand hygiene audits are also being undertaken regularly but, despite a significant improvement in compliance and excellent results in some areas, overall compliance falls short of the standards we would expect. The database is being refined to allow for detailed analysis of compliance by staff group and area, and the next steps will involve a major focus to improve hand hygiene in problem areas.

The antibiotic group continue with 'spot check' audits of compliance with the antibiotic policy and routine monitoring of use of restricted antibiotics (Figure 3). Appropriate choice of antibiotic remains excellent, but there has been a fall in number of those where a review or stop date is entered and this could result in an unnecessarily prolonged course of antibiotics. The antibiotic group intend to now focus on improving compliance with this aspect of the policy.

Figure 3. Percentage of restricted antibiotic prescriptions approved by microbiology



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Cleanliness/PEAT Report
SPONSORING DIRECTOR:	Rachel Stevens, Chief Nurse
AUTHOR:	Steve Clarke, Deputy Director of Facilities
DATE OF MEETING:	4 September 2008

KEY POINTS:

The report is provided to report to the Board the results from the National Standards of Cleanliness and PEAT audits and give an update on the PEAT inspections for 2008.

PURPOSE OF THE REPORT:

✓ **For Noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To receive and note the report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Continue to reduce hospital infection rates achieving national and local targets for MRSA and *clostridium difficile* including introducing MRSA screening in line with national guidance.

IMPACT ASSESSMENT:

FINANCIAL		
ALE		
CLINICAL	✓	
WORKFORCE		
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD

4TH SEPTEMBER 2008

Subject: Cleanliness/PEAT Report

1.0 INTRODUCTION

The following report details:

- The results from the National Standards of Cleanlines audits for April 2008 to July 2008.
- Cleanliness update.
- Feedback from the Management and PPI PEAT inspections.

2.0 NATIONAL STANDARDS OF CLEANLINESS (NSoC)

The NSoC audit scores have improved from 2007/08 in both the critical areas for 'very high' and 'high' level cleaning. The additional funding to support the cleaning and environmental development programme has helped not only to maintain but improve the overall standard, allowing investment in staff, equipment and new methods of work.

NSoC Audit Score Comparisons	Overall 2007/08 Very high	Overall 2007/08 High	April - July 2008 Very high	April - July 2008 High
City	92	90	94	94
Sandwell	95	91	97	96
Rowley	N/A	95	N/A	97
BTC	98	97	94	97
Overall %	**95**	**93**	**95**	**96**
Target %	**98**	**95**	**98**	**95**
Compliance %	**97**	**98**	**97**	**100+**

3.0 CLEANLINESS UPDATE

- **Discharge Cleaning Teams**

  The cleaning of the bed space area (bed, lockers, tables, chairs) after discharge has always been the responsibility of the nursing staff. The discharge teams were introduced to try and relieve the pressure on nursing staff and ensure there was a uniformed approach to the actual cleaning process.

  There are currently two discharge teams based at City and Sandwell. The teams are responsible to Hotel Services for their recruitment, training and contingency cover, however on a day to day basis the teams are managed by Bed Management, they control the teams' workload identifying available beds to clean against admission demands.

Although the number of cleans against the number of discharges are improving there is some more work required to ensure all cleans are undertaken by the discharge teams rather than the nursing staff.

City	Bed Cleans	Average per day
May	479	17
June	709	25
July	853	32
- Figures exclusive of MAU - MAU have a dedicated member of staff		

Sandwell	Bed Cleans	Average per day
May	602	22
June	719	26
July	824	30
- Figures exclusive of EAU - EAU have a dedicated member of staff		

- **Deep Clean (Side Rooms**
  A deep clean programme of all side rooms is currently on-going, the side room clean is complimented by the decontamination process (Sterinis Units) that sprays a hydrogen peroxide vapour for the final decontamination of the area, furniture and equipment before the readmission of the patients.

- **Equipment Cleaning**
  The general ward equipment cleaning at Sandwell and Rowley is now being undertaken by the Hotel Services' Ward Service Officers again releasing valuable nursing time. The programme at City will be introduced with the implementation of Ward Service Officers.

- **Ward Service Officers**
  The programme for the introduction of the Ward Service Officers is on track, the first phase of the implementation is for D11, D12, D41, D42 and MAU to go live on the 15th October 2008.

4.0 PATIENT ENVIRONMENT ACTION TEAMS (PEAT)

- **National Audit**
  The outcome from all categories of the PEAT inspections for 2007/08 were good and again there were noted improvements in grounds and gardens, cleanliness of both the general public and patient areas, cleanliness in wards and departments and the overall environment.

  The scores were sent to the National Patient Safety Agency (NPSA) where they have been weighted against the Trust scores from the National Standards of Cleanliness audits. There are three classifications and the official results for all four sites (City, Eye, Sandwell and Rowley) are as follows:

  - Environment = Good
  - Food = Excellent
  - Privacy & Dignity = Good

- **Local Audit**
  The local PEAT Management and PPI audits are on-going, the inspections are proving extremely productive and there have been some significant improvements on wards and in departments in terms of cleanliness, environment and adherence to policies and procedures.

  There have been no audits undertaken during August, this has allowed time to reduce the outstanding list of actions.

  The refurbishment programme for August is to redecorate all of the theatres at Sandwell (inclusive of SDU) and City before reverting back to the general wards programme and public areas.

5.0 RECOMMENDATION

The Board are asked to note the contents of the report.

STEVE CLARKE
DEPUTY DIRECTOR - FACILITIES

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REPORT TO THE PUBLIC TRUST BOARD

4th SEPTEMBER 2008

Subject:	Infection Control Assurance Framework
Report by:	Rachel Overfield, Chief Nurse
Author:	Rachel Overfield, Chief Nurse

PURPOSE OF THE REPORT:

To update the Trust Board with the latest version of the Infection Control Assurance Framework.

IMPLICATIONS:

Financial:	
Personnel:	
Healthcare/ National Policy:	Relates to HCC core standards, DoH Cleanliness standards, 2006 Health act Code of Practice for the Prevention and Control of health Care Associated Infection, Saving Lives.
Other:	

RECOMMENDATION(S):

That the Trust Board notes the current Assurance Framework in progress.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

24th July 2008

Infection Control and Cleanliness Trust Board Assurance Framework – Version 8

The following provides a framework in which assurance can be gained that the Trust understands the risks associated with infection control and cleanliness: has actions in place or planned to mitigate risk: has assigned responsible individuals: has decided the expected outcomes from each action and has monitoring and assurance structures in place.

The document takes into account standards expected from the HCC, National and local targets, national cleanliness specifications, and the Health Act 2006 – Code of Practice for the Prevention and Control of Health Care Associated Infections (more commonly known as the Hygiene Code) and incorporates recommended actions from documents such as Saving Lives, Bare Below the Elbow and Darzi report.

All assurance will be sought and overseen by the Executive Infection Control Committee. A separate action plan exists that details the specific actions required to gain assurance.

Status	
Green	Complete
Light Green	On track
Amber	Some delay but expected to complete as planned
Red	Significant delay needs explaining
White	Not yet commenced/new action

Management, Organisation and the Environment					
Duty 1 – General duty to protect patients, staff and others from HCAI's.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	The Board is fully briefed on all matters relating to infection control and cleanliness.	Chief Nurse	Chief Exec	• The Trust Board is equipped to ask relevant questions and seeks assurance that infection control and the environment are being managed.	Green
2	The Trust will receive an annual inspection of compliance with the Code of Practice by a specialist team.	Chief Nurse	Chief Exec	• The Trust will be prepared for annual visit by reviewing compliance against code at least twice a year.	Green
3	Well designed environments encourage good practice and are easier to clean and maintain. The Trust Board should ensure new hospital planning takes this into account.	Dir Estates	Chief Exec.	• 2010 programme will comply with relevant HFN guidance. • Infection Control advice will be sought with regard to new hospital design. • New systems/practices for cleaning will be encouraged for new hospital.	Green
4	A system exists that ensures non-compliance with practice/policy is monitored and managed.	Chief Nurse Med. Director	Chief Nurse Med. Director	• Advisory notes system is introduced. • Targeted support can be given. • Poor practice is corrected.	Green (Light Green)
5	Saving Lives High Impact Interventions are used effectively within the Trust to ensure best practice.	DIPC ICN	Chief Nurse	• Use of national best practice. • Reduction in infection rates. • Reports will guide further action.	Green (Amber)
6	Infection Control & Cleanliness is embedded within the organisations culture and discussed at all levels.	Chief Nurse	Chief Exec	• There is clear evidence of discussion at various forums, team brief etc. • Divisions are reporting on Infection Control at performance reviews.	Green (Light Green)
7	There is a programme agreed for Infection Control activity.	DIPC	Chief Nurse	• Infection Control activity is planned and reported to the relevant committee. • Resources are used effectively.	Green (Light Green)

Duty 2 – Duty to have in place appropriate management systems for infection prevention and control.					
No	**Assurance required** (standard or policy)	**Who by**	**Lead**	**Outcome expected**	**Status**
1	The Trust is compliant with HCC core standards, Health Act 2006 and national cleanliness standards.	Chief Nurse	Chief Nurse	• That the Trust Board is assured that appropriate processes and accountability is in place to ensure that infection control is being managed effectively within the organisation.	Green
2	The Trust Board has a collective agreement for its responsibility for minimising infection risk.	Chief Exec.	Chief Exec.	• Trust Board accept responsibility for infection prevention and control role	Green
3	There is a DIPC accountable to the Trust Board.	Chief Exec.	Chief Exec.	• There is an accessible person identified with clear role remit.	Green
4	The Trust should ensure there are sufficient Matrons and other specialist staff in post to deliver the IC agenda.	Chief Nurse	Chief Nurse	• There will be sufficient Matrons in post with relevant authority to deliver the actions required.	Green
5	All Matrons have personal responsibility and accountability for delivering a safe and clean environment.	Chief Nurse	Chief Nurse	• Matrons are clear about role and responsibilities.	Green
6	Nurses in charge are directly responsible for ensuring cleanliness standards are met on a shift by shift basis.	Chief Nurse	Chief Nurse	• Shifts are managed consistently.	Green (Amber)
7	The Trust Board should receive quarterly reports from Matrons and clinical directors on cleanliness and IC.	Chief Nurse/ Matrons	Chief Nurse	• Matrons are able to raise concerns directly with the Trust Board.	Green
8	The Trust Board should ensure that there is a clear route for staff to be heard re IC and cleanliness.	Chief Nurse	Chief Nurse	• Staff are able to raise concerns directly with the Trust Board.	Light Green (Amber)
9	There will be an audit programme for CDiff in place.	DIPC	DIPC	• Issues relating to CDiff are identified, managed and reported.	Amber (White)
10	There are programmes of audit in place around cleaning standards.	AD Facilities	Chief Nurse	• Issues relating to cleaning are identified, managed and reported.	Green

Duty 3 – Duty to assess risks of acquiring HCAI's and to take action to reduce or control such risks.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	A process exists for targeted support to high risk areas.	ICN	Chief Nurse	• There will be increased specific support to struggling areas. • Reduction in infection rates in these areas. • Greater compliance with policies and best practice. • Any areas of non-compliance are targeted and support given.	Green (Amber)
2	Processes exist to ensure risk is identified, assessed and managed appropriately. Risks are detailed on the Risk Register and Risk is mitigated wherever possible.	DIPC ICN Gov. Director	Chief Nurse Gov. Director	• Risk is identified, assessed and being managed. • Assurance is gained that the above is happening. • Risk is detailed on the Risk Register and discussed at the Risk Committee.	Light Green
3	There are processes in place to identify at risk or infected patients and appropriate action is taken.	ICN	Chief Nurse	• Patients with diarrhoea and CDiff are identified and the appropriate action is taken	Green
4	All cases of MRSA bacteraemias are reported, fully investigated and action taken to prevent re occurrence.	ICN Risk Manager Divisions	Chief Nurse	• MRSA cases are reported and reviewed correctly. • Lessons are learnt and action is taken.	Green (Amber)
5	All cases where CDiff is cited on death certificates are reported to the SHA as Red incidents and reviewed regularly.	Risk Manager	Gov. Director	• Numbers of CDiff associated deaths will be known.	Green
6	Learning is gained from CDiff associated deaths and systems exist to Reduce risk of reoccurrence. There will be an ongoing audit of CDiff deaths.	Risk Manager ICN	Gov. Director	• Lessons are learnt and action plans put in place to Reduce risk of re occurrence. • Findings from audits are reported and acted upon.	Green
7	Divisions and the Exec Team are aware of incident trends and systems exist to enable immediate action.	DIPC	Chief Exec	• Divisions and Exec Team are able to respond to information quickly.	Green
8.	A policy framework exists for the care and management of patients with infective diarrhoea.	DIPC ICN	Chief Nurse	• The policy will provide a framework for: Education of staff. • Best clinical practice. • Monitoring of care and management of infective diarrhoea.	Green

Duty 4 – Duty to provide and maintain a clean and appropriate environment for healthcare.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	Standards of Cleanliness are achieved consistently in line with Trust policy and national cleanliness specifications	Deputy Dir. Facilities	Chief Nurse	• That the Trust Policy is fit for purpose. • The hospital is cleaned to required standards. • Areas of non compliance are known and action to remedy the gap is identified. • That the Trust Policy is fit for purpose. • A strategy for cleaning exists.	Green
2	The hospitals are cleaned to national cleaning standards.	Deputy Dir. Facilities Matrons	Chief Nurse	• All clinical areas are cleaned to the required standard	Light Green
3	All bed spaces are correctly cleaned between patients.	ICN Deputy Dir. Facilities	Chief Nurse	• Patients and staff will have a visible check that beds etc have been cleaned. • Bed spaces will be cleaned properly. • Laminated terminal Bed Clean Sheets have been issued to all wards/departments to be placed on beds once cleaned.	Green (Light Green)
4	All items of furniture, rooms, equipment have a clearly responsible person for cleaning.	ICN Chief Nurse Deputy Dir. Facilities	Chief Nurse	• Sandwell & Rowley equipment clean undertaken. City to be implemented in conjunction with ward services.	Green (Light Green)
5	All ward areas are clean and tidy.	Deputy Dir. Facilities	Chief Nurse	• Enables targeted action. • Improved cleanliness of cupboards, commodes, equipment. • Replacement programme established.	Light Green
6	All areas are properly maintained and in a good state of repair.	Deputy Dir. Facilities Estates	Graham Seager Chief Nurse	• Clinical areas are well maintained.	Amber
7	The supply of linen and laundry reflects HSG (95) 18.	Deputy Dir. Facilities	Chief Nurse	• Linen and laundry is always available in sufficient quantity for the needs of the service	Green

No	Assurance required (standard or policy)	Who by	Lead	Outcome expected	Status
8	Lead managers have been identified for cleaning and decontamination of equipment.	Dir of Estates	Chief Exec.	• Managers are designated to be responsible for the cleaning and decontamination of equipment	Amber
9	New waste management standards are compiled with.	Deputy Dir. Facilities	Chief Nurse	• Waste is managed in line with national standards. • New policy to be approved at OMB.	Light Green
10	The DNS, Matrons and IC nurses are involved in cleaning services.	Chief Nurse	Chief Nurse	• Expectations are managed. • Standards are appropriate and effective.	Green
11	A system is in place that allows nurses, to request additional cleaning both urgently and routinely.	Deputy Dir. Facilities	Chief Nurse	• Additional cleaning can be requested via the supervisor's office (bleep out of hours).	Green (Light Green)
12	Commissioning for deep cleaning is appropriately agreed and funded.	Deputy Dir. Facilities DIPC	Chief Nurse	• Environmental & deep cleaning initiative for 2008/09 has been approved at SIRG.	Green (Light Green)
13	The current deep cleaning programme to be completed by Mar 31 08.	Deputy Dir. Facilities	Chief Nurse	• Completed by 31st March 2008. • The hospitals will have a good baseline to work from.	Green

Duty 5 – Duty to provide information on HCAI's to patients and the public.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	An appropriate mechanism is in place for controlling visitor numbers and behaviour.	ADN Matrons	Chief Nurse	• There is a clear policy for visitor handling. • Visitor numbers are kept to a minimum to reduce risk of infection spread. • Visitors take responsibility for own hand cleansing. • Nursing staff feel confident to operate policy.	Light Green (Amber)
2	Visitors are involved in infection control best practice.	ICN Matrons	Chief Nurse	• Visitors become more compliant with hand washing. • Visitors Policy Launch week commenced 14th July. Infection Control held information stand for all visiting hours on the City and Sandwell sites.	Light Green
3	Patients and users are aware of their responsibilities regarding infection control. Users are not afraid to come into hospital due to infection risk.	Comms Director	Chief Exec.	• Patients and visitors will adhere to policy. • Reduces risk of cross infection. • Prepares patients fro coming into hospital • Patients are well informed. • Positive truthful messages are given • Accurate factual information is given and set in correct context. • Patients are not afraid to come into hospital.	Light Green
4	There is a communication strategy in place aimed at keeping public confidence high.	Head of Comms	Head of Comms	• Public confidence remains high. • Information given is accurate.	Amber
Duty 6 – Duty to provide information when a patient moves from the care of one healthcare body to another.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	The Trust provides adequate information both on discharge to the patient and community staff and on transfer of any patient to another health care setting.	Deputy CC and Medical Director	COO	• Patients are discharge/transferred safely with due regard to public health	Green
2	A policy exists for the appropriate transfer, discharge, admission and movement of patients.	Chief Operating Officer	Chief Operating Officer	• Evidence of joint working between ICT and bed managers in patient movement.	Light Green
3	Community staff are aware of patients being discharged with infections.	Medical Director Deputy Chief Operating Officer	Chief Operating Officer	• Community staff will take necessary precautions for the patient, family and community.	Green

Duty 7 – Duty to ensure co-operation.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	The wider Health Economy shares common targets for infection reduction.	DIPC	Chief Nurse	• The Trust will be able to work with the wider health economy to reduce infection rates.	Light Green
2	All staff are aware of their role with regard to infection control. This will include Bank/ Agency staff, students etc.	Execs	Chief Exec.	• Ward managers will know what is expected of them within their role. • Doctors will have clear direction about the key things they can do to make a difference. • All staff will be clear that infection control is a key objective for them as individuals. • All staff will be clear that infection control is a key objective for them as individuals. • Concerns will be escalated to the right place at an early point allowing immediate action.	Green
3	Performance management systems are in place to ensure objectives/targets can be agreed and monitored.	Chief Exec.		• Objectives/targets are agreed at all levels. These are performance managed.	Green
Duty 8 – Duty to provide adequate isolation facilities.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	Patients with infections are always isolated appropriately. There is an appropriate isolation policy in place.	Chief Operating Officer	Chief Operating Officer	• Patients with infections will be appropriately isolated. • Reduces risk of cross infection. • Enables concentration of resources.	Light Green (Amber)
2	Additional nursing staff may be required to increase isolation of patients.	Chief Nurse	Chief Nurse	• There are sufficient staff to deliver appropriate care.	Green

Duty 9 – Duty to ensure adequate laboratory support.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	The Trust has adequate laboratory support for infection control and prevention.	DIPC	COO	• Laboratory support is available to support effective infection control and prevention	Green
2	The Trust must introduce screening for MRSA for all elective admissions by Mar 09 and for emergency admissions ASAP and no later than 2011.	DIPC	Chief Nurse	• As above.	Green
3	The Trust has sufficient specialist staff to tackle IF.	DIPC	COO	• Specialist staff are available when required.	Green
Clinical Care Protocols					
Duty 10 – Duty to adhere to policies and protocols applicable to infection prevention and control.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	**Outcome expected**	**Status**
1	A policy framework exists for the care and management of patients with infective diarrhoea.	DIPC ICN	Chief Nurse	• The policy will provide a framework for: Education of staff. • Best clinical practice. • Monitoring of care and management of infective diarrhoea.	Green
2	The Trust antibiotic policy is in line with national guidance.	DIPC	Medical Director	• The antibiotic policy is current and in line with best practice. • All clinicians are aware of the policy and act within it. • Non compliance without good clinical reason is not accepted and action is taken to ensure future compliance.	Green
3	All staff complies with the Trust uniform policy and standards.	ADN	Chief Nurse	• That all staff comply with expected standards of dress to minimise risk of infection and spread of infection by facilitating proper hand washing, change of soiled clothes etc. • Expect compliance with dress code in every area.	Light Green (Amber)
4	Practice is always effective and evidence based – Saving Lives recommendations and tools have been adapted and are regularly audited.	Matrons	Chief Nurse/ Medical Director	• All aseptic technique is underpinned by competency based training, assessment and ongoing monitoring. • Line associated contaminants and/or bacteraemias are reduced. • Reduction in line associated infection and sample contamination. • Reduction in patient self contamination and recontamination. • Increased compliance with good practice from medical staff. • Reports are produced regularly based on monthly Saving Lives audits.	Light Green (Amber)

No	Assurance required (standard or policy)	Who by	Lead	Outcome expected	Status
5	Best practice is adopted for the taking of blood cultures.	Medical Director Chief Exec	Medical Director	• Increased compliance with best practice for blood sampling • Reduction in the number of contaminants.	Light Green (Amber)
6	The Trust has all of the appropriate policies and protocols in place applicable to infection control and prevention.	DIPC ICN	Chief Nurse	• Staff are fully aware of clinical practice and behaviours expected.	Green
7	Best practice with regard to handwashing is embedded within the organisation.	DIPC	Chief Nurse/ Medical Director	• Staff wash hands appropriately at all times. • Audits identify individuals/areas of weakness. • Patients adopt correct handwashing.	Light Green (Amber)
8	A system exists for the management of non compliance with policy.	Chief Nurse	Chief Nurse/ Medical Director	• Non compliance is dealt with effectively within a management framework. • Reports on known non compliance are generation and acted upon.	Green
9	A system of escalation exists for poor performance.	Chief Nurse	Chief Nurse	• Targeted action occurs for poor performing wards/departments. • Resources are targeted appropriately. • Individuals are held to account.	Green (Light Green)
10	Clinical staff always adhere to hand washing best practice.	Matrons DGMs	Chief Nurse	• Greater compliance with hand washing. • Targeted action as a result. • Reduction in infection rates.	Light Green (Amber)

Healthcare Workers					
Duty 11 – Duty to ensure, so far as is reasonably practical, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work and that all staff are suitably educated in the prevention and control of HCAI's.					
No	**Assurance required (standard or policy)**	**Who by**	**Lead**	• Outcome expected	**Status**
1	All staff have received relevant training in infection control.	L+D	HR Director	• Increased compliance with good practice from clinical staff. • Increased compliance with good practice from non-clinical staff.	Light Green (Amber)
2	All staff are aware of their role with regard to infection control.	Execs	Chief Exec.	• Ward managers will know what is expected of them within their role. • Doctors will have clear direction about the key things they can do to make a difference. • All staff will be clear that infection control is a key objective for them as individuals. • All staff will be clear that infection control is a key objective for them as individuals. • Concerns will be escalated to the right place at an early point allowing immediate action.	Light Green
3	Occupational policies exist for the prevention and control of infection in health workers.	OH Physician	Director of HR	• Staff do not put staff or public at risk through spread of infection.	Light Green (Amber)
4	The Trust minimises the use of temporary staffing.	Chief Nurse	Chief Nurse	• Better use of temporary staff. • Temporary staff properly supervised. • Temporary staff are appropriately trained.	Light Green (Amber)
5	HR policies appropriately encourage mandatory training, induction and disciplinary action in relation to IC.	Dir HR	Chief Exec.	• Staff management re infection control procedures etc. are appropriate.	Light Green (Amber)

Please note the audits and monitoring methods described throughout this document will enable the trust to comply with Duty 2e of the Health Act

Other reference docs:

DOH Winning Ways 2003
Getting ahead of the curve 2002
Matrons charter 2004
Towards cleaner Hospitals

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Integrated Risk and Complaints Report: 2008/09 Quarter 1
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Ruth Gibson, Head of Risk Management Dally Masaun, Head of Health & Safety Debbie Dunn, Head of Complaints & Litigation
DATE OF MEETING:	4 September 2008

KEY POINTS:

This revised report combines information on risk, incidents and complaints in line with integrated governance principles.

Key incident statistics:

- Total incidents: 1539 (1506 in Q1 2007/8), an increase of 2% (Graph 1).
- Clinical incidents: 1195 (1046 in Q1 2007/8), an increase of 14%.
- Health and Safety incidents: 344 (460 in Q1 2007/8), a decrease of 25%.
- Red incidents: 36 (30 in Q1 2007/8) an increase of 20%.
- Top 3 incident types
    - Patient accident (195),
    - aspects of clinical care (190),
    - admission/discharge/transfer/missing patient (133)

Key complaints statistics:

- Total complaints: 172 (169 in Q1 2007/08), an increase of 2.3%
- Red complaints: 3 (2 in Q1 2007/08)
- Top 3 categories of complaint
    - Dissatisfied with clinical treatment (37%)
    - Delays/cancellations (20%)
    - Staff attitude (11%)

PURPOSE OF THE REPORT:

✓ **For Noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Relevant to the following 2008/09 corporate objectives:

2.2 Develop and begin delivery of a plan to enhance the safety culture and systems of the Trust

6.1 Continue to achieve Healthcare Commission Health Check standards

IMPACT ASSESSMENT:

FINANCIAL		
ALE		
CLINICAL	✓	
WORKFORCE		
LEGAL	✓	
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

Integrated Risk and Complaints Report: Quarter 1 2008/9

1. Overview

This report highlights key risk activity including:

- An overview of risk activity during Quarters 1/2 2008-09
- Summary incident data and details of lessons learned
- Summary complaints data and details of lessons learned
- Aggregated analysis of incidents and complaints, and lessons learned.

2. Introduction

As reported in quarter 4, this report has been revised to take into account good practice around integrated governance, to implement the Policy for the Investigation, Analysis and Learning of Lessons from Adverse Events and meet NHS Litigation Authority assessment requirements.

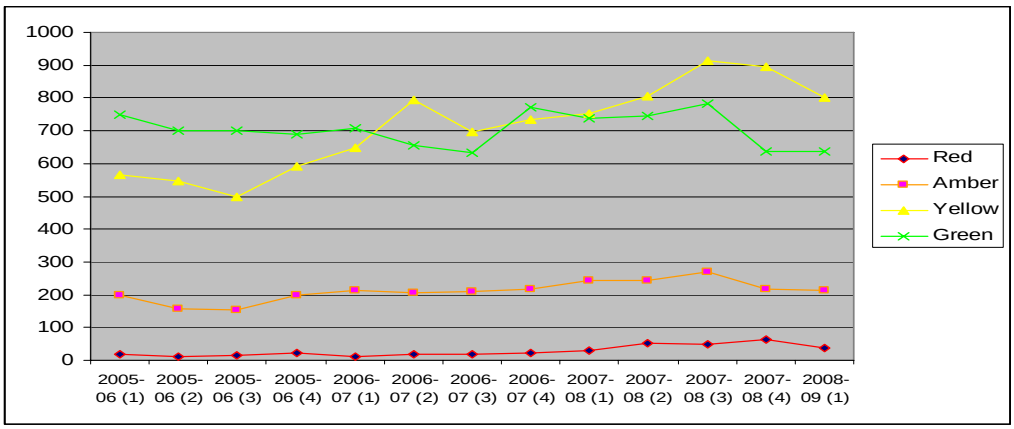
The report now combines the previous quarterly reports on incident/risk and complaints. Where possible, comparisons across these areas of activity will be made to try to identify common trends and actions. As management databases are being adapted to provide integrated data, the report will continue to develop and further information will become available.

3. Key Issues

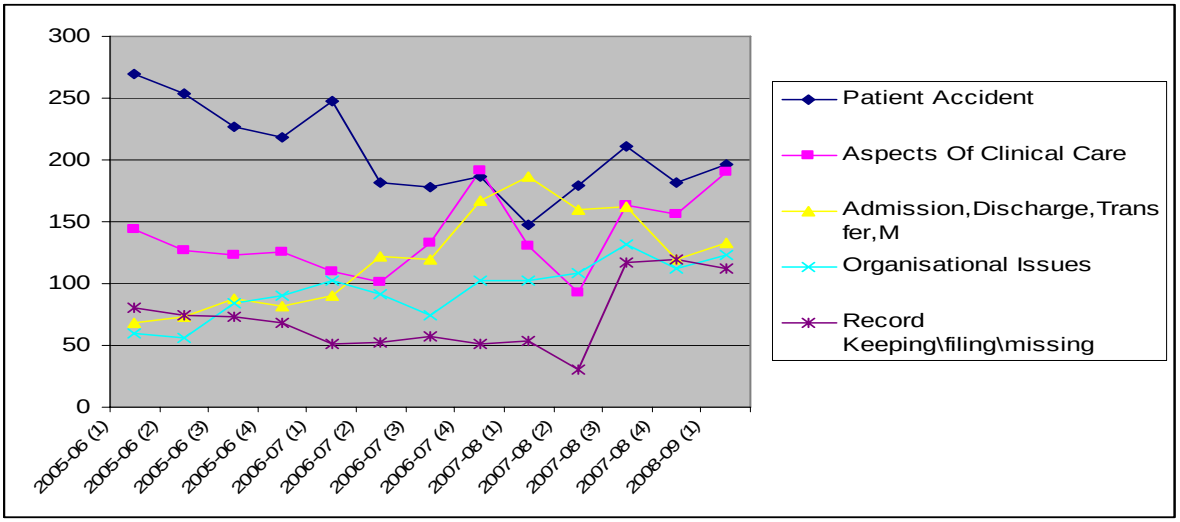
3.1 Review of Quarter 1 Incident Data

During quarter 1 there were 1539 reported incidents (1506 in Q1 2007/8). The number of clinical incidents rose from 1046 in Q1 2007/8 to 1195 (1046 in Q1 2007/8), an increase of 14%. The number of Health and Safety incidents fell by 25% to 344 from 460 in Q1 2007/8. There were 36 red incidents (2% of the total).

Graph 1 Trends by quarter by risk grade 1/4/05 – 30/6/08



Graph 2 Top 5 most frequently reported incidents by quarter (1/4/05 – 30/6/08)



More detailed data analysis is reported to the Governance Board and Governance and Risk Management Committee.

Examples of lessons learned from root cause analysis and incident reviews are attached at appendix 1.

3.2 Complaints

The Trust received 172 complaints, compared with 169 in the same quarter in 2007/08, an increase of 2.3%. The target response time was achieved in 84% of complaints, compared 80% in the same quarter in 2007/08.

The 172 complaints were graded as follows:-

Grade	April – June 2008	April – June 2007
Red	3 (2%)	2 (1%)
Amber	28 (16%)	17 (10%)
Yellow	61 (35%)	69 (41%)
Green	80 (47%)	81 (48%)

To date, 7 complaints (4%) have been re-opened and either a further response has been sent or a meeting has been held. This is consistent with previous quarters.

The main areas of concern are:-

Area of concern	April – June 2008	April – June 2007
Clinical treatment	37%	43%
Delays/cancellations	20%	18%
Staff attitude	11%	12%
Communication	9%	8%
Hotel services/food	4%	4%

Key lessons learned for complaints during Q1 are attached at Appendix 1.

3.3 Aggregated analysis

The most frequently reported incident category relates to patient accidents, of which the main component is patient falls. Although it is difficult to extract data on factors causing complaints (as these are logged against patient experience categories), patient falls are a recurrent theme amongst complaints.

The second most reported incident category (aspects of clinical care) correlates with the most frequently recorded complaint category (dissatisfaction with clinical treatment.

Incidents and complaints are categorized using the same grading system. It is of note that 2% of both incidents and complaints received during Q1 were red. A comparison has shown that for 2 of the 3 complaints received, a red incident investigation has taken place. Following investigation of the third red complaint, it is likely this will be downgraded to amber.

3.4 Key developments in risk for quarters 1/2

- Update of the Trust risk register is being presented to Governance Board, Governance and Risk Management Committee and Trust Board (separate report)
- Action plan developed for pilot CNST maternity standards, which is being presented to Governance Board
- Update on activity to comply with NHSLA risk management level 2 assessment in December 2008 is being presented to Governance Board. Key areas of concern are:
    - induction/mandatory training, where considerable work to cleanse data in the training database is underway, together with an overhaul of the Trust training needs analysis and
    - the ALE assessment score of 2 for area 4.1 (a score of 3 is required to achieve level 2 for 3 criteria of the NHSLA assessment)
- Update on Patient Safety Development Plan is being presented to Governance Board. This takes into account work required to implement the national Patient Safety First Campaign. Key areas of activity around the plan during Q1/2 include:
    - working with divisions to identify gaps in existing risk structures
    - a review of training requirements/resource
    - work to implement the Incident Decision Tree, to help managers review the actions of staff involved with incidents in line with the Trust “fair blame” approach.

4. Recommendations

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

Appendix 1

Lessons Learned from Incidents Q1 2008/9

35 red clinical incidents were reported during this period, of which 2 were MRSA bacteraemia and 9 maternity incidents. Table top reviews have been held for each and an action plan developed, which is monitored through the Adverse Events Committee, chaired by the Chief Executive.

All amber incidents should be monitored at Divisional Groups, with green and yellow incidents being reviewed and fed back at a local level.

Examples of some of the incidents and key actions taken/lessons learned during this quarter were:

Incident type	Actions taken/lessons learned and improvements
Pressure ulcers not identified on admission	• Clarification of reporting and risk scoring requirements for pressure ulcers to increase reporting • Reminder to all staff to ensure skin assessments are carried out on admission to any area and findings recorded • Checks to ensure wards have correct stock to manage pressure ulcers • Review of skin assessment tools for use in A&E • Training to be provided for staff on management of pressure ulcers
Delay in calling EMRT to unresponsive patient	Reminder to all staff of the correct response to an unresponsive patient is to press the emergency buzzer, unless able to certify death
Failure to give medication to patient awaiting a check x-ray for NG tube	• Audit to be carried out by pharmacy around missed doses • Guidance to be developed on check x-rays with imaging • Incident to be discussed with junior doctors
Patient fall resulting in fractured neck of femur	• Post falls assessment form to be developed • Reminder to all staff of reporting requirements for falls, in particular where these result in serious injury • Reminders to junior doctors of the need to attend to review patients following falls • Falls Project lead now in place, with programme of training for staff commenced and audits undertaken
Infection in post Caesarean Section patient not identified promptly	• White boards to be placed in clinical areas so patients requiring review can be identified • Post-take Consultant ward rounds to be arranged for maternity wards

	• Meeting with shift co-ordinators to discuss care plans for patients representing after c/s
Weakness in planning the discharge of potentially violent patients	• Arrange for security attendance before commencing with discharge.
Localised weakness in prompt consideration of 'Managing the Aggressor' procedures	• Local review of post-incident actions
Localised weakness in providing effective feedback to those involved in/reporting incidents	• Local review of communication channels and 'risk' as a fixed agenda item at ward/departmental meetings

Key lessons learned from complaints during Quarter 1

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:-

- Signage to the eye centre reviewed to ensure that clear directions given
- Staff reminded of the importance of informing patients of any delays in clinic and the reason for the delay
- Concerns regarding the location of the infertility service in the ante-natal clinic will be addressed by the relocation of the clinic. System put in place to prevent repeated cancellations of appointments
- Staff reminded to be aware of their body language and of how their actions can be perceived by patients/relatives
- Staff to ensure that allergies are documented and that the patient is given a red wrist band

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Annual 2007/8 Risk Report
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Dally Masaun, Head of Health & Safety and Ruth Gibson, Head of Risk Management
DATE OF MEETING:	4 September 2008

KEY POINTS:

This report highlights key risk activity including:

- NHS Litigation Authority assessments during 2007/8
- Risk register review and development
- Patient Safety Development Plan development
- Analysis of 2007/8 incident data

Key incident statistics:

- Total incidents: 6552 (6031 in 2006/7), an increase of 9% (Graph 1).
- Clinical incidents: 4690 (4122 in 2006/7), an increase of 14%.
- Health and Safety incidents: 1862 (1909 in 2006/7), a decrease of 2%.
- Red incidents: 199 (74 in 2006/7) an increase of 169%.
- Top 4 incident types
  - patient accident (710),
  - medical equipment (672)
  - admission/discharge/ transfer/missing patient (633)
  - verbal abuse (562).

The report was reviewed by the Governance and Risk Committee on 24 July 08.

PURPOSE OF THE REPORT:

✓ **For Noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive the report and note the contents.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically although supports corporate objectives regarding patient safety

IMPACT ASSESSMENT:

FINANCIAL		
ALE		
CLINICAL	✓	
WORKFORCE		
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

Risk report - Annual 2007/8

1. Introduction

This report highlights key risk activity including:

- NHS Litigation Authority assessments during 2007/8
- Risk register review and development
- Patient Safety Development Plan development (including 2008/9 objectives)
- Analysis of 2007/8 incident data

During 2007/8, the quarterly report was developed to include wider risk activity, in addition to the traditional incident analysis. This will be built on during 2008/9, in line with Integrated Governance and NHS Litigation Authority Risk Management standards, to provide integrated data on incidents, complaints and claims.

2. Key developments in risk for 2007/8

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

General

The Trust was successfully assessed at level 1 of the significantly expanded standards in January 2008. The Trust passed 49/50 standards. Improvements around the Trust training needs analysis for induction and mandatory training were identified.

The Trust is now preparing for a level 2 visit during 2008/9. This assessment demands evidence that the Trust is systematically implementing its policies in 50 key areas. Preparation to meet this challenging target is being undertaken by leads across the Trust.

Maternity CNST

The Trust was not assessed against the Maternity standards during 2007/8. An application to take part in the pilot of the new maternity standards during 2008/9 was not successful, as the pilot was over-subscribed. No assessment is likely until 2009/10. The CNST maternity project team continues to meet monthly and is working towards the significantly expanded pilot standards published in June 2008.

2.2 Risk register development

All divisions undertook full reviews of risk registers during 2007/8. These were reviewed at local and corporate committees.

This included an audit by the Health and Safety team of local Health and Safety risk assessments. This showed wide-spread compliance with the requirement to have a risk assessment, although there were quality issues in some areas. This will be addressed in more detail in the Annual Health and Safety report.

2.3 Development of a Patient Safety framework with linked objectives

During 2007/8, the Director of Governance and new Head of Risk Management undertook a review of existing systems and national priorities around patient safety, to identify areas for potential improvements. From this, a Patient Safety Development Plan has been developed. This, in addition to the achievement of the NHSLA standards, will form the basis of the objectives of the Risk Department during 2008/9.

This plan will assist the Trust in achieving its 2008/9 Corporate Objective around patient safety. It has been approved by Trust Board and progress will be monitored on a quarterly basis at corporate committees.

3. Review of Quarter 4 Incident Data

3.1 Incident data analysis

Incident data and comment on issues raised and steps taken is attached (appendix 1).

3. 2 Key issues highlighted within Appendix 1

- Total incidents: 6552 (6031 in 2006/7), an increase of 9% (Graph 1).
- Clinical incidents: 4690 (4122 in 2006/7), an increase of 14%.
- Health and Safety incidents: 1862 (1909 in 2006/7), a decrease of 2%.
- Red incidents: 199 (74 in 2006/7) an increase of 169%.
- Top 4 incident types: patient accident (710), medical equipment (672), admission/discharge/ transfer/missing patient (633) and verbal abuse (562).

4. Recommendations

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

Appendix 1

Incident Data Analysis

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 sets out comment on data. Graphs/tables setting out data appear in section 4.

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

The total number of incidents recorded for 2007/08 is 6552 (6031 in 2006/7), a 9% increase (Graph 1). Numbers of reported clinical incidents increased from 4122 in 2006/7 to 4690 in 2007/8, an increase of 14%. Numbers of reported health & safety incidents decreased from 1909 in 2006/7 to 1862 in 2007/8, a decrease of 2%.

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

Whilst overall levels of numbers of incidents gives information about patient safety activity, a breakdown by grade (graphs 3a & 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 Q4 2007/8 was 199 (Graph 3a). This is a 169% increase from 74 in 2006/7. This increase reflects a lower threshold for reporting post partum haemorrhage incidents introduced during Q2 as a quality improvement measure and the national requirement to manage certain infection control incidents as red. The number of reported red incidents as a proportion of the total number of incidents is 4%.

During 2007/8 a monthly report was introduced to Trust Board for all clinical incidents reported to the Strategic Health Authority. Analysis has shown that incident forms are not received for all red incidents. 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. 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 2007/8 has dropped by 11% (795 to 710) compared to 2006/7 (Graph 4). Training and

awareness raising around a change in policy to improve reporting of patient falls commenced during Q3/4 and reporting will be monitored during 2008/9 to assess the impact.

The number of **missing patients** reported increased from 213 to 325, despite a trend within year of decreasing numbers. There was a slight increase in total incidents reported under the category of **Aspects of Care** (Graph 6) from 335 in 2006/7 to 340 this year.

Graph 7 shows reported **medication errors**, which have increased by 18% from 333 to 393 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). There was an increase in reporting of 168%, from 277 to 672. This reflects continued reporting of issues around decontamination resulting from the move in suppliers.

Maternity incidents by area reporting and by trigger list category (Graphs 9a and 9b) are required reports for maternity CNST. There has been a significant increase in capacity /staffing issues, which have been investigated by the Head of Midwifery. Post partum haemorrhage and intra-uterine deaths have increased, although this is as a result of improved reporting. The division has worked hard to progress red incident action plans.

Moving & Handling (Graph 10) 93 incidents were reported under this Health & Safety category (*previous year: 126; **26% decrease***).

Sharps (Graph 11) 205 sharp injuries were reported under this Health & Safety category (*previous year: 196; **5% increase***). Injurious incidents down by 7%; 192 to 178. Over 32% (65) of these incidents were avoidable because they occurred during disposal or from discarded sharps. 13% (27) of all incidents are about sharp finds (i.e. no injury occurred). Occupational Health and Safety will carry out a more detailed analyse of “Sharp” incidents next year.

Verbal/Aggression (Graph 12) 562 incidents were reported under this Health & Safety category (*previous year: 268; **20% increase***).

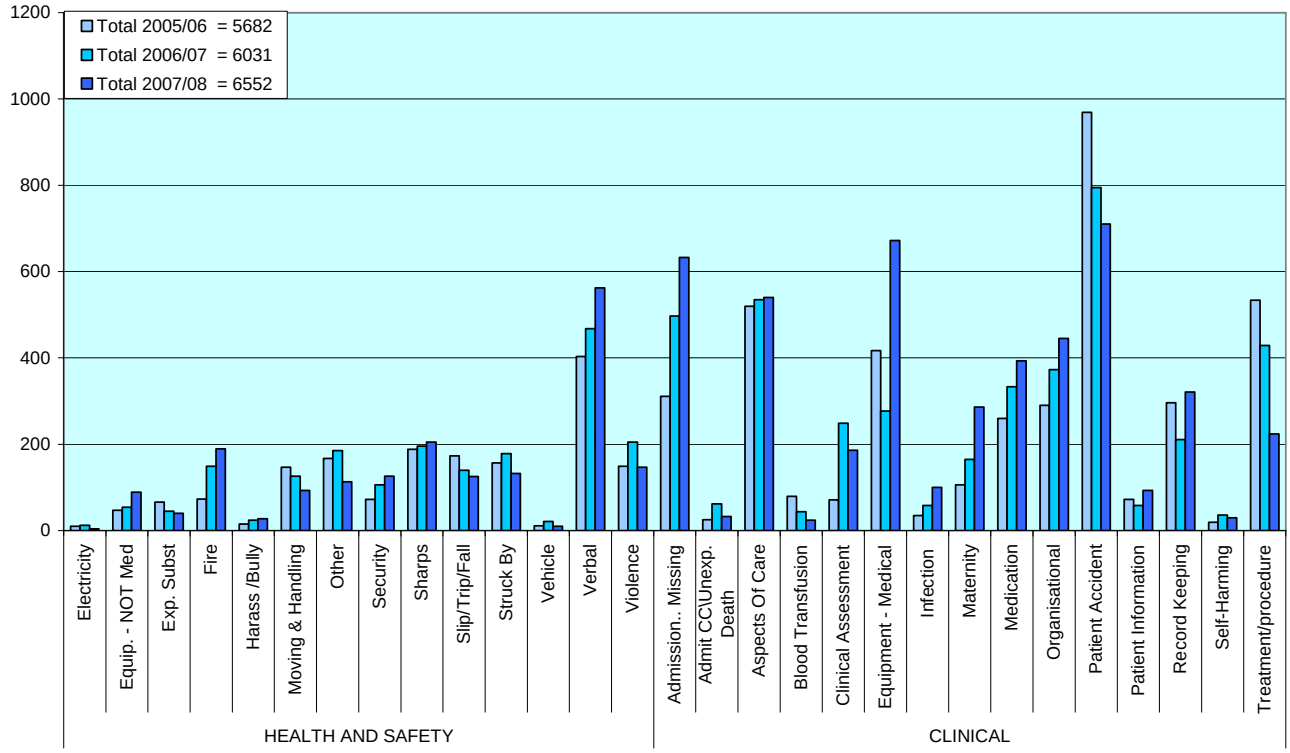
Violence (Graph 13) 147 incidents were reported under this Health & Safety category (*previous year: 205; **28% decrease***).

Security (Graph 14) data has now been cleaned-up. All security activity is now excluded from this category. 126 incidents were reported under this Health & Safety category (*previous year: 106; **19% increase***).

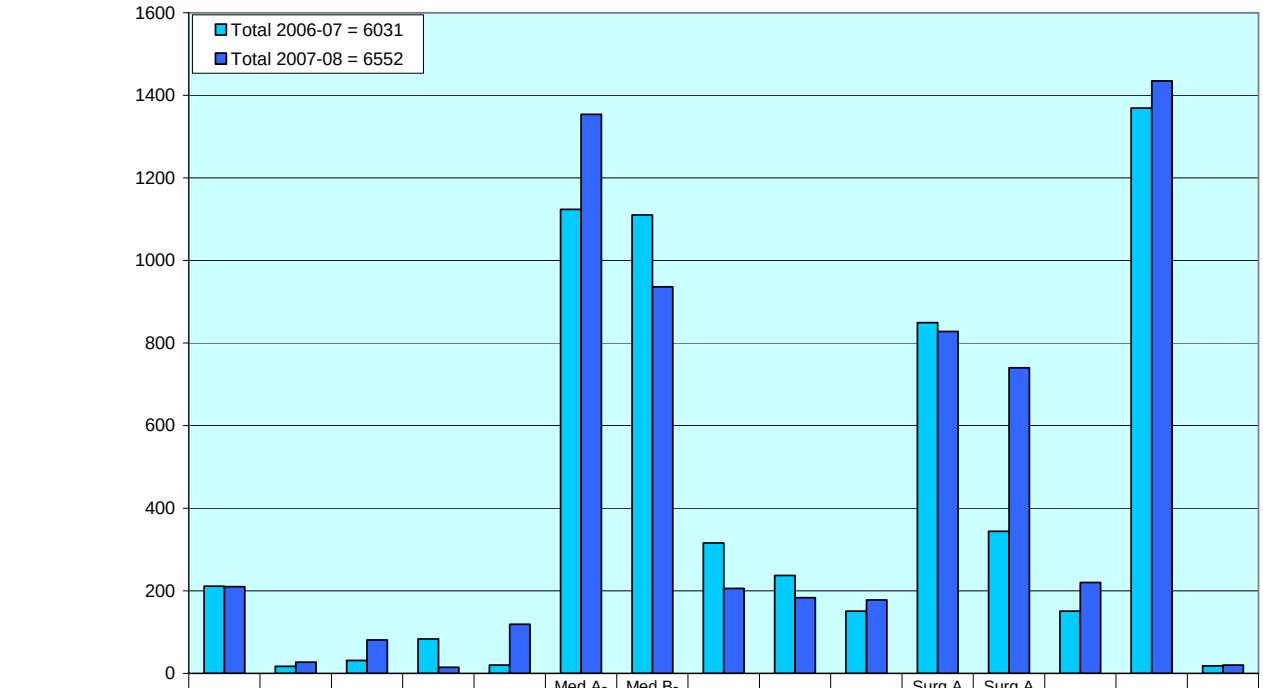
Fire (Graph 15) 189 incidents were reported under this Health & Safety category (*previous year: 149; **27% increase***).

4. Performance Monitoring Data

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

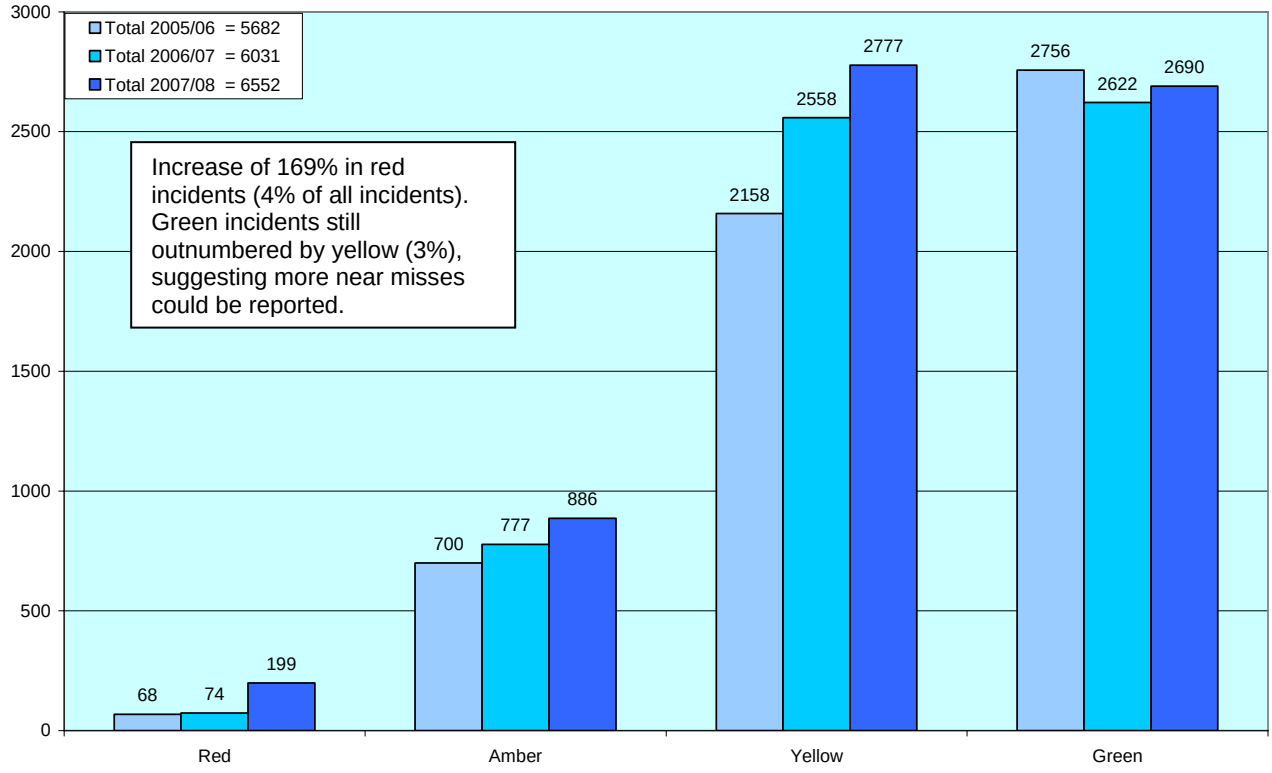


Graph 2: **Incidents by Division 2006/7- 2007/8** (divisional changes do not allow comparisons with 2005/6)

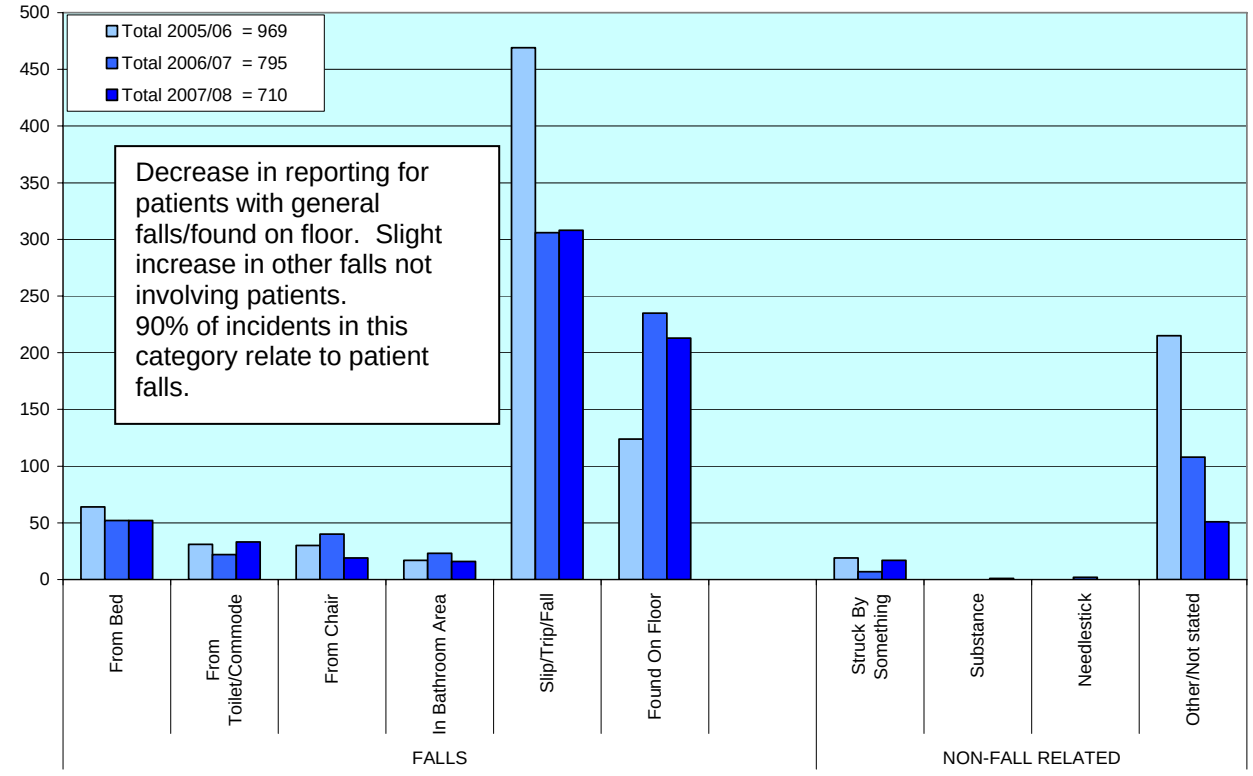


	A&CC	Dev	Est	Imag	IM&T	Med A-EC	Med B-EC	N&T	Ops	Path	Surg A (C)	Surg A (S)	Surg B	W&CH	WF
Total 2006-07 = 6031	211	17	31	83	20	1124	1110	316	237	151	849	344	151	1369	18
Total 2007-08 = 6552	210	27	81	15	119	1354	936	206	183	178	828	740	220	1435	20

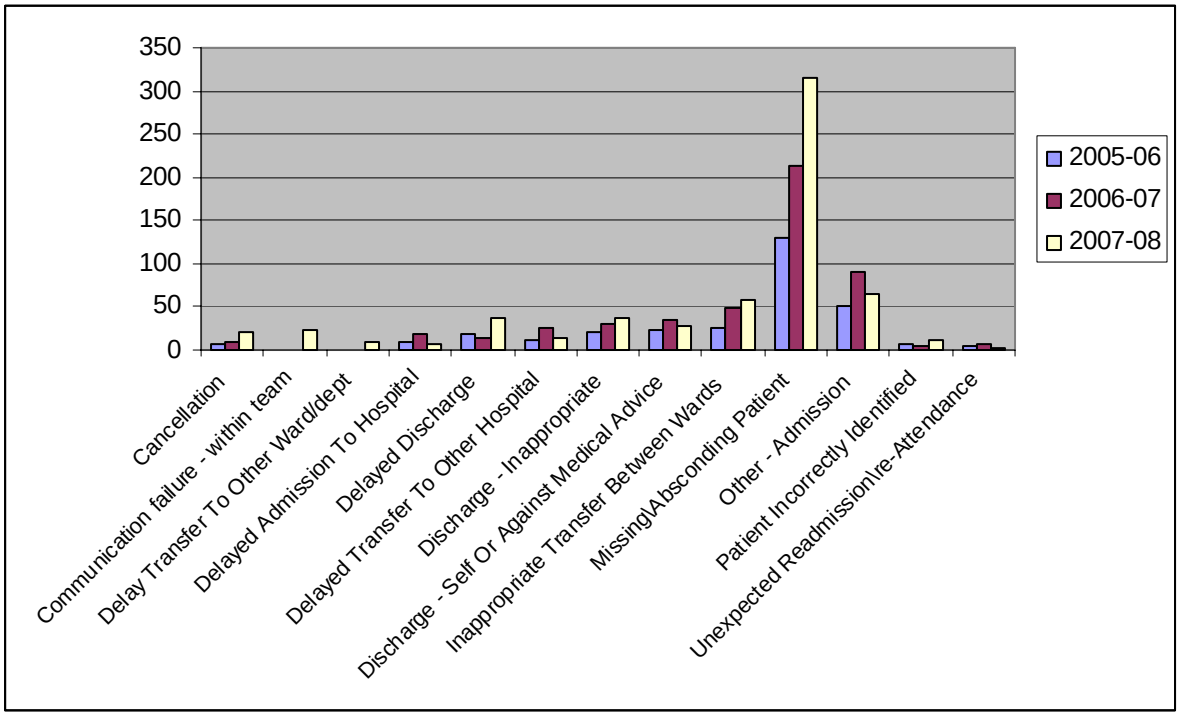
Graph 3: **Risk Rating Trends 2005/6 – 2007/8**



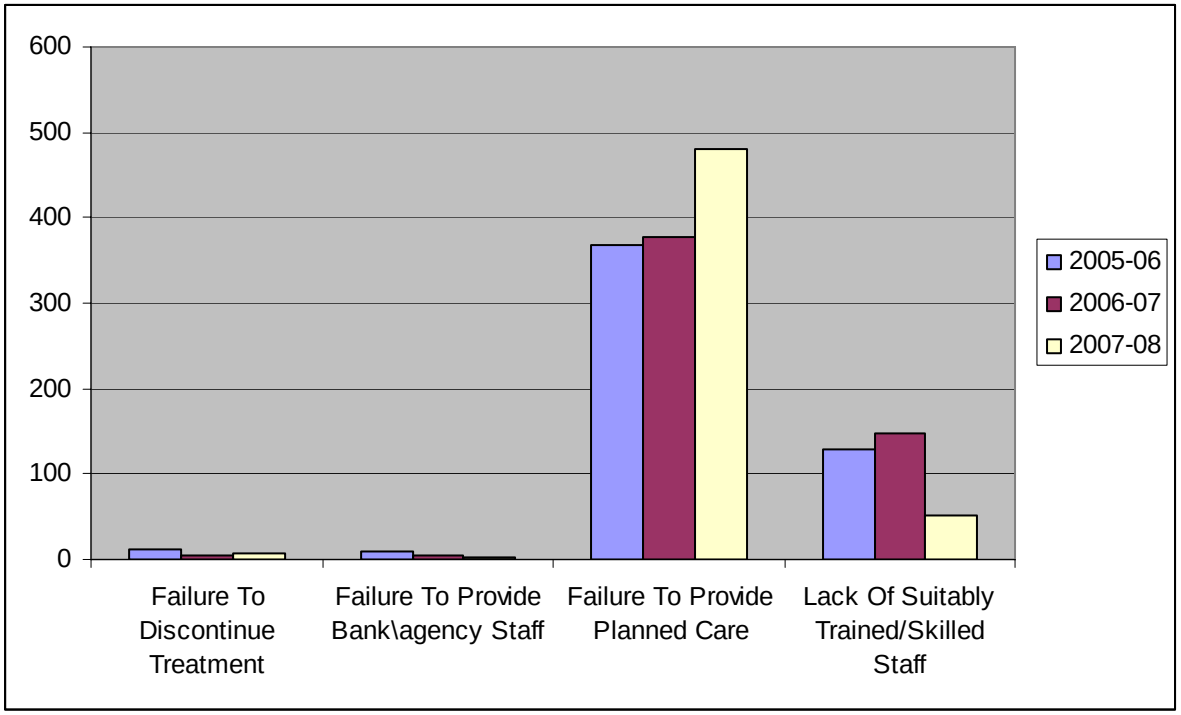
Graph 4: **Patient Accident (Trust) 2005/6 – 2007/8**



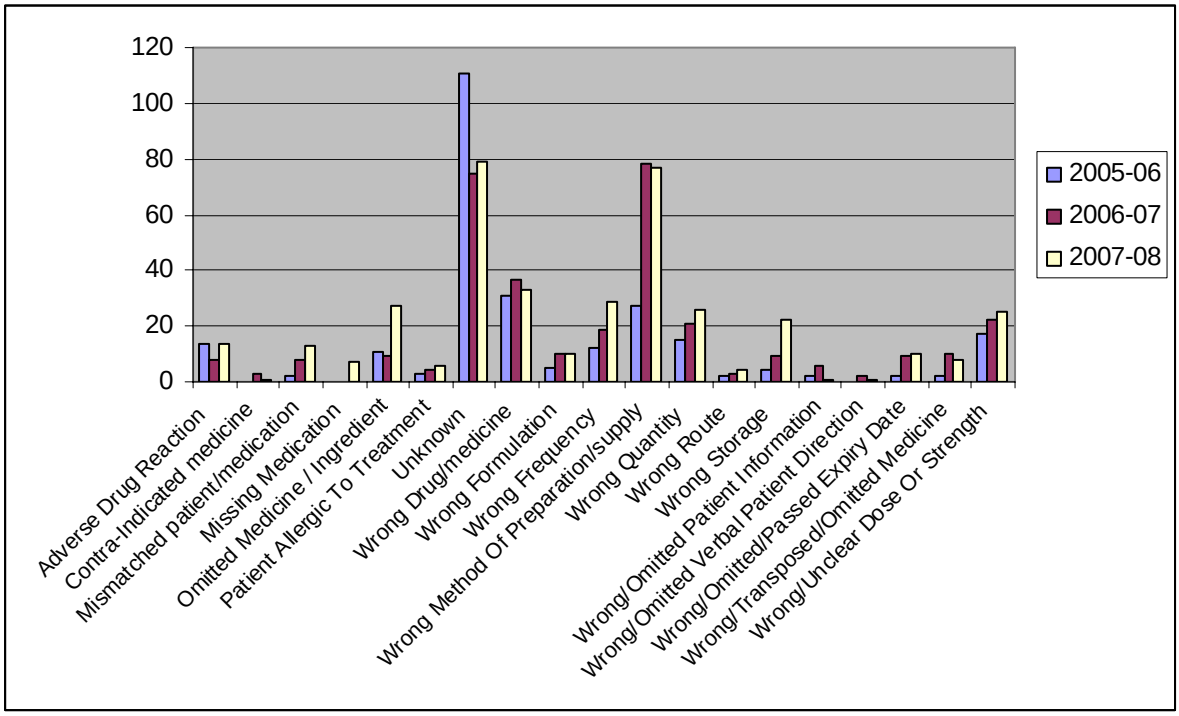
Graph 5: **Admission/discharge/transfer/missing patients 2005/6 – 2007/8**



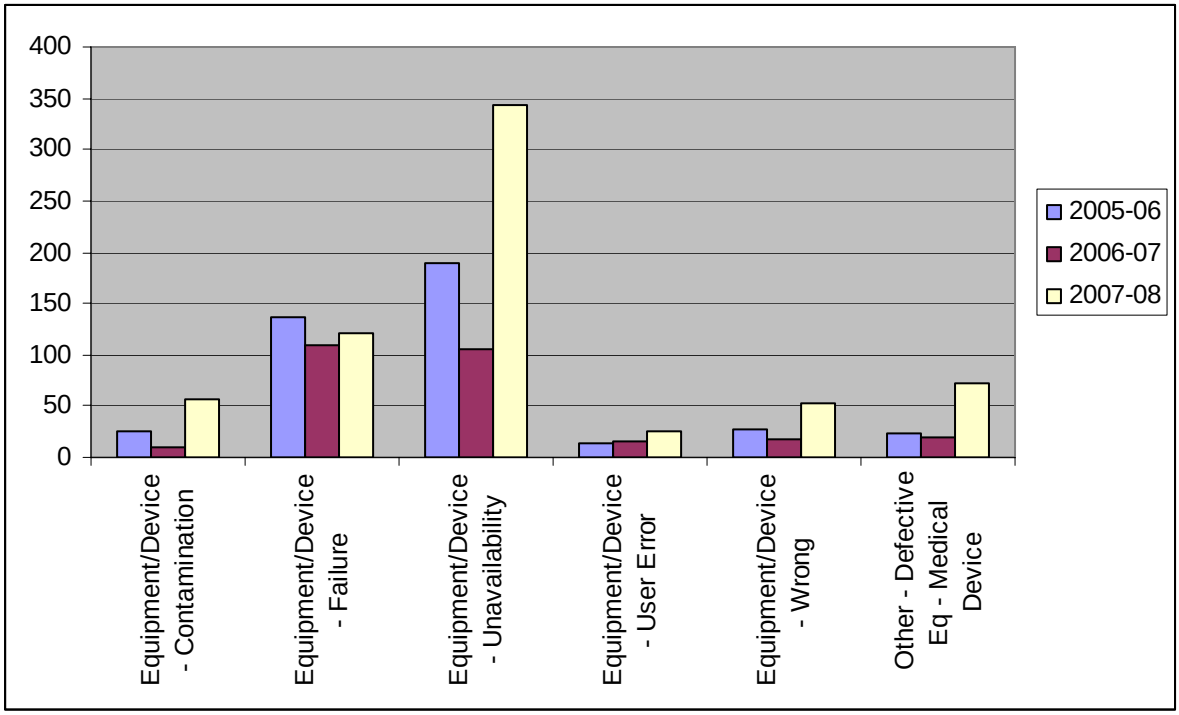
Graph 6: **Aspects of clinical care 2005/6 – 2007/8**



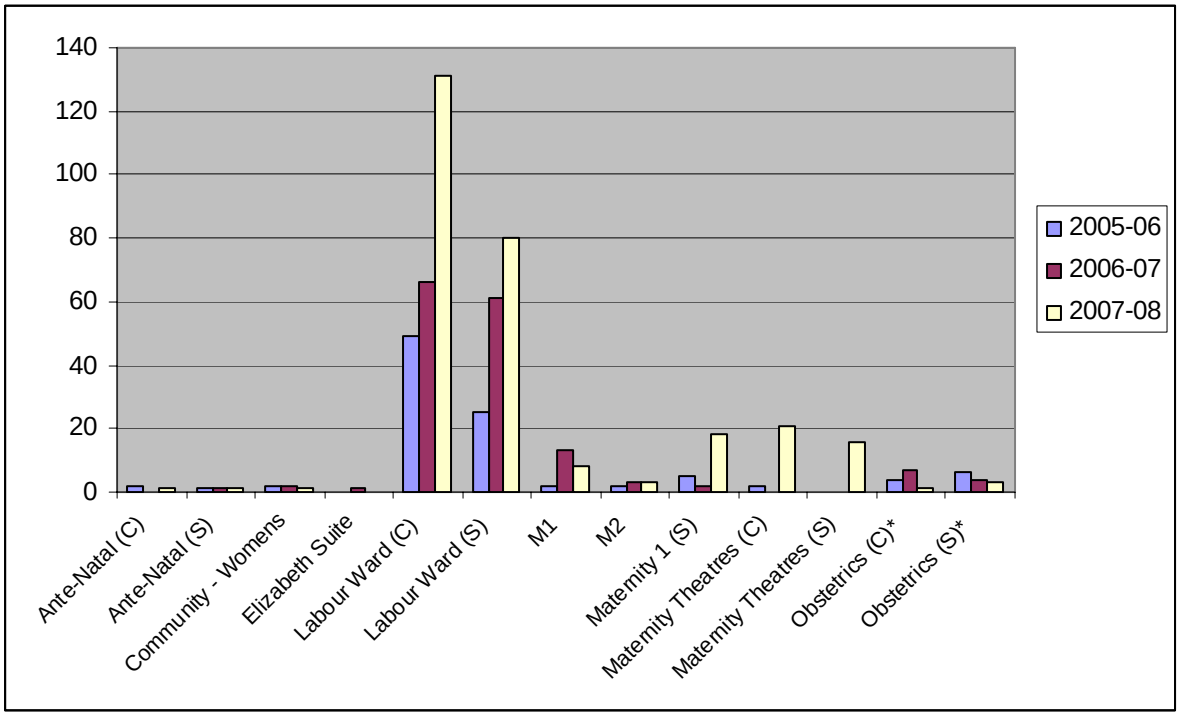
Graph 7: **Medication Errors Q4 2005/6 – 2007/8**



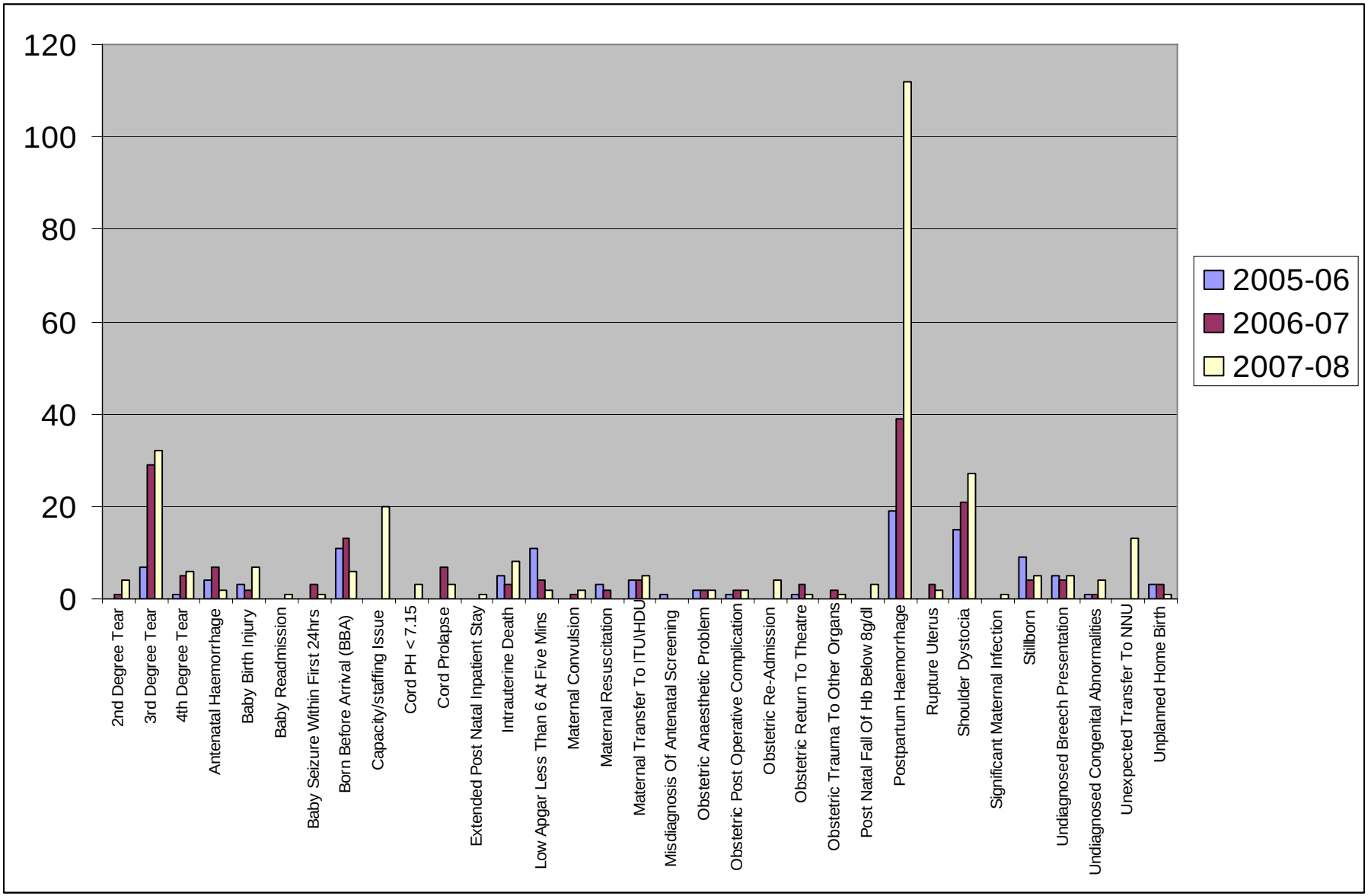
Graph 8: **Medical Equipment 2005/6 – 2007/8**



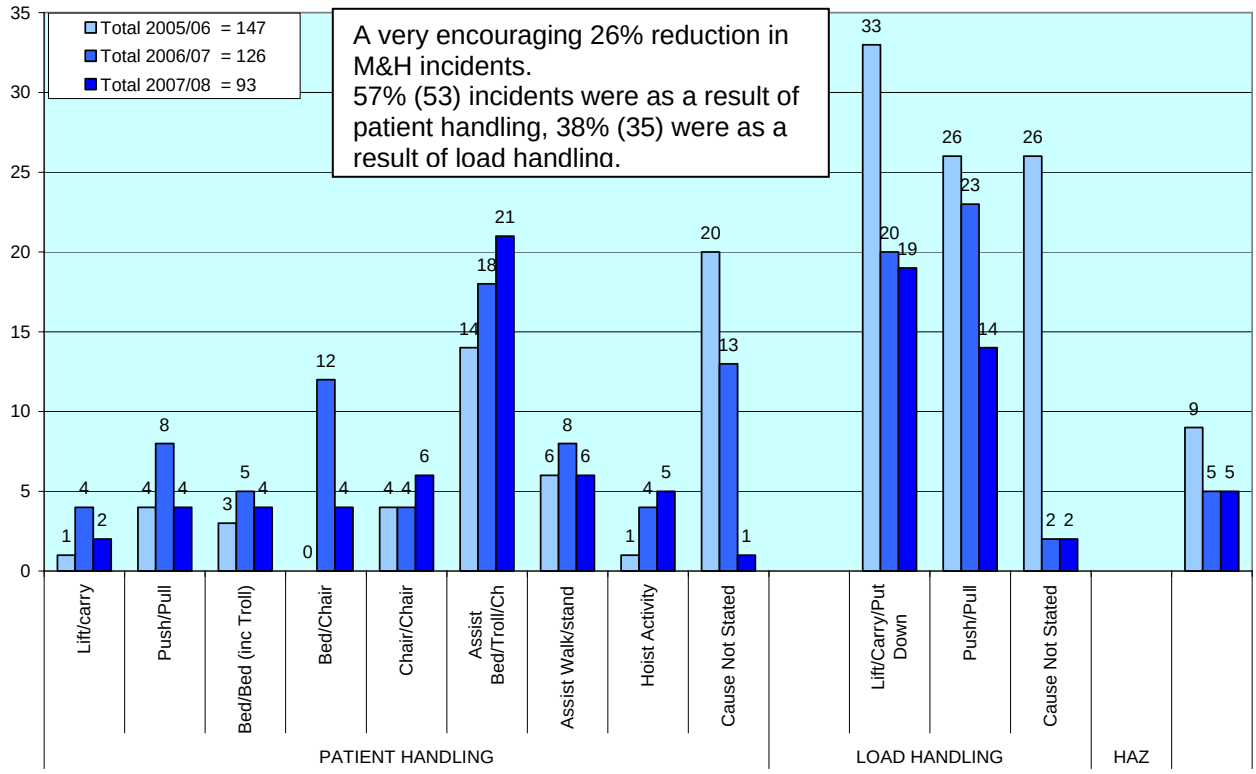
Graph 9a: **Maternity incidents by location Q4 2005/6 – 2007/8**



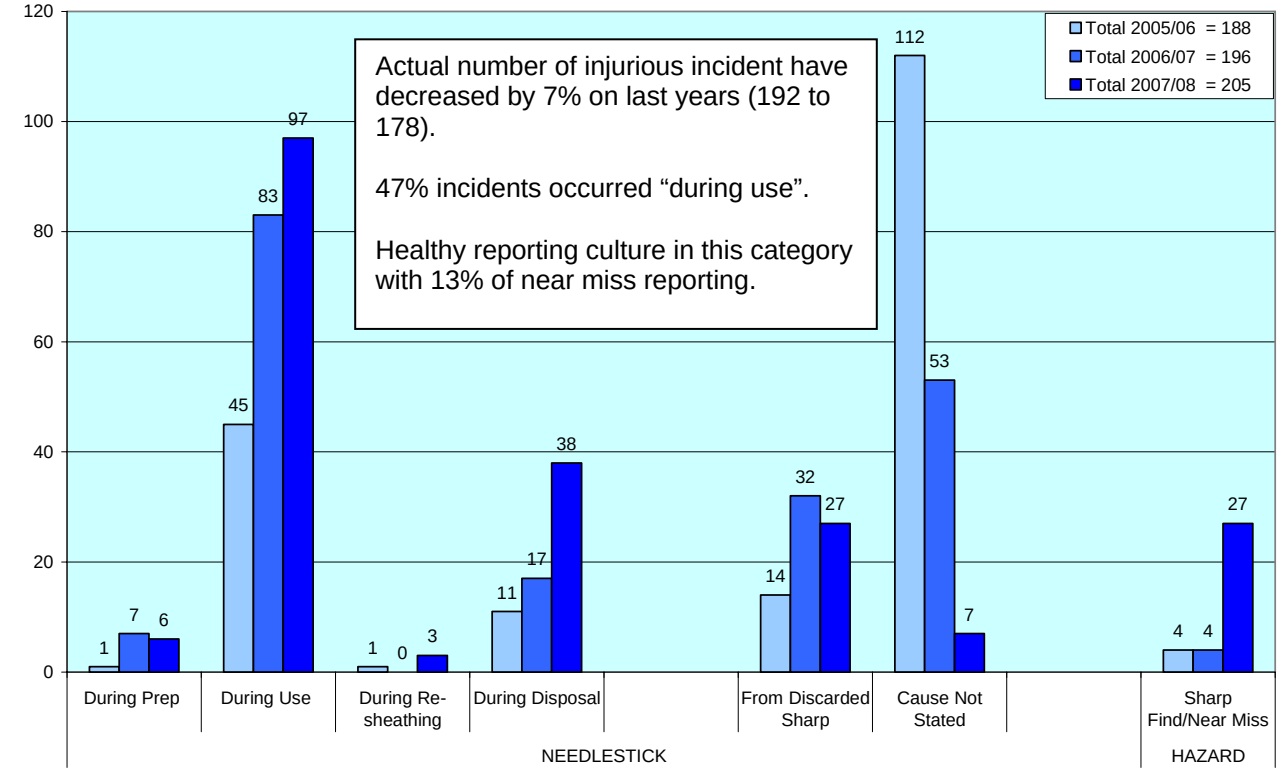
Graph 9b: **Maternity incidents by trigger list category 2005/6 – 2007/8**



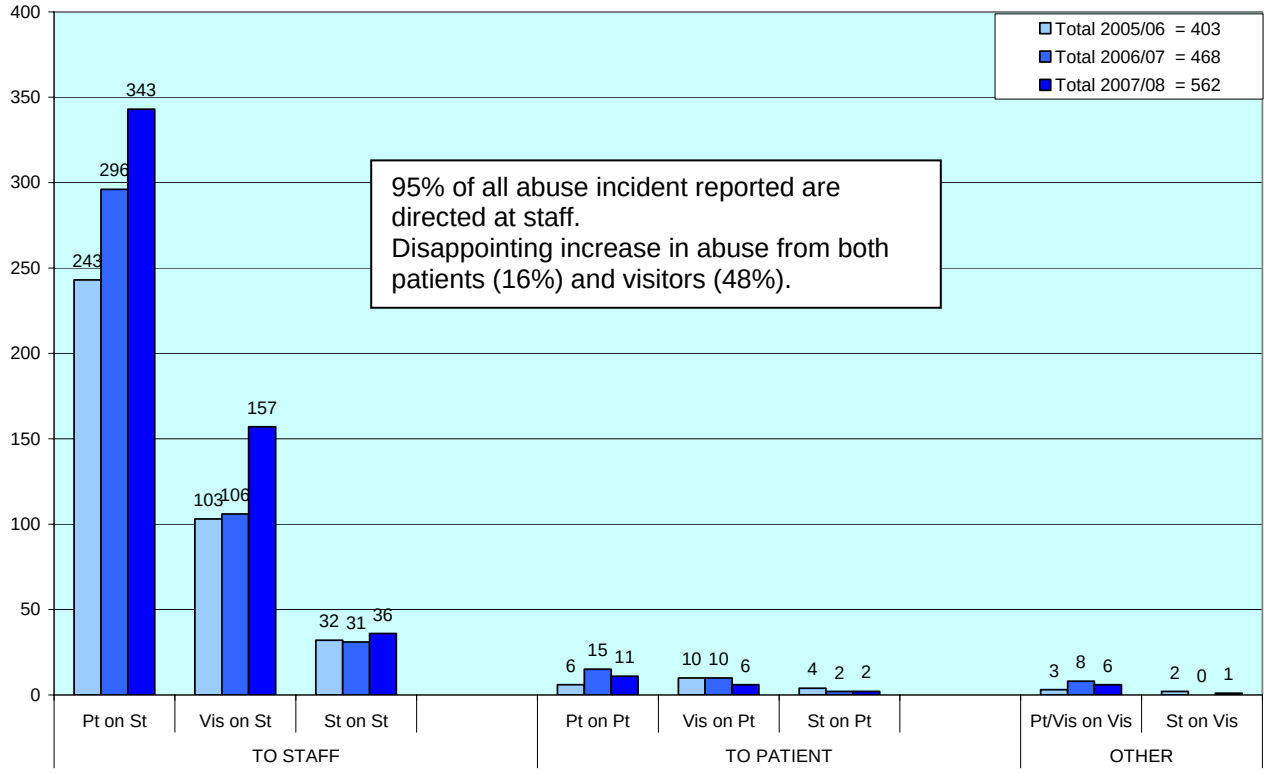
Graph 10: **Moving & Handling (Trust) 2005/06 - 2007/08**.



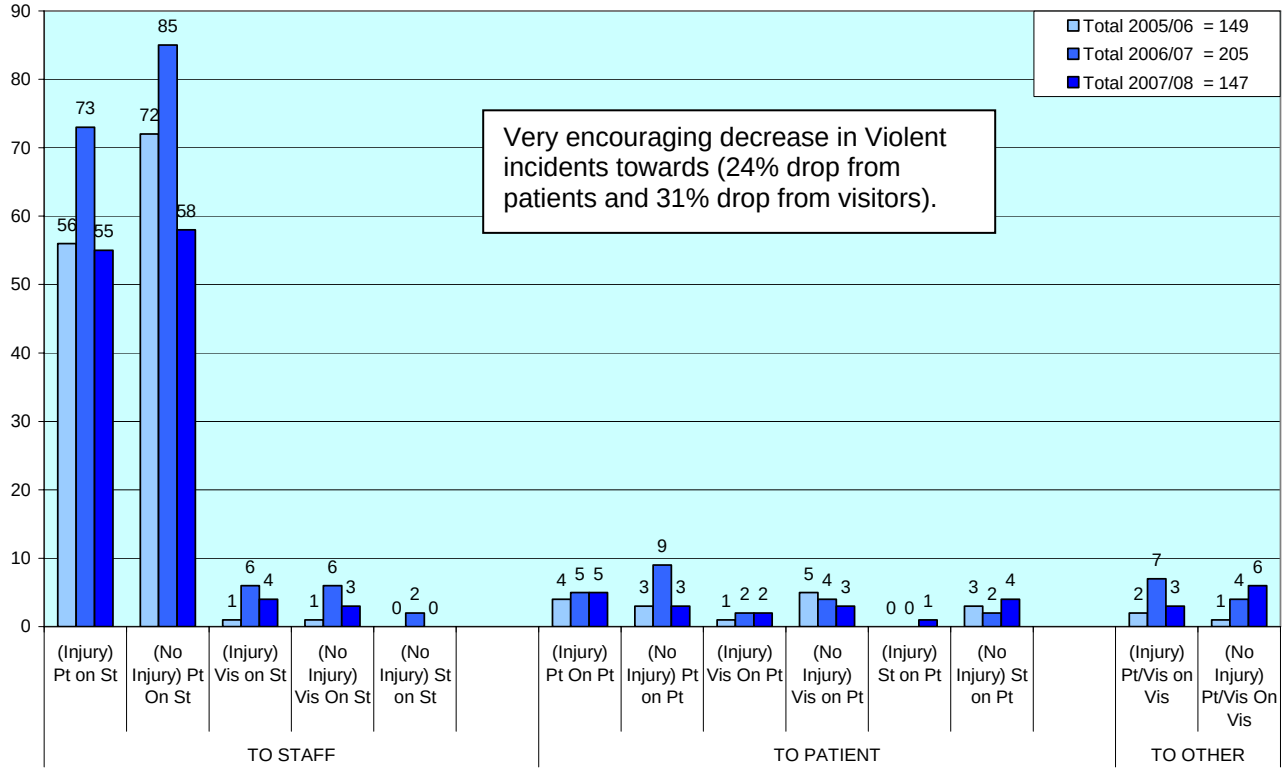
Graph 11: **Sharps (Trust) 2005/06 - 2007/08**.



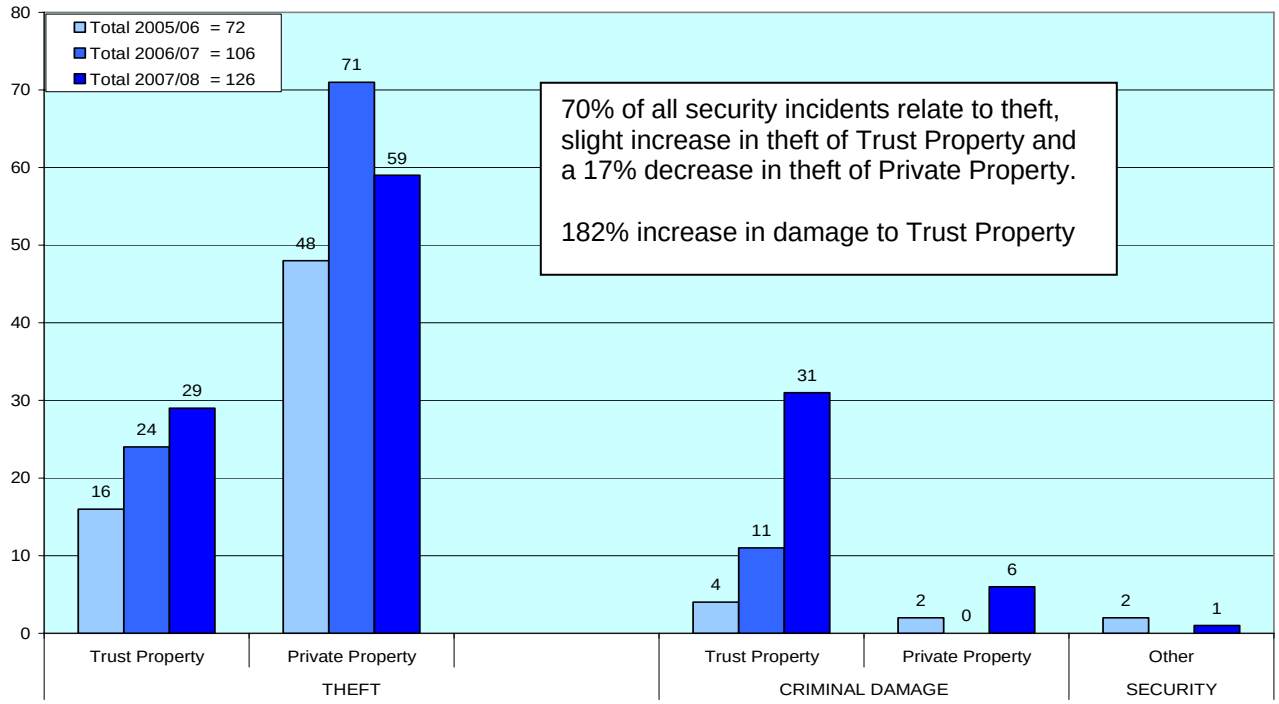
Graph 12: **Verbal/Aggression (Trust) 2005/06 - 2007/08**.



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



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



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

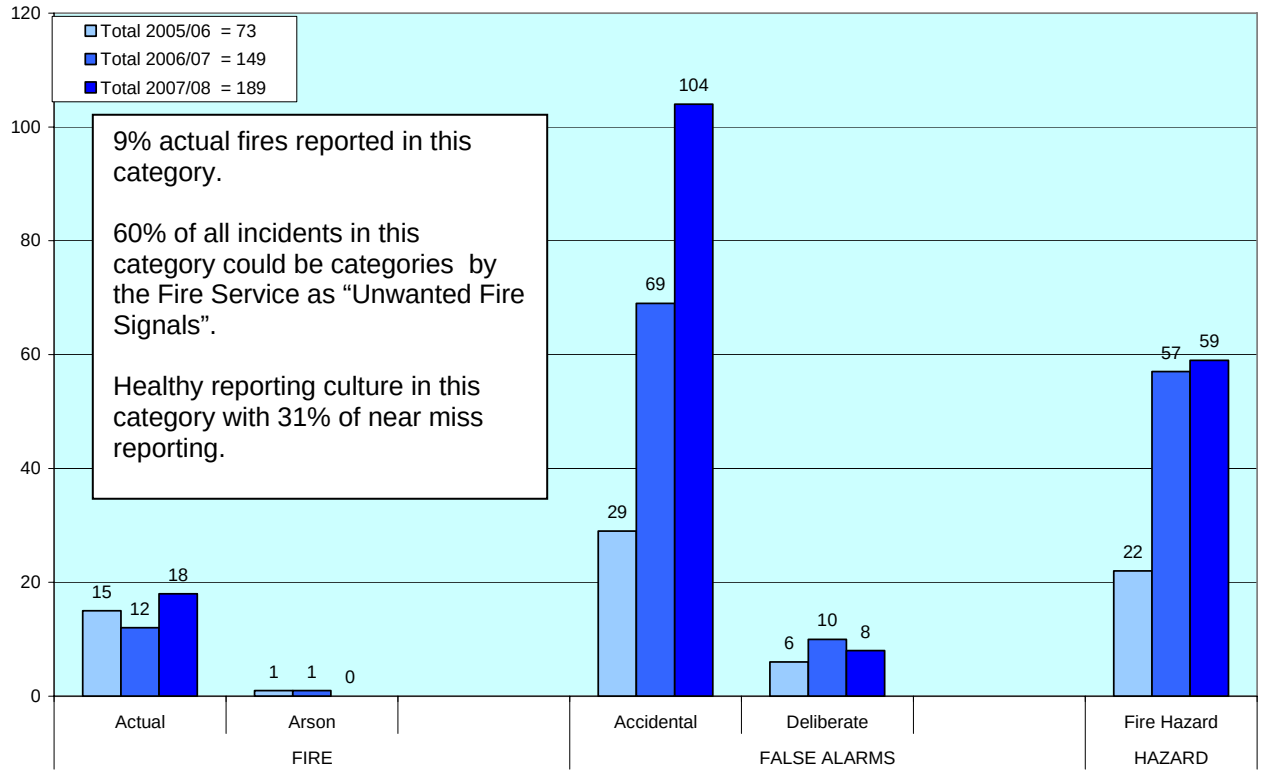


Table 1: **Reported Incidents (Cause Group & Risk Rating by Division) 2007/08**

	A&CC	D/S	Est	IM&T	Imag	Med A-EC	Med B-EC	N,T & F	Ops	Path	Surg A C	Surg A S	Surg B	W&CH	WF/F	Total
Electricity (Contact)			1											2	1	**4**
Equipment (Other)		4	2	1	1	11	7	6	10	1	10	8	3	24	1	**89**
Exposure Substance	5		2	1	1	5	1	1	1	10	3	2	2	6		**40**
Fire	7	1	21	4	1	46	16	35	7	5	18	5	5	15	3	**189**
Harassment/Bullying						4	5	2	1	1	3	4	1	6		**27**
Moving & Handling	5		7	3		19	9	17	1	2	11	10	3	5	1	**93**
Needlestick (Sharps)	6	1	1	3		41	26	4	6	5	41	34	8	28	1	**205**
Other Incident/Haz	10		3	2		15	10	21	4	4	11	7	3	20	3	**113**
Security		2	8	1	1	37	15	20	7	1	6	2	9	15	2	**126**
Slip, Trip, Fall	2	3	13	4	3	9	16	16	6	2	14	6	4	24	3	**125**
Struck By Something	2	1	11	4		10	9	25	5	7	20	7	11	16	4	**132**
Vehicle			1					5	1					3		**10**
Verbal Abuse	6		3	4		288	94	15	4	4	34	21	17	72		**562**
Violence - Assault	1			1		71	40	4			13	6	4	7		**147**
Admission	14		1	5		237	72	7	4	6	131	43	14	98	1	**633**
Clinical Care	41	1		9		82	70	6	11	6	74	50	14	176		**540**
Blood Transfusion						3	1			5	3	2	1	9		**24**
Clinical Assessment	2	1		5	1	15	11			61	19	10	3	58		**186**
Equipment (Medical)	30	1		8		18	16	1	4	2	132	329	31	100		**672**
Infection Control	10			1		28	7	1		4	7	20	2	20		**100**
Maternity						1	1							284		**286**
Medication	21	1		13	2	88	70		43	3	48	31	6	67		**393**
Organisational	20	3	3	7		64	68	2	19	13	50	43	7	146		**445**
Patient Accident	8	1	3	15	1	170	313	12	13		74	30	31	39		**710**
Patient Information			1	1		13	6	3	5	2	21	12	6	23		**93**
Record Keeping	8	2		6	4	19	26	1	24	25	46	37	34	89		**321**
Self-Harming						20	3				4	1	1	1		**30**
Treatment/procedure	12	5		21		34	18	1	7	9	34	20		63		**224**
Unexpect Death\CC						6	6	1			1			19		**33**
TOTAL	**210**	**27**	**81**	**119**	**15**	**1354**	**936**	**206**	**183**	**178**	**828**	**740**	**220**	**1435**	**20**	**6552**
	Risk Rating															
Red	9		1	1		31	29	2	1		10	16	2	97		199
Amber	21	9	10	7	2	190	90	19	24	21	83	132	31	247		886
Yellow	49	6	28	39	6	621	442	65	66	84	289	298	89	688	7	2777
Green	131	12	42	72	7	512	375	120	92	73	446	294	98	403	13	2690
TOTAL	210	27	81	119	15	1354	936	206	183	178	828	740	220	1435	20	6552

ABBREVIATIONS

Directorates

A&CC	Anaesthetics & Critical Care
D/S	Development/Strategy
Est	Estates & Capital Projects
WF/F	Workforce/ Finance
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 A C	Surgery A (City)
Surg A S	Surgery A (Sandwell)
Surg B	Surgery B
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

SWBTB (9/08) 086

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Reform of the NHS Complaints System – *Making Experiences Count*
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Debbie Dunn, Head of Complaints & Litigation
DATE OF MEETING:	4 September 2008

KEY POINTS:

Following the DoH consultation document Making Experiences Count, which set out proposals for the new approach to complaints handling, the Trust has been established as an "early adopter" of the new approach with a view to developing arrangements for more effective local resolution and to identify and resolve issues linked to transferring to a two stage complaints framework.

The Early Adopter Programme is a first step in the wider complaints reform programme and presents a prime opportunity to develop effective best practice in complaints handling that will ultimately meet the needs of both health and social care users and providers. Progress will be evaluated with a view to producing good practice guidance for wider implementation prior to April 2009.

PURPOSE OF THE REPORT:

✓ **For noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is recommended to note the national developments in complaints handling and the Trust's participation in the Early Adopter Programme.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

No specific objective relating to the handling of complaints

IMPACT ASSESSMENT:

FINANCIAL		
ALE		
CLINICAL		
WORKFORCE		
LEGAL	✓	Robust complaints management processes enable the Trust to meet the legal requirements of The National Health Service (Complaints) Amendment Regulations 2006
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REFORM OF THE NHS COMPLAINTS PROCEDURE - MAKING EXPERIENCES COUNT

Background

In June 2007 the Department of Health (DoH) produced a consultation document entitled 'Making Experiences Count', which set out their proposals for a more patient centred approach to the handling of complaints across health and social care. Responses to the consultation document supported reform of the complaints procedure and improved joint working. A major change is the removal of the second stage of the complaints procedure where the complainant can refer their concerns to the Healthcare Commission to request an independent review. Under the planned changes the complainant would be able to go straight to the Health Service Ombudsman if they remained dissatisfied after local resolution.

The Early Adopter Programme

In order to develop the new approach and prepare for the introduction of the proposed changes in April 2009, the DoH has set up an 'Early Adopter' programme. The objectives of the programme are to:-

- develop ways of responding to complaints that fulfil the commitment in the 'Our health, our care, our say' White Paper and the principles of Making Experiences Count;

- draw out the key components of good practice, responsiveness and organisational learning based on the experience of what works well and what does not;

- feed back to a national, central point for the development of a toolkit and standard for complaints handling and organisational responsiveness; and

- ensure that when the whole country adopts the new approach that it will have been developed and tested on the ground and will be fit for purpose; that complaints managers will have access to required training; and that commissioners receive sufficient information about provider complaints to inform commissioning decisions

Twelve early adopter sites were selected spanning health and social care provision. This Trust was chosen to participate in the 'Early Adopter' programme together with the following partners:-

Birmingham and Solihull Mental Health Trust
Birmingham Children's Hospital Foundation Trust
Birmingham City Council
Birmingham East and North Primary Care Trust
Birmingham Women's Healthcare Foundation Trust
Heart of Birmingham Teaching Primary Care Trust
Heart of England Foundation Trust

Royal Orthopaedic Hospital Foundation Trust
South Birmingham Primary Care Trust
University Hospital Birmingham Foundation Trust
West Midlands Ambulance Service Trust

The other sites are - Norfolk, Oldham, East Kent, Liverpool, Cornwall, Newcastle, Portsmouth, Derby, Hull/East Riding/N. Lincs, Westminster, and Barking.

Local meetings have been held, led by the Heart of Birmingham PCT, to discuss how to implement the changes and to share good practice. Support is also available from the DoH Early Adopter Field Implementation Team.

Within the Trust different approaches to resolving complaints are being explored. The key component of the new approach is flexibility so that the complainant's individual needs and wishes are met. For example, not all complainants may want a formal letter from the Chief Executive and may be happy with a telephone call, others may wish to proceed straight to a meeting rather than receiving a written response first. Greater use will also be made of the current provision to negotiate a response time in excess of 25 working days with the complainant for the more complex complaints.

The DoH has recognised that the early adopter sites will not fully comply with the current NHS Complaints Procedure while they are developing a number of different approaches to the way that complaints are handled. In view of this the Healthcare Commission and Health Service Ombudsman have confirmed that if a complaint is referred to them they will not be critical of the early adopted sites for not following the current Regulations.

Recommendation

The Board is asked to note this report.

Debbie Dunn
Head of Complaints & Litigation

September 2008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	***Staff Opinion Survey – Additional Questions***
SPONSORING DIRECTOR:	***Colin M. Holden – Director of Workforce***
AUTHOR:	***Colin M. Holden – Director of Workforce***
DATE OF MEETING:	***28th August 2008***

KEY POINTS:

For this years staff opinion survey we want to include a number of optional questions relating to Listening into Action.

The regulations that govern the use of the national survey allow for the addition of local questions, these however require notification to the Trust Board.

PURPOSE OF THE REPORT:

✓ **For noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The board is asked to note the additional questions to be included in the next survey.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

It is important that staff recognise the importance of Listening into Action.

IMPACT ASSESSMENT:

FINANCIAL		
ALE		
CLINICAL		
WORKFORCE	✓	
LEGAL		
EQUALITY & DIVERSITY		
COMMUNICATIONS		
PPI		
RISKS		

Introduction

For this years staff opinion survey we want to include a number of optional questions relating to Listening into Action.

The regulations that govern the use of the national survey allow for the addition of local questions, these however require notification to the Trust Board.

Additional Local Questions

The following have been prepared by our supplier, Quality Health, following a briefing from the Director of Workforce.

Have you heard about “Listening into Action” in the Trust?

- Yes I’ve definitely heard of it
- I might have heard about it
- Don’t remember hearing about it
- Don’t know

Do you know what “Listening into Action” is about?

- I have a clear idea of what it is
- I have some information about it but I’m not really clear about it
- I don’t have a clear idea of it
- Haven’t heard of Listening into Action

Have you been directly involved in “Listening into Action?” (please tick as many as apply)

- I went to one of the first five “Staff Conversations”
- I’ve been involved in planning it at Trust level
- I’ve had a discussion about it at team meetings at work
- I’ve read an email from the Chief Executive about it
- I’ve read about it in Heartbeat
- I’ve helped to identify the top ten eyesores
- I’ve read material about it sent to managers and leaders
- I went to a meeting to discuss how we could improve services in my work area
- I went to the “Enabling Our people” event in July
- I went to the meeting about Imaging Services in June
- I went to a discussion about improving maternity services
- I went to a discussion about how to improve medical records
- I went to a discussion about improving the hospitals’ theatres
- I went to a Trust wide meeting on vision and values in September

Do you think that Listening into Action is giving more power to the staff to change things?

- Yes, its giving more power to the staff
- It might be giving more power to the staff
- I am doubtful that it is giving more power to the staff
- Its too early to tell
- I don't know

Do you think that Listening into Action will improve services for patients?

- I have not heard of any improvements in services being planned as a result of Listening into Action
- I can already see improvements in services for patients being made
- I have heard about planned improvements but don't know whether they are improving services for patients
- I have heard about planned improvements but I think its unlikely that they will improve services for patients
- Its too early to tell
- I don't know

Is your immediate manager committed to listening to staff about improving services?

- My manager does not listen to staff suggestions on how to improve things
- My manager listens sometimes to staff suggestions but not always
- My manager does listen to staff suggestions on improving services
- I'm not aware of staff suggestions to improve services being made
- I Don't know

Does your immediate manager act on staff suggestions for improving services?

- I don't know if my manager acts on staff suggestions
- My manager does not act on staff suggestions
- My manager sometimes acts on staff suggestions
- My manager does act on staff suggestions
- I'm not aware of staff suggestions being made
- I Don't know

Do you think that the Listening into Action work will succeed?

- Its is very likely to succeed
- It is quite likely to succeed
- It is not likely to succeed
- I don't know if it will succeed or not
- Too early to tell

Recommendation

The Board is asked to note the proposed additional local questions to this year's staff opinion survey.

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance and Performance Management Committee – V1.0 (FINAL)

Venue Ground Meeting Room, Sandwell Hospital **Date** 26 June 2008; 1430h – 1630h

Members		**In Attendance**	
Mr R Trotman	[Chair]	Mr T Atack	
Mrs S Davis		Mr M Harding	
Cllr B Thomas	[Part]	Mr T Wharram	
Dr S Sahota	[Part]	Mr A Brown	[Item 2 only]
Mrs G Hunjan		Ms S Tyler	[Item 2 only]
Prof D Alderson			

Apologies	**Secretariat**	
Ms I Bartram	Mr S Grainger-Payne	[Minutes]
Mr J Adler		
Mr R White		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Isobel Bartram, John Adler and Robert White. It was noted that representation at the meeting was below quorum therefore any decisions taken at the meeting would be subject to ratification by absent members.	
2 Presentation by Medicine A Division	**SWBFC (6/08) 022** **SWBFC (6/08) 022 (a)**
Andrew Brown, summarised the financial performance of the Medicine A and Emergency Care division and discussed the CIP for 2008/9. The annual value of the activity undertaken by the division was reported to be £49m and the divisional target CIP for 2008/09 is £1.25m. A breakdown of the various schemes comprising the total CIP was presented, the majority of which was noted to be recurrent expenditure. At present all schemes are due to deliver their target value, except the workstream concerning the closure of beds on ward D18. These plans will not now be executed as this ward has now been designated as City Hospital's MRSA ward. Plans are underway to compensate for this scheme being abandoned, although at present only non-recurrent measures are being used.	

In terms of the financial position, there are currently no issues of significance. Income recovery in respect of neurophysiology work, elderly care and general medicine is slightly higher that anticipated at present, although this position has been offset against the underperformance against PCT contract lines. Pay expenditure is slightly ahead of plan for May mainly as a consequence of the flexible capacity on Wards D28 and D29, although these costs are largely offset by vacancies in nursing and midwifery. Tim Atack added that there is little room for further beds to be closed this year within the division as a result of the increased activity experienced.

There has been a slight overspend on non-pay expenditure, partially due to costs associated with the Community Dermatology Service equipment and room hire. Expenditure has also been high for staff uniforms and cleaning materials across various wards and departments. £250k has been removed from the drugs budget to assist the CIP target which has made the operation of the division challenging.

Key issues for the division over the next few years include the control of expenditure and reduction of beds open above the funded bed base. Reduced length of stay is also linked to this target, although this needs to be delivered in line with a number of other targets such as A & E waiting time.

There is much work to do to address sickness absence within the division. It is thought to be above average at present due to some instances of poor performance management and a number of long term sickness cases. The Chair asked what measures are planned to address the staff performance issues. He was advised that the optimal wards plans are key to this and an improvement should be seen within six months.

Measures are also underway to maximise income and the division is working with the service improvement team to identify areas where GP referral levels could be improved. Clinicians will be engaged to target those practices identified as having a low referral rate. Outpatient operations are currently being examined and a group job planning exercise has been performed. Extra outpatient clinics are also now being run. Specific attention is being given to ensuring that activity is being fully recorded and correctly coded.

As part of the 2010 exemplar programme, an integrated approach is being given to a community diabetes service. It is anticipated that this exercise may identify a number of diabetic patients in the community having their condition poorly managed. 2010 models of service for dermatology and rheumatism have also been developed and strong relationships have been made with the PCTs provider arms to deliver these services. If a community tariff is introduced this would therefore represent additional income to the Trust.

There has been little opportunity for reconfiguration in the division, apart from stroke services. The clinical and financial benefits of further reconfiguration need to be better understood before any changes are effected.

At subdivisional level it is apparent that stronger management support and clinical management is required. Tim Atack added that there is also a need to consider how to ensure that good nurses remain working at ward level. Discussions are underway with matrons.

Derek Alderson asked whether the issue of having medical outliers occupying non-medical beds was an issue restricted to winter pressures. He was advised that this

was not the case and the issue is now a year-round situation, due in part to a drop in community capacity. Elective surgery cases are being affected by the issue. Mr. Brown was asked to what extent surgical income was being reduced by the circumstances. He reported that it was not a significant issue as there had been minimal loss of income. Sue Davis revisited the situation regarding D18 and asked what benefits there were to the establishment of a separate ward for MRSA cases. She was advised that by creating this facility that overall patient length of stay was reduced as the infection was better contained. The PCTs also benefit from the reduced requirement for extra beds days in line with the reduced length of stay. The savings gained from this are then reinvested into MRSA screening activities. The target for completing PDRs by 31 August is in hand and good systems have been implemented for logging those PDRs completed and identifying those still to be held. Completion of PDRs is currently at 44%, which was noted to be above average for the Trust. Gianjeet Hunjan asked what readmission rates the division experienced. She was informed that it was c.10%, a figure which needed to be improved. An encouraging declining trend has however been noted. Mr Brown was asked what two key initiatives are being put into place within the division to improve the patient experience. He advised that the introduction of housekeepers was a major initiative which starts in October. Effort is also being directed to more effective management of capacity where admissions are being limited to only those patients definitely needing to come into hospital; better discharge planning is also underway where patients have a clearer idea of when they can expect to return home; facilitated discharge is being implemented and interim care is used to hold patients not requiring an acute bed. Tim Atack added that work is progressing to improve the state of the wards over a 2-3 year timeframe, incorporating reconfiguration where necessary. Side rooms are due to be installed into the Surgical Assessment Unit. Roger Trotman thanked Mr Brown and Ms Tyler for the informative presentation.	
3 Minutes of the previous meeting	**SWBFC (5/08) 017**
The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held on 29 May 08.	
AGREEMENT: The minutes of the previous meeting were approved	
4 Matters arising from the previous meeting	**SWBFC (5/08) 017 (a)**
There were no matters outstanding. Tim Atack reassured the Committee that the concerns regarding the outpatient experience at Rowley Regis Hospital reported by Cllr Thomas at the last meeting, were being addressed. Additional staffing has been arranged for the anti-coagulant clinic and the phlebotomy function now has extended opening hours. Mr Atack was asked to consider arranging a press release to promote the improved situation.	
ACTION: Tim Atack to consider issuing a press release to promote the	

improved patient experience at Rowley Regis Hospital	
5 Trust Board performance management reports	
5.1 2008/09 month 2 financial position and forecast	**SWBFC (6/08) 023** **SWBFC (6/08) 023 (a)** **SWBFC (6/08) 023 (b)**
An amendment to the commentary in the divisional performance section of the report was noted, which Simon Grainger-Payne offered to amend for the version to be issued to the Trust Board. The Committee was pleased to hear that an in-month surplus of £359k was achieved against a target of £253k. It noted however that there was a significant negative variance against WTEs (187 below plan). This is attributed in part to a mismatch between staff bids and the actual recruitment of staff. This should be alleviated to some degree by the introduction of the new electronic vacancy approvals process. A particular problem area at present is theatres, where there is difficulty in recruiting staff. The cash balance was reported to be £2m above plan as at 31 May. Patient-related income is above budget, which is reflective of activity levels being higher than plan. Pay expenditure was £153k under budget in line with the shortfall in WTEs. Expenditure in respect of agency staff however was noted to be high in areas such as internal audit therefore Tony Wharram was asked to ensure that the paybill narrative is amended in future versions of the report to provide a breakdown showing costs attributed to agency staff. Tim Atack remarked that a number of changes to the Trust year have necessitated an increased use of agency staff. At a divisional level it was noted that Medicine B has underperformed during the month. This is driven by income issues however and much work is underway to address this situation. At present this is not a major cause for concern. An additional issue is thought to be that not all short stay activity is being recorded. Again measures are in hand to ensure that this activity is logged. At this point Sarindar Sahota and Bill Thomas left the meeting. The chair enquired about the position regarding outstanding debts and credits. He was advised that the most significant debts are attributed to University Hospital Birmingham, although it is expected that this debt will be cleared by July. Tony Wharram drew the Committee's attention to the budget tracking detail within the appendices to the Finance report. Although this was highlighted to be a work in progress, Mr Wharram was thanked for this useful analysis.	
ACTION: Simon Grainger-Payne to amend the financial report prior to receipt by the Trust Board	
5.2 Performance monitoring report	**SWBFC (6/08) 024**
Mike Harding presented the Trust's summary performance for the period May 2008. In month there has been one breach of the 62 day cancer referral to treatment target. The responsibility for the breach is shared with UHB. Cancelled operations halved during the month to 0.7%. Delayed transfers of care have also reduced,	

particularly in respect of the previously reported issues concerning the performance of Sandwell Social Services. Delayed transfers of care have increased slightly at City Hospital however, mainly due to a lack of care home capacity in the region. The opening of a facility in Ladywood will assist with this issue. The Committee was concerned to hear of the continued reduction in the proportion of patients offered an appointment within 48 hours of contacting the GUM service and percentage of patients seen within 48 hours of contacting the service. Performance was noted to be considerably short of the 100% target. The situation has been investigated and it appears that changes implemented in mid May would achieve this target, although it is thought that the information cannot be retrospectively submitted. Cancelling of any GUM clinics is now subject to an escalation process whereby approval at a senior level is required before a cancellation is made. In the longer term the operation of the service is to be examined more widely with a view to running the service under a partnership arrangement in the community. There has been a continued reduction in incidents of infection, with no MRSA cases having been reported in May and a continued downward trend in *C difficile* cases. The *C difficile* baseline has been revised recently with a requirement to reduce incidents by 16% over 3 years. Internally, targets are much more demanding however. Management of side rooms and the use of Hydrogen Peroxide cleansing has ensured that infections are more stringently controlled. RTT data is 93.4% for admitted patients for the month and 90.0% for non-admitted patients. Diagnostic waits in excess of 6 weeks reduced to 13 from 43 prior month. There has been a slight underperformance against contracted plans for the month for the majority of activity types. Activity levels overall still remain significantly higher than delivered during the same period prior year. PDR returns to Learning and Development during the month were disappointing at only 115. The CEO is however taking a personal hand to ensure an improved compliance rate against this target.	
6 Cost improvement programme (2008/09)	
6.1 CIP delivery report	
Tony Wharram reported that a breakdown of recurrent and non-recurrent expenditure is now included in the report, in addition to an analysis of pay vs. non-pay costs. The CIP delivery is not significantly different from the approved programme, although the report now shows progress against the full CIP including the value assigned to the corporate workstreams as well as the divisional element. The position as at the end of May reported that the CIP was slightly short of target due to the underperformance of a couple of areas, although there is little cause for concern at present. Tim Atack added that the outline CIP for 2009/10 needed to be finalised for the application for Foundation Trust status. A figure of 12% over three years is the agreed programme. A 2% growth in activity is assumed together with a 10% cut in costs. It is thought that the majority of this will be achieved by closing beds.	

Gianjeet Hunjan enquired if the £1.9m savings planned and achieved in April was recurrent cost. She was advised that this was the case and does not relate to posts being given up.	
7 Minutes of the Financial Management Board	**SWBFM (5/08) 018**
The minutes of the FMB held on 29 May 08 were noted by the Committee.	
8 Strategic Investment Review Group	**SWBFC (6/08) 019** **SWBFC (6/08) 020**
The Committee noted the minutes of the SIRG held on 20 May 08 and the actions arising from the meeting held on 17 June 08	
9 Any other business	**Verbal**
There was none.	
10 Details of next meeting	**Verbal**
The next meeting is planned for 31 July 2008 at 1430h in the Executive Meeting Room, City Hospital.	

Signed .....

Print .....

Date .....

MINUTES

Sandwell and West Birmingham Hospitals NHS Trust

Finance and Performance Management Committee – V0.3

Venue Executive Meeting Room, City Hospital **Date** 31 July 2008; 1430h – 1630h

Members

Mr R Trotman [Chair]
Ms I Bartram
Dr S Sahota
Mrs G Hunjan
Mr J Adler
Mr T Atack

In Attendance

Mr T Wharram
Mr M Harding
Ms K Olley [Item 2 only]
Ms H Lemboye [Item 2 only]
Mr S Power [Item 2 only]
Mr G Seager [Item 6 only]
Mr R Banks [Item 6 only]

Apologies

Mrs S Davis
Cllr B Thomas
Prof D Alderson
Mr R White

Secretariat

Mr S Grainger-Payne [Minutes]

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Sue Davis, Cllr Thomas, Professor Alderson and Robert White.	
2 Presentation by Surgery B Division	**SWBFC (7/08) 027** **SWBFC (7/08) 027 (a)**
Roger Trotman welcomed Kathy Olley, Hilary Lemboye and Shaun Power who presented an overview of the performance of Surgery B division. Ms Olley reported that by the end of June Surgery B was £42k underspent and there is anticipation that a balanced financial position will be delivered in 2008/09. Income is £153k over-recovered, although outpatient and day case performance is to contract. The major area of over performance is against A & E. Pay expenditure is higher than planned at £188k above budget. This is mainly as a consequence of additional sessions being conducted to ensure 18-week referral to treatment targets are maintained. Nursing in the division has also overspent by £40k, mainly on extra bank costs due to pressures in theatres and A & E. It was noted that these pressures are likely to have had an adverse impact on patient experience, however every effort is being made to ensure that patient preparation for theatres	

is more efficient. Hilary Lemboye advised that much work is underway to reduce outpatient waiting times. These have reduced from 11 to 5 weeks. Tim Atack added that a 'one-stop' service is provided by the area so patients do not have to have a return visit for visual function tests. Gianjeet Hunjan enquired what the sickness level was within the division. She was advised that this was below the Trust average at less than 4%. Focus is also being given to cases of long term sickness where department heads are being asked to concentrate on rehabilitation of these individuals. Overall timeliness of clinics is not a significant problem for the division, although some late clinics may be delayed as consultants need to travel between locations. Non pay costs are lower than planned, largely as a result of below budgeted drugs costs in line with lower than planned PDT activity. The Committee was assured that the division is on track to meet its CIP target. A good proportion of the CIP relates to recurring cost reductions. Mr Trotman asked what two initiatives the division had undertaken to improve patient experience within the area. He was advised that achieving shorter waiting times has been a major contributor to ensuring waiting lists are now much smaller. Ms Lemboye reported that work is underway to improve customer service within the division. A dedicated workshop facilitated by the Learning and Development department is planned for October. The success of this work will be gauged according to complaints received regarding waiting times and cancelled and changed appointments. Theatre throughput has improved over recent months, with average cases per list improving from 3.0 to 3.6. There is a need however, to ensure that this level of utilisation remains at this level or improves further. The improved performance of the ophthalmology area was noted: this is now achieving a significant level of income generation due to a number of productivity benefits. Activity has also increased by 15-20%, while capacity remains stable. Mrs Hunjan asked whether there was any additional income that could be generated from private patient treatment. She was advised that there are currently a modest number of private patients treated on a Saturday list. At present however there is no option to increase the private patient capacity due to the limitations under the constitutional arrangements applicable to acute trusts. Furthermore, there is currently no ability to offer private patients the private facilities that they require. In terms of performance against Mandatory Training and PDRs, attendance at the training has improved and 64% of PDRs have been completed. John Adler reported that South Birmingham PCT is tendering for ophthalmology services and the Trust is planning to submit a response to the invitation to tender. An appropriate pricing for the service needs to be carefully considered. Mr Trotman thanked Ms Olley, Ms Lemboye and Mr Power for the informative presentation.	
3 Minutes of the previous meeting	**SWBFC (6/08) 025**

The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held on 26 June 08.	
AGREEMENT: The minutes of the previous meeting were approved	
4 Matters arising from the previous meeting	**SWBFC (5/08) 017 (a)**
There were no matters outstanding. Two actions are due to be completed by the next meeting.	
5 Trust Board performance management reports	
5.1 2008/09 month 3 financial position and forecast	**SWBFC (7/08) 028** **SWBFC (7/08) 028 (a)** **SWBFC (7/08) 028 (b)**
The Committee was pleased to hear that an in-month surplus of £325k was achieved against a target of £220k. The year to date surplus was reported to be £904k. The big area responsible for the surplus is pay costs, which is linked to the current level of vacancies to some degree, together with an overly optimistic view of forecast appointments. Income is reported to be slightly ahead of plan, although as the year progresses a more accurate picture will be gained. It was noted that the 'Hotel Service Costs' and 'Other Costs' are broad categories of expenditure. 'Other Costs' comprises minor works and maintenance, plus provisions for doubtful non PCT debts. Main reasons for variance on 'Hotel Services' comprise staff uniforms and clothing, mainly in theatres As well as costs attributed to environment work and an amount allocated to catering provisions. Tony Wharram was asked to check where the unitary change for the BTC is represented. At a divisional level, operating units are performing well. The Medicine B position was noted to have improved significantly during June. The 'Operations and Corporate' division was reported to include reserves and provisions for uncertainty. It was agreed however that presentationally this group needed to be amended to clarify these elements. Sarindar Sahota suggested that it may be inappropriate to represent this group as contributing to the surplus. It was agreed that the revisions planned will address this issue. Capital spend was noted to have increased significantly, mainly as a consequence of spend associated with the pathology and neo-natal schemes. SIRG has approved the enhancement of retail catering facilities at City Hospital: the Archers Café will be refreshed and expanded and a Costa Coffee outlet will be installed into the BTC. The facilities will generate income for the Trust. Additional contributions to the high level of capital spend during the month include significant capital purchases and three changes to the capital programme. The £5m in respect of the purchase of the land for the new hospital has now been removed as a result of the change to the timescales of the project. Dr Sahota asked whether there were plans to purchase any further wheelchairs. Tim Atack reported that considerable expense had been given to the purchase of wheelchairs during the previous year. Trust's beds were also replaced, in recognition of the organisation's strong non recurrent financial position. Dr Sahota and Mrs Hunjan raised issues linked to their site walkabouts and meetings with staff. These need to be fed back to Rachel Stevens	

who will add these to the PEAT action plans. The balance sheet was noted to report that the cash position is below that planned, albeit marginally. Virtually all debts with UHB have been cleared in July, which has provided the Trust with £2.5m that had been outstanding. The Committee was informed that in line with the Chair's request to clarify the vacancy position, an amended analysis of WTEs is being developed. Mr Wharram distributed an initial analysis, showing that the overall gap between WTE budget and the actual position is less than 3% adverse variance. The largest number of outstanding vacancies lies with management and administration areas. Roger Trotman asked if the vacancies were currently being occupied by temporary staff. He was advised that this was the case to some degree, however bank staff are included within the payroll figures, but not the WTEs position. In terms of clinical areas, there are plans to address any gaps in most instances. John Adler agreed that the revised WTE analysis is useful. Mr Trotman asked for confirmation that an additional £100k is being gained from additional car parking capacity. He was informed that this figure was an annual budget change, rather than an in-month value. The additional income is being generated due to more stringent measures to manage car parking payments and barriers. It was confirmed that Speech Therapists previously supplied via an SLA with South Birmingham PCT had joined the Trust and are now positioned within Nursing and Therapies area. Gianjeet Hunjan commented that the bubble chart representing the divisional variances was a useful addition to the finance report. She asked if a recurrent and non-recurrent breakdown could also be included for budget changes.	
ACTION: **Tony Wharram to check where the unitary change for the BTC is represented within the financial reports** **ACTION:** **Tony Wharram to revise the Operations and Corporate inclusion within the financial report** **ACTION:** **All Non Executive Directors to send any issues raised by staff to Rachel Stevens** **ACTION:** **Tony Wharram to include breakdown of recurrent and non-recurrent budget changes in a future version of the report** **ACTION:** **Tony Wharram to present the WTE analysis as an appendix in future reports**	
5.2 Performance monitoring report	**SWBFC (7/08) 029** **SWBFC (7/08) 029 (a)**
Mike Harding presented the Trust's summary performance for the period May 2008. More than 50% of cancelled operations were attributed to the Ophthalmology area, although work is underway to address this issue, the financial impact of which is due to be presented at the next meeting of SIRG. The position has been heavily influenced by sickness levels and emergency VR admissions, which have resulted in the cancellation of a number of elective cases. Delayed transfers of care have	

reduced, particularly in respect of the previously reported issues concerning the performance of Sandwell Social Services. A dedicated team has been arranged by Sandwell Social Services to address the needs of the Trust. Stroke care data is now included in the report, which indicates the proportion of patients admitted who spend in excess of 90% of their hospital stay in an acute stroke unit. It was noted that the performance of the Trust is skewed by the rehabilitation phase offered by the Trust, which increases the overall spell of care. Further work is to be done to refine this indicator to take this factor into account. It was suggested that a breakdown of patients in the acute unit and the rehabilitation unit should be included. Isobel Bartram asked if there were any further stroke indicators required to support the Department of Health's operating framework, such as the length of time that patients wait for a scan. She was advised that there are and these will be incorporated in time. The Committee noted an improved performance in respect of GUM services. This performance is being maintained and enhanced to some degree. The Trust is still someway below the national performance of 99% for patients offered an appointment within 48 hours and the targets of 100% for patients offered and 95% of patients seen within 48 hours. Local clinics have been arranged to assist with meeting this target. Good performance with infection control was reported, with no post 48 hour bacteraemias reported for the third month in succession. Additional measures for this area are also now included, such as phlebitis rates and saving lives compliance. There was also good performance against RTT targets, with only one patient waiting in excess of 6 weeks in audiology. Orthotics waiting times were noted to be particularly encouraging. In terms of activity, performance has improved to reduce the level of underperformance against contract and the new to review ratio is improving. Year on year activity levels look to be consistently strengthening, although the position also reflects the higher levels of activity requested by the PCTs. Standard mortality rate data, obtained for Dr Foster is included in the report, although this is 2-3 months in arrears. Peer SHA data is also reported, which suggests that the Trust's performance is good. Contact centre data is included in the report. There is a concern over the current waiting times reported. Targets and a status report for this indicator will be devised for the next version of the report. Switchboard data will also be reported. Ambulance turnaround data was noted to be those reported by West Midlands Ambulance Service. This performance does not take into account the adjusted position when the waiting times are verified however. It was suggested that the Trust's verified performance should be included in future versions of the report. Sickness absence rates continue to decline and are now 4.11% against 4.26% in the previous month. There are still a large number of PDRs outstanding, although the number of returns has increased significantly. It was suggested that as the figure relates only to the non-medical workforce, consideration should be given to including junior doctors' data. Isobel Bartram asked whether there was an improved performance against attendance at Mandatory Training sessions. She was advised that a full review of	

Mandatory Training is underway and it is likely that a training passport will be implemented, proposing a suite of training tailored to the needs of the individual's role.	
ACTION: **Mike Harding to include verified Ambulance Turnaround data within future versions of the monthly performance report**	
6 Impact of the Global Energy Crisis on the Trust's Utility Costs	**SWBFC (7/08) 030** **SWBFC (7/08) 030 (a)**
Graham Seager and Rob Banks presented an overview of the impact of the energy crisis on the Trust's budget. The Committee was informed that impact is confined to gas and electricity; water is not affected at present by the energy crisis. All fuel spend is monitored on a month by month basis and a predicted tariff to the year end is predicted. The electricity contract currently in place covers the supply of energy until October 2008. After this a cost increase of 40% is expected, which has a financial impact of £1.2m this year and £1.6m next year.. The cost is likely to be determined from purchase from a variable market rate, rather than by a fixed term deal. The additional costs expected are likely to be met from uncommitted central contingency budgets. Volume of energy is also being considered and a number of schemes are planned over the next year to raise staff awareness in ways to reduce energy consumption. It is hoped that the Department of Health will fund some of these initiatives. Roger Trotman noted that the forecast outturn for energy and utilities is expected to be £8.7m. This includes rates. He also asked whether the possibility of reducing the ambient temperature had been considered and was advised that a good energy management system is needed to control temperature in this way. A balance between this cost saving and staff morale is also needed when considering this measure. There is the possibility that an energy manager may be appointed in the future to consider such issues. Tim Atack asked if the energy management workstreams were progressing as planned. It was confirmed that these were all on track for delivery by September. Mr Trotman thanked Mr Seager and Mr Banks for their report.	
7 Cost improvement programme (2008/09)	
7.1 CIP delivery report	**SWBFC (7/08) 031** **SWBFC (7/08) 031 (a)** **SWBFC (7/08) 031 (b)** **SWBFC (7/08) 031 (c)**
Tony Wharram reported that all CIP schemes are on track. This is reinforced by the Trust's financial position. The Committee was pleased to note that the schemes mainly address recurrent costs.	
8 Minutes of the Financial Management Board	**SWBFM (6/08) 026**
The minutes of the FMB held on 26 June 08 were noted by the Committee.	

9 Strategic Investment Review Group	**SWBSI (7/08) 001** **SWBFC (7/08) 032**
The Committee noted the minutes of the SIRG held on 17 June 08 and the actions arising from the meeting held on 15 July 08.	
10 Any other business	**Verbal**
John Adler reported that the Trust's official 2007/08 rating by the Healthcare Commission is due to be released in October. Quarterly divisional reviews have recently been completed, the focus of which has been mainly on quality and service development.	
11 Details of next meeting	**Verbal**
The next meeting is planned for 28 August 2008 at 1430h in the Ground Floor Meeting Room, Sandwell Hospital.	

Signed .....

Print .....

Date .....

MINUTES

Sandwell and West Birmingham Hospitals NHS Trust

Audit Committee – Version 0.3

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 19 June 2008; 1600h

Members

Mrs G Hunjan [Chair]
Mr R Trotman
Ms I Bartram
Dr S Sahota

Apologies

Cllr B Thomas
Prof D Alderson
Mr J Adler

In Attendance

Ms H Dempsey
Mr M McDonagh
Mrs S Davis
Mr R White
Mr R Kirby
Mr G Seager
Mrs J Kinghorn
Mr T Atack
Ms K Dhami
Mr C Holden
Mr P Smith
Mr M Watkins
Mr T Wharram

Secretariat

Mr S Grainger-Payne [Minutes]

Minutes	**Paper Reference**
1 Opening comments	**Verbal**
The Chair welcomed all to the meeting and introductions were given.	
2 Apologies for absence	**Verbal**
The Committee received apologies from Cllr Bill Thomas, Professor Derek Alderson and John Adler.	
3 2007/08 statement on Internal Control	**SWBAC (6/08) 018**
Robert White presented the draft Statement on Internal Control (SIC), which outlines the measures in place to manage risk within the Trust to a reasonable level. The SIC also discussed the review of the effectiveness of the system of internal control and highlighted the Trust's governance framework. The Committee was pleased to note that the SIC reported that internal audit gave an opinion of overall significant assurance on the Trust's system of internal control, an improvement on limited control given for 2006/07.Non-compliances with the HCC's Core Standards were also presented in relation to standards concerning safe systems for managing risk associated with the acquisition and use of medical devices, equality and diversity impact assessment and compliance against the requirement to undertake	

an annual appraisal for all staff. Improvement plans to address the shortfalls are underway. The Trust is also required to disclose any issues concerning the protection of patient data, therefore the Trust reported the single loss of patient data residing in a portable computing device within the SIC. The Audit Committee was asked for its approval to recommend acceptance of the Statement on Internal Control to the Trust Board. Approval was given.	
AGREEMENT: The Audit Committee agreed to recommend the acceptance of the Statement on Internal Control to the Trust Board	
4 2007/08 annual accounts	**SWBAC (6/08) 016** **SWBAC (6/08) 016 (a)**
Robert White presented an overview of the annual accounts. The Trust's income and expenditure surplus reduced to £6,524k as a result of some small movements around decisions not to capitalise some expenditure, a decrease in the provision for doubtful debts, reduction in interest payable and an adjustment to the audit fees. Income increased by £2m in respect of a change in the treatment of doubtful debts for Foundation Trusts which was previously offset against income but is now treated in the same way as non-NHS doubtful debts. The Committee was pleased to learn that the Trust's performance for 2007/08 satisfied all statutory duties. The Trust's cumulative breakeven position was presented, which takes into account the requirement to complete the approved recovery plan by repaying prior year deficits by the end of the year. The performance of the Trust therefore marks the end of the formal recovery of the organisation. In terms of the Trust's Capital Resource Limit (CRL) an undershoot of £1,752k was achieved, of which half relates to the change in accountancy treatment of digital hearing aids. The Committee was asked for its approval to recommend adoption of the accounts to the Trust Board. Approval was given. The Chair thanked Mr. White and team for their hard work in delivering a successful outcome to the year end accounting process. Mr. White was asked to cascade this gratitude to his team	
ACTION: Robert White to communicate the Audit Committee's thanks for the hard work to ensure the timely delivery of the annual accounts to the finance team **AGREEMENT: The Audit Committee agreed to recommend the adoption of the annual accounts for 2007/08 to the Trust Board**	
5 2007/08 audit memorandum	**SWBAC (6/08) 017**
Mike McDonagh reported that the audit process for the year had gone very well	

and thanked Robert White and team for their co-operative approach, which had ensured that all deadlines were met. He also observed that the quality of the paperwork had been very high which ensured that the audit had been completed without unnecessary delay and minimised the need to revisit information provided. The audit memorandum was presented which summarised the outcome of the audit and provided assurance that the statutory audit requirements had been successfully fulfilled. The Committee was pleased to hear that the auditors proposed to give an unqualified audit opinion when the key financial statements were due to be signed on 20 June. No material adjustments had been made in connection with the accounts. In terms of the use of resources, the Auditors Local Evaluation suggested indicative scores of 3 for financial standing and financial reporting themes, although these scores were noted to be subject to Audit Commission quality control review. No issues were reported in connection with public interests during the year. Fraud was also considered and it was concluded that the Trust has appropriate arrangements in place for the prevention and detection of fraud and corruption. The auditors' fees were as suggested in the audit plan. A number of recommendations have been made, although these are of low priority. The Chair noted a couple of presentational errors which Mr. McDonagh offered to amend. Sue Davis asked if there is an expectation for continued improvement, particularly in terms of ALE scores for the coming year. Helen Dempsey reported that a score of 4 across the various ALE themes is not a requirement that may hinder the approval of the Foundation Trust status application if not attained. Should the Trust wish to aspire to these scores however evidence of continued embedding of the systems and processes implemented this year would be needed. The Committee was also recommended to consider the cost impact of aiming for ALE level 4. Robert White agreed and suggested that additional evidence of partnership working and a networking strategy would also be needed to support a higher score in some themes. Mike McDonagh remarked that the process by which the evidence to support the assessment was gathered had been labour intensive and therefore suggested that the responsibility for the collation of the evidence should be reconsidered. Mr. White reminded the Committee that Trust Secretary, Simon Grainger-Payne would be overseeing the collection of evidence for the current financial year. In terms of the integrity of the accounts, Ms. Dempsey commented that it would be unlikely that a situation would be reached whereby there would not be a need to clarify any detail in the accounts, therefore to achieve the production of a set that would not be questioned to any extent by the auditors was highly ambitious. The Chair thanked KPMG representatives for their work with the Trust.	
6 Letter of Representation	**SWBAC (6/08) 019**
Robert White presented the letter of representation, fulfilling the Trust's obligation to confirm matters such as that the Trust has disclosed all material related party transactions, that the Trust is not aware of any non-compliance with laws and	

regulations that would affect the accounting opinion and to acknowledge that the Trust is responsible for the fair presentation of the financial statements. The Committee was asked for its approval to recommend that the signing of this letter should be recommended to the Trust Board. Approval was given.	
AGREEMENT: The Audit Committee agreed to recommend the signing of the Letter of Representation to the Trust Board	
7 BSIAC – Merger with CW Audit	**SWBAC (6/08) 015**
Mark Watkins presented an update on the proposed merger of Birmingham and Sandwell Internal Audit Consortium (BSIAC) with Coventry and Warwick Internal Audit (CW audit). Background to the formation of BSIAC was given. Following a review of BSIAC and CW audit, it was recommended that in view of the similarities and proposed benefits, that the two organisations should merge to form one consortium. It is anticipated that the merger will create a much stronger organisation, making better use of resources and skills in addition to providing staff with greater opportunities for career progression and creating increased ability to invest in new services. A business case is being prepared to outline the financial impact of this merger, however both parties have agreed to the plans in principle and it is proposed that Warwickshire PCT will be the host organisation on the basis of the size of the existing workforce. The Audit Committee was asked to approve the proposed merger and associated project plan. Robert White is positioned to oversee the implementation of the plan. Formal agreement from Warwickshire PCT will be sought once approval has been gained from SWBH NHS Trust. The staff consultation process will also begin ready for the transfer. Roger Trotman observed that the turnover of BSIAC in comparison to that of CW audit is forecast to be much less for the current financial year. In relation to this he suggested that the merger should eliminate any competition between the two organisations and therefore there was an expectation that costs per member of staff may be more favourable. Mr. Trotman also sought reassurance that any potential issues concerning planned TUPE transfer process were identified and in hand. Mark Watkins confirmed that these issues were built into the business case currently being constructed. Sue Davis recommended that there should be greater clarity as to the governance arrangement surrounding the merger, for instance the notice period of the staff consultation. Greater understanding of the size of the group and the geographical representation of the consortium is also needed. She stressed that the focus of the organisation should be on quality and value for money rather than a single focus of costs per member of staff. Isobel Bartram enquired if there were any risks associated with the plans. Robert White suggested that the current flexibilities of the in-house internal audit team may be reduced, although contingency audit days have been built into the audit plan to take this into account. The benefits for staff development and shared skill base are clear however. The Committee was asked for its approval to recommend that the Trust Board gives its support to the merger. Approval was given, providing the caveats raised are satisfied in the business case.	

AGREEMENT: Subject to a number of caveats, the Audit Committee agreed to recommend that the Trust Board gives its support to the merger of BSIAC and SW audit	
8 Any Other Business	**Verbal**
There was none.	
9 Details of Next Meeting	**Verbal**
The next meeting of the Audit Committee is planned for 11 September 2008 at 1000h in the Executive Meeting Room, City Hospital.	
10 Closing Remarks	**Verbal**
The Chair thanked all for their contributions to the meeting.	

Signed .....

Print .....

Date .....

MINUTES

Sandwell and West Birmingham Hospitals NHS Trust

Governance and Risk Management Committee – Version 0.2

Venue Executive Meeting Room, City Hospital **Date** 24 July 2008; 1400h – 1600h

Members

Ms I Bartram [Chair]
Mr R Trotman
Prof D Alderson
Mr J Adler
Mr R White
Mrs R Stevens
Ms K Dhami

Apologies

Mr D O'Donoghue
Ms D McLellan [HoBtPCT]
Dr K Sidhu [Sandwell PCT]

Secretariat

Mr S Grainger-Payne [Minutes]

In Attendance

Mr P Finch [Items 1 - 4 only]
Mr C Holden [Items 1 - 5 only]
Mrs R Gibson [Items 1 - 6 only]

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
The Committee received apologies from Donal O'Donoghue, Denise McLellan and Khesh Sidhu.	
2 Minutes of the previous meeting	**SWBGR (5/08) 010**
The Committee approved the minutes of the meeting held on 29 May as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**Verbal**
It was agreed that all matters had been completed or were covered by items on the agenda.	
4 Security annual workplan	**SWBGR (7/08) 011** **SWBGR (7/08) 011 (a)**
Peter Finch presented the security management workplan for 2008/09. It was suggested that a regular progress report against the workplan should be presented to the Governance and Risk Management Committee. An annual report	

of work achieved is to be presented at the May 2009 meeting. Roger Trotman asked what progress had been made on developing the new Trust ID card policy and observed that there did not seem to be any mechanism for ensuring that staff return Trust material when they leave the organisation. Mr Finch advised that the Trust ID card policy is due for completion by March 2009. He provided assurance that staff leaving the Trust are removed from the car park pass and access pass databases at the end of each month. Those staff placed on gardening leave are also removed, should a risk assessment on the individuals suggest that this would be appropriate. Colin Holden added that the termination form completed by the manager of the member of staff due to leave specifically asks for any Trust equipment to be returned. It was suggested that there may be a need to reinforce this requirement with managers. In terms of security, Mr Finch reported that there is a difference in approach between City and Sandwell hospitals. At Sandwell, portering takes a responsibility for security, whereas dedicated security resources are in place at City Hospital. Lapses in security are reported through the usual incident reporting mechanism. Derek Alderson queried where IT security breaches are reported. He was advised that this would be through information governance reports. An Information Governance Manager has been recruited who will handle these cases. Ruth Gibson suggested that CNST requirements in relation to security should be included within the workplan and progress reports.	
ACTION: **Peter Finch to present a quarterly update on progress against the security workplan and present to the Governance and Risk Management Committee** **ACTION:** **Peter Finch to include CNST requirements in relation to security within the security annual workplan**	
5 Quarter 1 SABS report	**SWBGR (7/08) 017** **SWBGR (7/08) 017 (a)**
The quarterly SABS report was presented by Colin Holden. The report contains details of all SABS alerts sent to the Trust Health and Safety Manager. During the past year c. 150 alerts have been received, many of which have long term requirements and are resource intensive. In terms of those reported as being outstanding, the Committee was reassured that in many cases actions have been taken, however this has not been formally communicated to the Health and Safety Manager and therefore actions appear to still be outstanding. A number of concerns with the report and process for managing the alerts were raised. It was suggested that an introduction to the report and narrative of the key points should be included in future versions. In relation to the process, it was agreed that an escalation process is required to ensure that actions required are completed. This escalation should be worked up in liaison with Tim Atack to ensure it has application at a divisional level. Roger Trotman noted the variation in timescale for implementation of actions plans to address the alerts. He was informed that a suggested two week implementation either indicates that it is regarded as a matter quickly addressed by implementing a simple action plan, otherwise it indicates that it is a serious issue that needs to be addressed without delay. One of the Trusts suppliers was noted to be mentioned a number of times in the alerts, which suggests	

that the performance of the supplier may need to be reviewed. In summary it was agreed that a complete review of the process was required and the report to the next meeting should take into account comments made and highlight progress against the various action plans. Colin Holden agreed to lead this piece of work. He will present the revised system to the Executive team prior to updating the Committee at the next meeting.	
ACTION: **Colin Holden to lead work on undertaking a root and branch review of reporting and management of health and safety alerts** **ACTION:** **Colin Holden to present the revised proposals for reporting and management of health and safety alerts at a future Executive team meeting and the September Governance and Risk Management Committee**	
6 Risk Management	
6.1 Annual risk report	**SWBGR (7/08) 016** **SWBGR (7/08) 016 (a)**
Ruth Gibson presented the annual risk report. She advised that future reports will also include claims data and complaints information. New standards for maternity have been released for CNST, against which the Trust will be assessed from 2009. Progress against these will be reported on a quarterly basis. Over the last year 6552 incidents have been reported. An 'amnesty' of incident forms has been undertaken across the Trust and a number of forms are still anticipated, therefore the annual figure may increase slightly. There has been a slight decrease in Health and Safety incidents and an increase in clinical incidents during the year. The PPH threshold to trigger a red incident has now been increased from 1000ml to 2000ml, although this does not prevent any cases being reported if deemed a serious situation that needs to be flagged. Cases of *C difficile* inclusions on death certificates are also now included in the incidents reported. Roger Trotman questioned where the responsibility for medication errors was positioned. He was advised that these incidents are mainly at a ward level, however very few incidents were reported during the year that are attributed to medication errors. The Medicines Safety Committee, which meets quarterly also reviews any incidents reported and a list of issues is also held by pharmacy. It was noted that a recent charitable funds request should support the effort to reduce falls within the Trust, although as this is a recent inclusion to the information it may elevate the overall incident statistics to some degree. Mrs Gibson was asked to distinguish those falls that result in serious injury within the next report and consider reporting falls in relation to thousands of bed days. The cumulative incident totals, currently reported in histograms also requires a piece of narrative to explain the seriousness of the situation. Mrs Gibson was thanked for her informative report.	
ACTION: **Ruth Gibson to highlight falls that result in serious injury within the next risk report**	

6.2 Quarter 4 risk report	**SWBGR (7/08) 016** **SWBGR (7/08) 016 (a)**
The Committee noted the report, which had been previously presented to the Trust Board.	
7 Clinical Audit forward plan	**SWBGR (7/08) 012** **SWBGR (7/08) 012 (a)**
Kam Dhami presented the clinical audit forward plan and reported that much of the audit schedule is prescribed by national guidance and bodies such as CNST, NCEPOD and NICE. It has been proposed that reporting period of the schedule be amended to two years to allow sufficient time for audits to be fully completed should it be required. It was noted that the Saving Lives and Hand Hygiene audits are ongoing and therefore the review period should be monthly. Essence of Care was also noted to be an annual audit. Derek Alderson observed that there are a number of national audits that are not within the Trust's authority to close, therefore although these should continue to be included in the report, they should be distinguished from audits within the Trusts remit to progress to closure. The process for construction of the schedule was questioned. It was reported that there is a formal approval process where divisions are consulted and the plan is then presented to the Governance Board for approval.	
8 Mortality/morbidity report	**SWBGR (7/08) 013** **SWBGR (7/08) 013 (a)**
The Committee was asked to receive the report and to agree that it should be presented more fully at the September meeting when the mortality and morbidity steering committee will have met. In summary, the report advises that mortality and morbidity meetings are not happening as routinely as desired across the Trust. It is the intention that the data in connection with mortality and morbidity are included within divisional reviews that are now occurring regularly. John Adler remarked that there is now a greater focus on this information given the closer scrutiny of this indicator as a result of the recent Darzi review and Monitor's suggestion that SMR information should be included in progress reports. SMR data is now included within the monthly performance monitoring report.	
9 Governance and Risk Management Committee reporting cycle	**SWBGR (7/08) 014** **SWBGR (7/08) 014 (a)**
Simon Grainger-Payne presented the revised annual workplan and reporting cycle for the Governance and Risk Management Committee. The cycle now includes details of reports being presented to the Governance Board and Trust Board. The ideal sequence of reports being presented is firstly to the Governance Board, then to the Governance and Risk Management Committee and finally to Trust Board, however due to the bimonthly nature of the Governance and Risk Management Committee cycle and the cancellation of the August Trust Board it was noted that this is not always possible. It was suggested that the appropriate level of detail reported at the Governance and Risk Management Committee needs to be considered and a balance	

reached that minimises any duplication of reporting, yet provides enough information to assure the committee that risk and governance is being adequately managed in the Trust. Rachel Stevens requested that infection control be included in the cycle**.**	
ACTION: **Simon Grainger-Payne to amend the reporting cycle/annual workplan of the Governance and Risk Management Committee to include infection control**	
10 Any other business	**Verbal**
Rachel Stevens provided an update on the recent ward review exercise. This work has been undertaken in conjunction with the nursing objectives which have been set recently. The review process is largely based on self assessment against a number of criteria such as discipline and grievance, infection control and sickness absence. The outcome of the exercise has revealed that there is a need for wards to have access to a greater amount of information: sickness absence is a particular issue. Capacity and expertise to handle mental capacity issues is also a problem, although this is being addressed at an executive level. Day to day communications on wards is a further issue that needs to be addressed, maybe through increasing the accessibility of consultants. As the ward review process embeds, the review tool will be refined and an accreditation process implemented to recognise good ward performance. It was suggested that it might be appropriate to give the Chair's award to the best performing wards. It was agreed that the work is an excellent initiative.	
11 Details of next meeting	**Verbal**
The next meeting of the Committee is scheduled for 18 September 2008 at 1400h in the Executive Meeting Room at City Hospital.	

Signed ……

Print ……

Date ……