Working towards better health for all

Annual Report 2003/04
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Foreword by the Chairman and Chief Executive

This annual report describes how, in our second full year, we have made progress as a Strategic Health Authority in delivering on the six key objectives we set out in our business plan for 2003/04:

- improving health and reducing inequalities;
- promoting patient-centred care;
- maximising patient and public involvement;
- developing a first-class workforce;
- ensuring high quality clinical care;
- increasing value for money.

In particular, the report underlines the critical importance of effective collaboration between all parts of the NHS, and between the NHS, local authorities, the voluntary sector and our diverse communities.

We should like to express our thanks to all the staff - both within the SHA and our many partner organisations - who have made possible sustained good performance in meeting key national targets.

While we continue to be ahead of national targets on reducing waiting times for treatment, we recognise the enormous task ahead of us in addressing some of the major health problems which inevitably impact on an area with historically significant levels of deprivation. That is why our priorities for the future include tackling health inequalities, establishing a healthy start to life, empowering people to make decisions about their health, and improving services for people with chronic disease.

We have worked closely with local health economies on a range of innovative ideas for service improvement. We have also supported major service reviews in the health economies of The Black Country, North Birmingham and South East Staffordshire and across Sandwell and Heart of Birmingham. These reviews have developed plans for new ways of providing services that will bring care closer to home.

A key element of our work over the past year has focused on developing a strategic framework for the whole of our area. Following extensive discussion with our partners, we have recently published A Wider View, a consultation document which sets out our strategic priorities for 2004 to 2010.

Finally, this report looks at how we have developed our own organisation to enable us to discharge our statutory functions as effectively as possible. During the year, the SHA received Improving Working Lives accreditation, established a Race Equality Scheme and prepared for the transfer of the staff of the Birmingham and The Black Country Workforce Development Confederation in April 2004.

It has been a significant year for the NHS in Birmingham, Solihull and The Black Country, and for the SHA. We look forward to continuing to work with all our partners in 2004/05 to deliver the ambitious agenda we have proposed in A Wider View.

Elisabeth Buggins, Chairman

David Nicholson CBE, Chief Executive
Birmingham and The Black Country Strategic Health Authority is one of 28 SHAs in England. Established in 2002, it serves as the local headquarters of the NHS and works with 12 Primary Care Trusts and 13 NHS Trusts to ensure that the health needs of 2.4 million people are met. We have four main functions:

- to set the strategic direction for the NHS in our area;
- to ensure delivery on national targets and local ambitions;
- to support service improvement and learning from best practice;
- to develop the capacity of the NHS in our area in terms of its workforce, leadership, infrastructure and information and management technology.

This annual report records the progress we have made during 2003/04 and highlights the work undertaken in that year to develop a strategic framework for improving health and health services in Birmingham, Solihull and The Black Country.
Successful strategies for health improvement and reducing health inequalities are likely to be those which address lifestyle and the wider determinants of health, including employment, housing, education and the environment.

Local strategic partnerships should therefore become the means by which PCTs and other agencies work together to tackle the root causes of health inequalities. This is particularly important in our area, as public health research shows that health inequalities have been widening, despite overall improvements in the health of the population.

To reflect our strong commitment, as a Strategic Health Authority, to making progress on this front, in 2003/04 we made health inequalities a key focus of our annual reviews of local health economies in Birmingham, Solihull and The Black Country.

We have backed innovative measures at a local level to address health inequalities, including smoking cessation programmes and promotion of breast-feeding.

We have also supported initiatives designed to target new investment at the most vulnerable sections of our population, including pilot schemes in Walsall and Eastern Birmingham that aim to improve the management of chronic disease in the community. We have worked with PCTs and NHS Trusts to develop new models of care for heart failure patients and those with chronic obstructive pulmonary disease.

During the year, we appointed a public health specialist to ensure that key stakeholders and the public are well informed about the sources of health inequalities in Birmingham, Solihull and The Black Country - and the progress being made in reducing them.

Ways of reducing health inequalities have been major factors considered by the Strategic Health Authority in appraisal plans for the development of state of the art primary care facilities through Local Improvement Finance Trusts (LIFTs).
We have worked to support greater patient choice, with the aim of ensuring that services are better tailored to the needs of their users.

In particular, we have been preparing to implement the requirement - ahead of national timescales wherever possible - that all patients who need non-emergency surgery should routinely be offered a choice of hospitals.

Given that over 90% of patient contacts with the NHS are in primary care, we plan also to investigate the possibility of patients being offered choices when they go for diagnostic tests or the monitoring of chronic diseases.

We are determined that the introduction of the Choice initiative in Birmingham, Solihull and The Black Country will reduce current inequalities in access to services and health outcomes.

We are working closely with the voluntary sector to ensure that patients, especially those from traditionally ‘hard to reach’ groups, are better informed about the options available to them.

In an effort to promote integrated working and an improvement to patient care pathways, we have been encouraging our local health economies to adopt the Medic to Medic information programme which, by agreement between GPs and hospital doctors, provides a template for diagnostic investigations and referrals for a given set of symptoms.

Already, Dudley PCTs and the Dudley Group of Hospitals have proved to be national pathfinders in the use of this approach.

We have also worked with local NHS organisations to evaluate an information system, linked to managed care, which provides patients with simplified, evidence-based information to support informed choice.
In August 2003, we commissioned MORI to undertake a comprehensive survey of public attitudes towards choice in health care.

Using both telephone interviews and discussion groups, MORI researchers spoke to a wide range of people, including frequent NHS users, parents, carers and people from black and minority ethnic communities.

Results from the survey show that the 'one size fits all' approach to health care delivery will not meet people's needs and expectations. Half of those polled say they are not given enough choice as an NHS user.

This information, together with the feedback from patient surveys conducted across Birmingham, Solihull and The Black Country, has informed our approach to the strategic framework on which we launched consultation this summer.

During the year, we supported PCTs and NHS Trusts with guidance on their statutory duties to involve and consult patients, their carers and the public in the planning and delivery of health services.

We also appointed two new Patient Experience and Public Involvement Managers to provide support to NHS Trusts across our area in improving the patient experience of care and engaging with the public on future service development.

We liaised closely with the six local authorities’ Health Overview and Scrutiny Committees in our area on proposals for major service change and reconfiguration and signed an agreement with them about the framework for future joint working.

In the forthcoming year, we will focus on developing a tool to enable us to measure effectively the way Trusts use feedback from patients about their experience of care in order to improve service delivery. Patient and Public Involvement networks will be strengthened through a series of focused learning events.
Developing a first-class workforce

A review of stakeholders’ views about future arrangements for education and training in Birmingham, Solihull and The Black Country highlighted the need for greater strategic direction for investment in these key activities.

During 2003/04, the SHA supported the NHS in Birmingham, Solihull and The Black Country in achieving targets for the take up of individual learning accounts and NVQs by non-clinical staff. This was accompanied by significant investment in continuing professional development to enhance skills and competencies across a range of clinical disciplines.

Greater emphasis was given to the development of ‘healthcare leaders’, with a particular focus on harnessing the talents of junior and middle managers and on providing the necessary support to enable staff from black and minority ethnic groups to advance their careers.

We worked closely with NHS Trusts and PCTs to ensure that our local health economies met their targets for the recruitment and retention of staff needed to deliver plans for expanding and improving services.

During the year, the target for additional consultants was achieved and, in collaboration with the Modernisation Agency, we renewed our emphasis on the recruitment of GPs.

Work was undertaken to pave the way for the implementation of the new GP contract on 1st April 2004 and to prepare for the new consultant contract.

Workforce plans for each health economy in our area are due for publication during 2004. They are intended to show where and how the NHS needs to develop skills and recruit staff in order to deliver modern health services in line with national and local improvement strategies.

We have also been working on proposals for the implementation of Agenda for Change, which has implications for the pay structure and terms of service of a significant proportion of NHS staff. An SHA project manager has been appointed to lead and co-ordinate the process.

Key achievements

- The SHA supported PCTs and NHS Trusts in ensuring compliance with the EU Working Time Directive for junior doctors’ hours.
- We supported PCTs in implementing the new general medical services contract.
- Improving Working Lives - practice status was achieved by the Strategic Health Authority and by all Primary Care Trusts and NHS Trusts.
- Consultant recruitment targets were met, with the appointment of an additional 88 specialist doctors, bringing the total to 1,533 as at March 2004.
- 68 additional GPs and 188 practice nurses were recruited to help expand primary care services.
- A Higher Education Strategic Partnership was established between the NHS and local universities to ensure the effective development of skills and knowledge required to deliver modern, high quality care.
In January 2004, the Strategic Health Authority established a Clinical Governance Committee to provide leadership across the NHS in Birmingham, Solihull and The Black Country in developing robust and effective systems for ensuring high quality patient care.

The work of the Committee has included ensuring an effective response by the SHA to independent reviews and investigations (e.g., maternity services in Wolverhampton).

It has also co-ordinated SHA support to PCTs and NHS Trusts in preparing for reviews of their performance by the Healthcare Commission, and has ensured that they make progress in implementing action plans arising from those reviews.

We have put processes in place to support the implementation of the main National Service Frameworks for Cancer, Coronary Heart Disease, Diabetes, Children and Older People.

We have worked closely with Primary Care Trusts on preparing for the introduction of the new contract for GPs being introduced in stages during 2004. In particular, we have focused on the need to meet the requirements of the Quality and Outcomes Framework that forms an integral part of the contract.

We have also been working to ensure that adequate arrangements are in place for providing out of hours cover to patients whose practices (covering about two thirds of our population) have decided to opt out of that responsibility.

In collaboration with PCTs across our patch, we are now seeking a provider of an ‘out of hours’ single call access for the public wishing to obtain advice or treatment.
Increasing value for money

Primary Care Trusts receive funding from the government according to a national formula. Over time, the Department of Health is seeking to move all PCTs towards their ‘capitation target’, which reflects local population size, make up and needs. Currently, eight of our 12 PCTs are below their target level of funding. We have raised this with the Department of Health in order to ensure that all our local health economies receive their fair share of nationally available resources for the NHS.

We seek to ensure that NHS capital investments in our area demonstrate a good rate of return in terms of the effective delivery of high quality health care and their impact on the health of our population. We have therefore had a significant role to play, for example, in appraising proposals to establish Local Improvement Finance Trusts (LIFTs) to modernise the infrastructure of primary care in the Authority’s area and provide innovative ways of delivering ‘one stop’ services.

The major capital schemes currently approaching completion in our area include:

- an £18 million scheme at the Royal Orthopaedic Hospital in Birmingham to expand capacity for elective surgery;
- a £57 million investment in new cardiac surgery and cardiology facilities on the New Cross Hospital site in Wolverhampton, which will help to address the historic shortfall in heart surgery capacity in The Black Country;
- an £11 million scheme to provide a brand-new ambulatory care centre at Good Hope Hospital in Sutton Coldfield;
- a £30 million treatment centre at the City Hospital site in west Birmingham.

We have been directly involved in work to improve the efficiency of Pan-Birmingham sterile supply services, ensure cost-effective prescribing in primary and secondary care, and make intelligent use of benchmarking and comparative information on the performance of our local health economies.

Key achievements

- Both the Sandwell Local Improvement Finance Trust (LIFT) and Birmingham & Solihull LIFT have concluded financial negotiations for their respective projects, opening the way for public-private partnerships to deliver major improvements in the quality of local facilities for primary care.

- Approval was given to a ‘state of the art’ emergency centre at Sandwell District Hospital.

- As at March 2004, 91.6% of GP practices were able to offer an appointment with a doctor within 48 hours and 91.3% with a primary care professional within 24 hours.

- As at March 2004, only 365 patients were waiting over 6 months for in-patient care and no patient was waiting over 9 months for in-patient treatment.
Developing our role

Meeting our key targets

Along with all other Strategic Health Authorities across the country, we were assessed for our performance against a set of 15 key indicators - all of which we achieved during 2003/04.

Figures for NHS services in Birmingham, Solihull and The Black Country (see table opposite) show that, overall, they met targets for the time patients wait to obtain appointments with a GP, primary care professional or hospital consultant, to get treatment in an accident and emergency department, or to be admitted to hospital for surgery.

Targets were also met in relation to the number of day cases, in-patient admissions and out-patient appointments booked in advance (i.e., patients being given a time and date at the outset, so that they know well in advance when to expect to attend hospital).

These results maintain our position as one of the best performing SHAs in the country, according to the Department of Health’s key indicators.

How we did on 15 performance indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual outcome</th>
<th>Was the target achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance calls</strong>: at least 75% of category A (most urgent) calls responded to in 8 minutes</td>
<td>76%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>A&amp;E waiting times</strong>: at least 90% of patients waiting fewer than four hours</td>
<td>92%</td>
<td>Yes</td>
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<tr>
<td><strong>GP waiting times</strong>: at least 90% of patients able to see a GP within 2 working days</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Primary care professional waiting times</strong>: at least 90% of patients able to see a PCP within 1 working day</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Out-patient waiting times</strong>: maximum 17 week waiting time for new out-patient referrals</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Out-patient waiting times</strong>: percentage of new out-patients waiting less than 13 weeks</td>
<td>88%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>In-patient waiting times</strong>: maximum 9 month waiting time for in-patient treatment</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>In-patient waiting times</strong>: percentage of patients waiting under 6 months</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total numbers on the in-patient waiting list</strong>: continued reduction in numbers waiting</td>
<td>-2%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Booking</strong>: at least 66% of in-patient and day case appointments booked</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Booking</strong>: at least 66% of out-patient appointments booked</td>
<td>88%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Booking</strong>: percentage of day cases booked</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Cardiac surgery waiting times</strong>: maximum 6 month waiting time for revascularisation</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Finance</strong>: achievement of financial balance</td>
<td>Financial balance</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Developing our role

Improving performance across the health economy

One of our roles, as the local headquarters of the NHS, is to ensure that our services are meeting the standards expected of them. Star ratings of our 12 PCTs and 13 NHS Trusts in 2003/04 have been published by the Healthcare Commission. They show that we sustained and improved on the good performance achieved in secondary care during the previous year. Of particular note was the rise from one to three stars by the Dudley Group of Hospitals NHS Trust, while Good Hope Hospital NHS Trust went from zero to one star in line with its franchise plan.

Significant improvements were also achieved in primary care, with two PCTs (Solihull and Rowley Regis & Tipton) becoming the first in our patch to achieve three stars. Compared with results for the previous year, two thirds of our PCTs have had their rating moved up from one star to two stars.

<table>
<thead>
<tr>
<th>Star ratings for PCTs and NHS Trusts</th>
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<tbody>
<tr>
<td><strong>Primary Care Trusts</strong></td>
</tr>
<tr>
<td>2003/04 rating</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Rowley Regis and Tipton PCT</td>
</tr>
<tr>
<td>Solihull PCT</td>
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<tr>
<td>Dudley Beacon and Castle PCT</td>
</tr>
<tr>
<td>Dudley South PCT</td>
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<tr>
<td>Eastern Birmingham PCT</td>
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<tr>
<td>North Birmingham PCT</td>
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<tr>
<td>Oldbury and Smethwick PCT</td>
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<tr>
<td>South Birmingham PCT</td>
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<tr>
<td>Walsall Teaching PCT</td>
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<tr>
<td>Wolverhampton City PCT</td>
</tr>
<tr>
<td>Heart of Birmingham Teaching PCT</td>
</tr>
<tr>
<td>Wednesbury and West Bromwich PCT</td>
</tr>
<tr>
<td><strong>Mental Health Providers</strong></td>
</tr>
<tr>
<td>2003/04 rating</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Birmingham and Solihull Mental Health NHS Trust</td>
</tr>
<tr>
<td>Sandwell Mental Health and Social Care NHS Trust</td>
</tr>
<tr>
<td>Dudley Beacon and Castle PCT</td>
</tr>
<tr>
<td>Walsall Teaching PCT</td>
</tr>
<tr>
<td>Wolverhampton City PCT</td>
</tr>
</tbody>
</table>

Note: Stars indicate performance: one to three stars, zero to zero stars.
Developing our role

Major service reviews - bringing care closer to home

During the year, we supported major reviews of the way health needs are met in The Black Country, North Birmingham and South East Staffordshire, and Sandwell and West Birmingham.

Whilst local circumstances differ across these areas, a broad theme which emerged from all the reviews was the need to bring care closer to home wherever possible.

The Black Country Review - Better Health by Design

This review looked at how, in the long-term, health services should be designed to meet the needs of people in Dudley, Walsall and Wolverhampton.

Led by Professor John Brooks, a Non-Executive Director of the Strategic Health Authority, and with wide representation from within and outside the NHS, the review team undertook extensive public consultation to determine the aspirations and concerns of local residents.

The team concluded that delivery of a patient-centred model of care would require substantial improvements of community-based services against a background of lower than national average levels of primary care. Other key conclusions focused on the need for:

- case management of older people to reduce hospital admissions and maintain independence;
- planning the discharge of hospital patients from the moment of their admission or sooner;
- centralisation of some elements of specialised services, but with out-patient and rehabilitation services being provided more locally;
- provision of 24-hour a day, seven day a week emergency services in the community;
- combined or co-ordinated emergency services to ensure that the sickest patients are treated first.

Importantly, the recommendations emerging from the review have been jointly agreed by local PCTs and NHS Trusts who, with the support of the Strategic Health Authority, can now work towards the goal of bringing care closer to home.

The review also provided the foundation for taking forward major capital developments in Walsall and Wolverhampton, and for the implementation of local LIFT (Local Improvement Finance Trust) programmes to improve primary care facilities in the community.
North Birmingham and South East Staffordshire Review - Working Better Together

Also during the year, we set in motion a second major review to look at the future of health care in North Birmingham and South East Staffordshire.

Again, there was considerable emphasis on extensive consultation with key local stakeholders. The report of the review concluded that improving local services and increasing efficiency depended on developing:

- services that facilitate self-care by patients with chronic conditions, with greater support from health and social care professionals in the community and rapid access to diagnostic tests and specialist advice where necessary;

- services that offer rapid access to urgent, out of hours primary care through ‘urgent care centres’, backed up by enhanced A&E and medical assessment at Good Hope Hospital;

Sandwell and West Birmingham - Towards 2010

We have worked with the PCTs and NHS Trusts in Sandwell and West Birmingham to develop a strategic vision for the future of services in that part of our patch.

A Strategic Outline Case for the development of local primary and secondary care has been agreed. Further work, including public consultation on the proposals, will take place during 2004/05 to develop the vision.
Developing our role

Supporting local service improvement

During 2003, responsibility for overseeing service improvement and modernisation in Birmingham, Solihull and The Black Country was devolved from the NHS Modernisation Agency to the Strategic Health Authority.

From Local Delivery Plans and several consultation events held with PCTs and NHS Trusts, a number of priorities emerged. They included urgent care systems; intermediate care; chronic disease management; demand management; primary care access; mental health services; surgical networks; booking; and better use of diagnostics.

The Board for Excellence Through Service Transformation (BEST)

In order to lead the programme of service improvement, the Strategic Health Authority set up The Board for Excellence Through Service Transformation (BEST). Chaired by Lord Hunt of Kings Heath, BEST has supported programmes of service improvement across the seven local health economies and has provided resources to help promote accelerated development of some key initiatives.

Accelerated programmes of work

In 2003/04, the Strategic Health Authority provided funding to support accelerated programmes of work in service improvement priority areas with a common importance across the whole patch.

In particular, good progress has been achieved in a programme designed to enhance heart failure services across Birmingham, Solihull and The Black Country. This recognises the pivotal role played by specialist nurses in ensuring the delivery of accessible services, as well as the need for a consistent approach to heart failure care across the health economy and the active involvement of patients in their own care.

The SHA has also supported a radiology modernisation programme which will see a 50% increase in machine capacity in the area, together with the recruitment and development of assistant practitioners and advanced practitioners to expand and enhance the radiology workforce. The aim of this significant investment is to speed up the diagnostic process for patients and reduce the total amount of time they wait before treatment begins.

Academy for Health Service Improvement

The Academy was established in April 2004 under the auspices of BEST as a partnership between the SHA, local healthcare organisations and the Health Services Management Centre at the University of Birmingham. Overall, its role is to support learning and development associated with improvements in health and social care. Specifically, the Academy will drive rigorous evaluation of clinical services, facilitate the sharing of good practice, help to develop the key skills needed for service improvements and promote clinical leadership.
Local examples of service improvement

Celebrating the Best
In May 2004, the Strategic Health Authority held a major event designed to celebrate best practice in the delivery of health care across Birmingham, Solihull and The Black Country.

Attended by 1,200 staff from local NHS organisations and their partner agencies, the event highlighted examples of best practice across a very wide range of services. Just a few of the many examples included:

- a 3-month pilot scheme in Walsall aimed at diverting 25% of patients arriving in A&E to a primary care setting;
- joint working by Eastern Birmingham and Solihull PCTs and Birmingham Heartlands and Solihull NHS Trust to improve hospital discharge planning and procedures;
- development of a healthy living network in Sandwell to promote greater physical activity through easier and cheaper access to local facilities;
- a ‘best buddies’ scheme for families with under-5s in Heart of Birmingham PCT, which offers peer support, advice and information;
- an anti-coagulation nursing outreach service developed in Dudley to provide 365-day a year support to patients diagnosed with deep vein thrombosis and related problems;
- establishment of a community diabetes team in Washwood Heath and Saltley to raise awareness of the condition and improve self-management skills;
- establishment by South Birmingham PCT of a rapid access clinic for oral cancer;
- use of direct marketing techniques by North Birmingham PCT to target smokers registered with two local general practices;
- making the most of GP clinical expertise in Walsall, where the PCT has developed a scheme to provide minor surgery in a primary care setting;
- introduction of a gastroenterology nurse specialist by Sandwell and West Birmingham Hospitals NHS Trust to improve patient health education and reduce waiting times;
- development of a community health network in Rowley Regis and Tipton to implement innovative ways of meeting different cultural needs.
Developing our role

Staffing and structure to meet the challenges ahead

As a result of a successful assessment in February 2004, the Strategic Health Authority received Improving Working Lives Practice accreditation. The report praised our ethos of flexible working, internal communications and human resources strategy.

Following accreditation, we reviewed our health and safety arrangements, and made progress in improving our premises to meet the requirements of the Disability Discrimination Act. Occupational Health Services were provided by University Hospital Birmingham NHS Trust, and the service was extended to provide access to free counselling for all SHA staff.

Preparations were made during the year for the full integration of the Workforce Development Confederation into the Authority, following a review of stakeholders’ views about future arrangements for education and training in Birmingham, Solihull and The Black Country.

The enlarged size of the SHA workforce led to improved arrangements for communication and consultation with staff, including senior managers’ briefings, the development of an intranet and a whole-staff consultation on organisational development.

In May 2003, David Nicholson was appointed Chief Executive of the Authority, replacing Geoff Scaife, who had taken up the post of Chief Executive at Avon, Gloucestershire and Wiltshire SHA.

During the year, we reshaped our management structure in ways designed to match our resources to the main challenges ahead.
Carrying out our statutory functions

Parliamentary business

The Strategic Health Authority provides a key contact point between Ministers and the Department of Health at a national level and local services in the NHS front line.

During the year, we dealt with 160 requests for briefings and answers to correspondence, and signed an agreement with the Department of Health on procedures and standards for dealing with Parliamentary matters.

Independent inquiries

We play a central role in setting up and co-ordinating action in response to independent inquiries into NHS services in our area.

In April 2004, for example, we received the report from the inquiry team set up in 2003 to review Avonside, a mental health facility in North Birmingham where there had been a number of adverse incidents.

The report specifically calls on the Strategic Health Authority to monitor progress achieved over the next twelve months by the new Birmingham and Solihull Mental Health NHS Trust in addressing the issues identified by the inquiry team. In addition, we have been involved in setting up inquiries into maternity services in Wolverhampton and learning disability services in Walsall.

Review of continuing care criteria

Following the Ombudsman's report in February 2003 on continuing health care and subsequent guidance from the Department of Health, we worked with our 12 PCTs and six local authorities to review eligibility criteria for continuing health care. In December 2003, we published new criteria for use across the Authority’s area.

We also established independent review panels to deal with the 75 requests we received for reviews of continuing health care assessment decisions by PCTs.

Race Equality Scheme

The Strategic Health Authority has a statutory responsibility for ensuring that the organisation meets the requirements of the Race Relations Act 1976 and the Race Relations Amendment Act 2000.

In September 2003, we approved a Race Equality Scheme setting out a firm commitment to creating an attitude of equality and fairness across every aspect of our functions and activities. A Race Equality Steering Group, chaired by a non-executive director, has been established to oversee progress in implementing a race equality action plan.

Publication Scheme

In line with the requirements of the Freedom of Information Act 2000, in October 2003 we established a Publication Scheme which sets out the types of information we publish and how members of the public can seek to obtain that information.

Full details of the scheme, including an index to our publications, are given on our website (www.bbcha.nhs.uk).
The Board of the Strategic Health Authority

Elisabeth Buggins, Chairman
David Nicholson CBE, Chief Executive
Donald McIntosh, Vice Chairman
Malcolm Bailey, Non-Executive Director
Professor John Brooks, Non-Executive Director
Professor William Doe, Non-Executive Director
Bridget Nisbet, Non-Executive Director
Rodney Pitts, Non-Executive Director
Dr Tony Snell, Medical Director
Andrew Snowden, Director of Workforce and Strategic Human Resources
Peter Spilsbury, Director of Health Policy and Strategy
Tom Taylor, Deputy Chief Executive and Director of Delivery
It was with great sadness that we learned of the death of our former Chief Executive, Geoff Scaife, who was killed in a tragic car accident on 20th April 2004.

Geoff had been our Chief Executive from January 2002 to December 2003, having previously been Chief Executive of the former Birmingham Health Authority from October 2000 to January 2002.

He had moved in January 2003 to be Chief Executive of Avon, Gloucestershire and Wiltshire Strategic Health Authority.

Geoff made a major contribution to the improvement of health services across Birmingham, Solihull and The Black Country. His achievements included forming the Pan Birmingham Cancer Network, establishing the Workforce Development Confederation, and establishing the Strategic Health Authority itself.

Before moving to the West Midlands, Geoff was Chief Executive of the NHS in Scotland for seven years, where he served three different Secretaries of State and led major changes in culture and systems.

He started his career in the Department of Health and Social Services in 1968. He was seconded to work in the Prime Minister’s Private Office from 1971 to 1974 before moving to the Department of Health in 1975. He joined the Mersey Regional Health Authority in 1983, becoming its Chief Executive in 1989.

Paying tribute to Geoff, Chairman of Birmingham and The Black Country Strategic Health Authority Elisabeth Buggins spoke for many when she said: “Geoff was an outstanding NHS Chief Executive. Widely respected, he also earned sincere affection from many who worked with him. His keen sense of humour, his canny insight and his professional skill added value to health services in our area.”

She added: “His greatest delight was in watching people grow and seeing the enhanced contribution they made as a result of his sponsorship and support. I thoroughly enjoyed working with him in setting up the SHA to lead the change process across our patch. His death is a great professional and personal loss to all who knew him.”

Geoff was 55 and married with four children.

Memorial Fund

A Geoff Scaife Memorial Fund is being established to support an annual memorial lecture which will celebrate the life of this exceptional manager who supported and encouraged effective leadership at all levels in the NHS.

The lecture will be devoted to an aspect of health or health services leadership with an emphasis on the future and the challenges facing the rising cadre of managers.

The fund will be held by the Nuffield Trust. Donations should be sent to Kim Beazor, Deputy Secretary, The Nuffield Trust, 59 New Cavendish Street, London W1G 7LP.
Looking forward

Consultation on ‘a wider view’

During the year, we have worked closely with our partner organisations, both within and outside the NHS, in developing a vision for meeting the health care needs of our population. Views expressed in our MORI opinion surveys and in local service reviews have also helped to shape and inform our approach.

The outcome of this work is reflected in A Wider View, a consultation document we published in the early summer of 2004 which sets out a proposed strategic framework for health and health services in Birmingham, Solihull and The Black Country.

As this annual report goes to press, consultation on our proposals is ongoing. When we have assimilated the comments and views expressed, a definitive framework will be published in the autumn.

Our proposals take account of the substantial legacy of social deprivation in many parts of the conurbation.

Ten out of our twelve PCTs have a rate of premature death worse than the average for England. Only 14% of our wards currently have death rates better than or even equal to the national average.

Around 20% of our population live with a limiting, long-term illness, and two of our PCTs have hospital admission rates for diabetes and asthma among the top 10% for all PCTs.

Substantial health inequalities persist. Infant mortality, for example, is about 15 times higher in our most deprived wards than in the most affluent. The disadvantages which many children from deprived backgrounds face stay with them after birth and throughout life.

Over 20% of our population are from ethnic minorities, who tend to live in the most economically deprived areas with the highest levels of ill health.
Consultation on ‘a wider view’

Identifying seven key priorities

Within our consultation document, we have identified strategic priorities for improving health services across our patch and the health of the 2.4 million people who use and rely on the NHS locally.

Through these seven priorities, our proposed strategic framework envisages:

1. A programme of co-ordinated, evidence-based actions to reduce health inequalities
   .... local action to address smoking, alcohol and drug misuse, obesity and sexual behaviour, supported by expert patient programmes, health equity audits and the targeting of specific vulnerable groups.

2. Delivering services that really meet the needs of all ethnic groups .... improved access to services, better coding of ethnicity by NHS organisations, development of community advocates, and measures to boost the recruitment of black and minority ethnic staff.

3. A major emphasis on reshaping services to support a healthy start to life.... steps to integrate midwifery services within primary and community settings, promote breastfeeding, improve children’s mental well-being, and develop SureStart, the Government’s programme to deliver the best start in life for every child by bringing together early education, childcare, healthcare and family support.

4. A new and systematic approach to chronic disease management and supporting vulnerable people.... development of agreed care pathways, new methods of measuring improvements in care, and systems for identifying vulnerable people in the community.

5. Empowering people to make choices about services provided to them.... offering alternatives for chronic disease monitoring, ensuring that more diagnostic procedures are carried out in primary care, and reducing the number of first out-patient appointments which take place in hospital settings.

6. Developing capacity and models of care.... greater emphasis on self care and family care, more active support to individuals at most risk of a major health breakdown, establishment of ‘one stop shop’ services, and development of primary care centres.

7. Establishing a five star health economy.... delivering the very best services all of the time to all of our population.
Financial statements

Director of Delivery’s Commentary

During the year the Authority’s net operating costs amounted to £176 million, £5.91 million less than the approved expenditure limit set by the Department of Health. The surplus will be carried forward into the Birmingham and The Black Country health economy in the financial years 2004-05 and 2005-06. The net operating costs for the year include the expenditure for Birmingham and The Black Country Strategic Health Authority, Birmingham and The Black Country Workforce Confederation, the West Midlands Deanery and other host organisations.

Statutory background

Birmingham and The Black Country Strategic Health Authority is a public body and part of the National Health Service. It is a statutory body governed by Acts of Parliament and came into existence on the 1st April 2002 under Statutory Instrument 2002 No 553 as amended by Statutory Instrument 2002 No 2469. As a statutory body, the Strategic Health Authority has specified powers to act as regulator, to contract in its own name, to act as a corporate trustee, to fund projects jointly planned with and to make payments and grants to local authorities, voluntary organisations and other bodies.

Principal activities

Birmingham and The Black Country Strategic Health Authority secures the improvement in the physical and mental health of people in the area of Birmingham, Dudley, Sandwell, Solihull, Walsall and Wolverhampton through resources available to it.

This is done by:
- Creating a strategic framework to deliver the NHS Plan in the area
- Securing annual performance agreements and performance management of PCTs and NHS Trusts, and
- Building capacity and supporting performance improvement across all the local health agencies.

From 1st October 2002, Birmingham and The Black Country Strategic Health Authority (SHA), together with all SHAs, ceased to provide healthcare and related services when the statutory function in respect of the relevant services transferred to Primary Care Trusts. These services incurred expenditure of £63.454 million in 2002/03.

Review of performance against financial targets

The Authority, in line with other NHS bodies, operates resource based accounting. The Income and Expenditure Statement was replaced by an Operating Cost Statement which reflects the Authority’s net expenditure. This expenditure is measured against a Resource Limit set by the Department of Health. In 2000-01 this Resource Limit was illustrative. From 2001-02 the Authority has a statutory duty to contain expenditure within the Resource Limit and an administrative duty to achieve “Operating Financial Balance”.

Details of Post Balance Sheet Events

Since 31st March 2004, 7 Brosil Avenue, Handsworth has been sold for £176,000.

Better Payment Practice Code

The Authority is required to pay its non-NHS trade creditors in accordance with the Better Payment Practice Code. The target is to pay non-NHS trade creditors within 30 days of the receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed with the supplier. The performance of the Health Authority appears below.

<table>
<thead>
<tr>
<th>Details</th>
<th>£000</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total invoices paid 2003-04</td>
<td>67,364</td>
<td>10,663</td>
</tr>
<tr>
<td>Total invoices paid within target</td>
<td>63,429</td>
<td>8,858</td>
</tr>
<tr>
<td>Percentage of bills paid within target</td>
<td>94.2%</td>
<td>83.1%</td>
</tr>
</tbody>
</table>

Fixed assets

There were no significant changes in fixed assets or any significant differences between market value and net book value.

Future developments

There are no approved or planned future developments.
### Operating Cost Statement for the year ended 31 March 2004

<table>
<thead>
<tr>
<th>Details</th>
<th>2003-04</th>
<th>2002-03</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenditure</strong></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Health care and related services</td>
<td>0</td>
<td>63,454</td>
</tr>
<tr>
<td>Authority administration</td>
<td>16,278</td>
<td>3,726</td>
</tr>
<tr>
<td>Authority programme expenditure</td>
<td>229,995</td>
<td>223,017</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>246,273</td>
<td>290,197</td>
</tr>
<tr>
<td>Exceptional Gains</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Miscellaneous income</td>
<td>69,943</td>
<td>63,171</td>
</tr>
<tr>
<td><strong>Net Operating Costs</strong></td>
<td>176,330</td>
<td>227,026</td>
</tr>
<tr>
<td>Net Resource outturn</td>
<td>5,910</td>
<td>5,268</td>
</tr>
</tbody>
</table>

### Cashflow Statement for the year ended 31 March 2004

<table>
<thead>
<tr>
<th>Details</th>
<th>2003-04</th>
<th>2002-03</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Operating Cost</strong></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Adjust for non-cash transactions</td>
<td>272</td>
<td>(2,528)</td>
</tr>
<tr>
<td>Adjust for movements in working capital other than cash</td>
<td>5,230</td>
<td>3,127</td>
</tr>
<tr>
<td>Adjust for transfer from provisions</td>
<td>(339)</td>
<td>1,699</td>
</tr>
<tr>
<td><strong>Net cash flow from operating activities</strong></td>
<td>181,493</td>
<td>229,324</td>
</tr>
<tr>
<td><strong>Capital expenditure and financial investment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments to acquire tangible fixed assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Receipts from sale of tangible fixed assets</td>
<td>(173)</td>
<td>(173)</td>
</tr>
<tr>
<td><strong>Net cash outflow from investing activities</strong></td>
<td>(173)</td>
<td>(173)</td>
</tr>
<tr>
<td><strong>Net Cash Outflow From All Activities</strong></td>
<td>181,320</td>
<td>229,151</td>
</tr>
</tbody>
</table>

### Balance Sheet as at 31 March 2004

<table>
<thead>
<tr>
<th>Details</th>
<th>2003-04</th>
<th>2002-03</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed Assets</strong></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tangible assets</td>
<td>6,716</td>
<td>6,319</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,716</td>
<td>6,319</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtors: amounts falling due within one year</td>
<td>7,615</td>
<td>14,255</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7,618</td>
<td>14,272</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors: amounts falling due within one year</td>
<td>12,599</td>
<td>24,580</td>
</tr>
<tr>
<td>Bank overdraft</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12,599</td>
<td>24,580</td>
</tr>
<tr>
<td><strong>Net Current Assets/(Liabilities)</strong></td>
<td>(4,981)</td>
<td>(10,308)</td>
</tr>
<tr>
<td><strong>Total Assets Less Current Liabilities</strong></td>
<td>1,735</td>
<td>3,989</td>
</tr>
<tr>
<td><strong>Creditors falling due after more than one year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions for liabilities and charges</td>
<td>(3,492)</td>
<td>(18,862)</td>
</tr>
<tr>
<td><strong>Total Net Assets</strong></td>
<td>(1,757)</td>
<td>(22,851)</td>
</tr>
<tr>
<td><strong>Financed by</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td>(6,042)</td>
<td>26,588</td>
</tr>
<tr>
<td>Donated asset reserve</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>4,285</td>
<td>(3,737)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(1,757)</td>
<td>22,851</td>
</tr>
</tbody>
</table>

### Statement of Recognised Gains and Losses for the year ended 31 March 2004

<table>
<thead>
<tr>
<th>Details</th>
<th>2003-04</th>
<th>2002-03</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unrealised surplus on the revaluation of properties</strong></td>
<td>548</td>
<td>913</td>
</tr>
<tr>
<td><strong>Transfer to NHS bodies and Department of Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed asset impairment losses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Recognised gain/(loss) for the year</strong></td>
<td>16,541</td>
<td>49,084</td>
</tr>
</tbody>
</table>
## Financial statements

### The Salary and Pension Entitlements of Senior Managers

#### 2003-04

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Age</th>
<th>Salary (bands of £5,000)</th>
<th>Remuneration (bands of £5,000)</th>
<th>Golden Hello/ Compensation for loss of Office</th>
<th>Real increase in pension at age 60 (bands of £5,000)</th>
<th>Total accrued pension at age 60 at 31 March 02 (bands of £5,000)</th>
<th>Benefits in Kind (rounded to the nearest £00)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malcolm Bailey - Non-executive Director</td>
<td>49</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Mike Bailey - WDC Director of Finance</td>
<td>54</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>John Brooks - Non-executive Director</td>
<td>55</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Elisabeth Buggins - Chairman</td>
<td>48</td>
<td>20-25</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>William Doe - Non-executive Director</td>
<td>47</td>
<td>1-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Jacky Doyle - WDC Director of Workforce Development</td>
<td>45</td>
<td>30-35</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>0.5</td>
<td>0</td>
</tr>
<tr>
<td>Judy Foster - Non-executive Director</td>
<td>39</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Donald McIntosh - Non-executive Director</td>
<td>46</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Sheila Marriott - Director of Organisational</td>
<td>48</td>
<td>15-20</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>Chris Moore - Acting Finance Director</td>
<td>49</td>
<td>30-35</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>10-15</td>
<td>0</td>
</tr>
<tr>
<td>David Nicholson - Chief Executive</td>
<td>48</td>
<td>130-135</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>0.5</td>
<td>0</td>
</tr>
<tr>
<td>Bridget Nisbet - Non-executive Director</td>
<td>41</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Rodney Pitts - Non-executive Director</td>
<td>47</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>David Poynton - Finance Director</td>
<td>59</td>
<td>85-90</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>35-40</td>
<td>30</td>
</tr>
<tr>
<td>Tony Snell - Medical Director</td>
<td>50</td>
<td>85-90</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>10-15</td>
<td>41</td>
</tr>
<tr>
<td>Andrew Snowden - Director of Workforce &amp; HR Strategy</td>
<td>49</td>
<td>30-35</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>0.5</td>
<td>20</td>
</tr>
<tr>
<td>Peter Spilsbury - Director of Health Policy &amp; Strategy</td>
<td>42</td>
<td>95-100</td>
<td>0</td>
<td>0</td>
<td>2.5-5</td>
<td>20-25</td>
<td>60</td>
</tr>
<tr>
<td>Glenn Warren - WDC Chief Executive (to 31/7/03)</td>
<td>42</td>
<td>Consent to disclose withheld</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Previous service in NHS was transferred to Civil Service and has not been transferred back.

** Pension figures are based on last 13 months’ service. Previous information not available.

#### 2002-03

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Age</th>
<th>Salary (bands of £5,000)</th>
<th>Remuneration (bands of £5,000)</th>
<th>Golden Hello/ Compensation for loss of Office</th>
<th>Real increase in pension at age 60 (bands of £5,000)</th>
<th>Total accrued pension at age 60 at 31 March 02 (bands of £5,000)</th>
<th>Benefits in Kind (rounded to the nearest £00)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geoff Scaife - Chief Executive (to December 2002)</td>
<td>54</td>
<td>95-100</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>0.5</td>
<td>39</td>
</tr>
<tr>
<td>David Poynton - Finance Director (to December 2002)</td>
<td>58</td>
<td>75-80</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>45-50</td>
<td>20</td>
</tr>
<tr>
<td>David Poynton - Acting Chief Executive (from January 2003)</td>
<td>58</td>
<td>35-40</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>20-25</td>
<td>0</td>
</tr>
<tr>
<td>Chris Moore - Acting Finance Director (from January 2003)</td>
<td>48</td>
<td>20-25</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>20-25</td>
<td>0</td>
</tr>
<tr>
<td>Sheila Marriott - Director of Organisational</td>
<td>47</td>
<td>75-80</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>20-25</td>
<td>0</td>
</tr>
<tr>
<td>Peter Spilsbury - Director of Health Policy &amp; Strategy</td>
<td>41</td>
<td>90-95</td>
<td>0</td>
<td>0</td>
<td>2.5-5</td>
<td>15-20</td>
<td>38</td>
</tr>
<tr>
<td>Tony Snell - Director of Clinical Effectiveness (from March 2003)</td>
<td>49</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>Elisabeth Buggins - Chairman</td>
<td>47</td>
<td>20-25</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Rodney Pitts - Non-executive Director</td>
<td>46</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>William Doe - Non-executive Director</td>
<td>61</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Malcolm Bailey - Non-executive Director</td>
<td>48</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Donald McIntosh - Non-executive Director</td>
<td>45</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Bridget Nisbet - Non-executive Director</td>
<td>40</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Judy Foster - Non-executive Director</td>
<td>38</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>John Brooks - Non-executive Director</td>
<td>54</td>
<td>3-5</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Mike Bailey - WDC Director of Finance</td>
<td>51</td>
<td>90-95</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>30-35</td>
<td>25</td>
</tr>
<tr>
<td>Glouce Warren - WDC Chief Executive</td>
<td>53</td>
<td>75-80</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>15-20</td>
<td>26</td>
</tr>
<tr>
<td>Jacky Doyle - WDC Director of Workforce Development (from February 2003)</td>
<td>44</td>
<td>10-15</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>0-5</td>
<td>0</td>
</tr>
</tbody>
</table>

* Pension figures based on current employment only. Previous service in NHS England and Wales was transferred to NHS Scotland and has not yet transferred back.

** Pension figures based on 1 month’s service. Previous information not currently available.

The financial statements represent a summary of the full accounts which are available to the public at no charge. Requests for a copy of the full accounts should be addressed to Tom Taylor, Director of Delivery, Birmingham and The Black Country Strategic Health Authority, St. Chad’s Court, 213 Hagley Road, Edgbaston, Birmingham B16 9RG.
Financial statements

Statement of the Chief Executive’s Responsibilities as the Accountable Officer of the Organisation

The Secretary of State has directed that the Chief Executive should be the Accountable Officer to the organisation. The relevant responsibilities of Accountable Officers are set out in the Accountable Officer’s Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the authority;
- the expenditure and income of the authority has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Date: 15 July 2004

Signed: [Signature]
Chief Executive

Statement of the Directors’ Responsibilities in respect of the Accounts

The Directors are required under the National Health Service Act 1977 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the organisation and the net operating cost, recognised gains and losses and cash flows for the year. In preparing these accounts, Directors are required to:

i. apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

ii. make judgements and estimates which are reasonable and prudent;

iii. state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the organisation and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the health authority and hence for taking reasonable steps for the prevention of fraud and other irregularities.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the financial statements.

By order of the board.

Date: 15 July 2004

Signed: [Signature]
Accountable Officer

Date: 15 July 2004

Signed: [Signature]
Director of Delivery
1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation’s policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation’s assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

The SHA’s internal controls are based on the organisation’s business plan which sets out our annual objectives and is the basis for our planning, performance review and risk management processes.

The SHA has established an ongoing risk management process designed to identify the principal risks to the achievement of the Authority’s objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and economically. The system of internal control is overseen by the Risk Management Committee, summarised in our Assurance Framework and underpinned by compliance with the requirements of the core Controls Assurance standards:

- Governance
- Financial Management
- Risk Management

The approach adopted by the Authority takes into account the functions of the hosted organisations as well as the “core” strategic health authority. These organisations are the West Midlands Deanery, the Pan Birmingham Cancer Network, the West Midlands Specialised Services Agency, the West Midlands Perinatal Institute, the Finance Staff Development Unit, the West Midlands MREC and South Birmingham LREC. The SHA has established processes for working closely with other NHS organisations in Birmingham and The Black Country, including monthly Chief Executive Meetings, performance management processes, monthly finance and activity information flows, and periodic review meetings. The SHA also works with service and professional networks throughout the area.

The SHA participates in the national Performance Assessment Framework for SHAs run by the Department of Health to provide an external assessment of SHA performance.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organization’s policies, aims and objectives;
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has not been in place in Birmingham and The Black Country Strategic Health Authority for the whole year ended 31st March 2004 but was in place by 31st March 2004 and up to the date of approval on the annual report and accounts.

3. Capacity to handle risk

Risk management is considered by the Board to be a priority, and is led through a Risk Management Committee which is chaired by the Authority’s Vice Chairman and reports direct to the Board. Each executive director with a responsibility for the implementation of a section of the Authority’s Business Plan is a member of the Committee, and identified with responsibility for the management of risk in their area of the Authority’s activity. There is a complementary Clinical Governance Committee. Until the development of these committees, the Audit Committee took a significant role in overseeing the handling of risk. The Audit Committee was established in April 2002, the Risk Management Committee (in its current form) and the Clinical Governance Committee in January 2004.

Key staff, especially in the Corporate Development, Finance, Communications and Medical directorates have gained both awareness and experience of risk management through a fairly substantial programme of managing risks, and through close working with, for example, branches of the Department of Health and CHI. All directorates and hosted organisations have been involved with a systematic process to identify risk during the preparation of the Assurance Framework.

Designated staff in the Finance, Corporate Development and Medical directorates provide advice to colleagues on the identification and management of risks.

The SHA Director of Corporate Development and Director of Delivery will be reviewing these arrangements during 2004/5 to ensure that the organisation continues to develop its capacity to manage risk effectively.

4. The risk and control framework

The Authority’s risk management strategy includes as its key elements:

- training and support; key performance indicators;
- arrangements for monitoring and review.

Executive Directors are responsible for the identification of risks, and an assurance framework exercise has been undertaken in the context of the Authority’s Business Plan. Controls Assurance standards are reviewed annually. Risks are also identified through the reporting of serious untoward incidents, and are reviewed by the Risk Management and Clinical Governance Committees.

It is a developing strategy, taking into account the changing functions and areas of responsibility for the Authority, and the legal frameworks within which it operates. Alongside the Controls Assurance processes, the Authority has developed its Assurance Framework, based on a systematic assessment of the main risks to the delivery of its objectives and the systems and processes that are in place to manage these risks.

The Assurance Framework is rooted in the Authority’s Business Plan. It identifies a number of priority high risk areas, existing controls and sources of assurance, and the actions taken or planned to ensure that the right level of controls and assurance are in place.

Given the Authority’s role as “the headquarters of the NHS locally” with a key performance management responsibility, it has set up processes to identify and manage risk, and to learn from incidents that do arise. All NHS Trusts and PCTs are required to report in a particular format on any serious untoward incident and activity reports help to identify risks of non-delivery against key activity targets.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by external audit reports to the Audit Committee and the Authority, and regular meetings between the external auditor and the Director of Delivery. The former has identified areas that needed strengthening and these have been addressed through action plans whose achievement is monitored by the Audit Committee. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit Committee, Risk Management Committee and Clinical Governance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place. This has been endorsed by the Board’s approval of new Terms of Reference for the Risk Management Committee, with a direct reporting responsibility to the Board.

The process used to maintain and review the system of internal control during 2004/5 includes:

- reports to the Board from the Risk Management, Audit and Clinical Governance Committees;
- the Audit Committee’s duty to review the establishment and maintenance of an effective system of internal control and risk management;
- work by the Risk Management and Clinical Governance committees to ensure that the SHA has appropriate systems in place to manage risk;
- the internal audit approach of taking risk assessments as an effective means of prioritising their workload. The result of adopting this risk based approach is that resources are directed to the high risk areas, whilst seeking to ensure that all areas are covered over the medium to long term. This review of the assessment of risk is reviewed on, at least, an annual basis;
- production of the SHA Assurance Framework and approval of this by internal audit. Auditing of the SHA’s assessment and action plan under the controls assurance standards. This has been approved by the Board and quality assured by Internal Audit.

- The SHA Executive Team has been restructured and a Director of Delivery and Director of Corporate Development appointed. These Directors will ensure that the SHA’s internal control processes are kept under review and continue to develop during 2004/5.

Signed…………………………….

Chief Executive

Date………………………….

(On behalf of the Board)
Members of the Strategic Health Authority Board

**Chairman:** Mrs Elisabeth Buggins

**Non-Executive Directors:**
- Mr Malcolm Bailey
- Professor John Brooks
- Professor William Doe
- Ms Judy Foster
- Mr Donald McIntosh, Vice Chairman
- Mrs Bridget Nisbet
- Mr Rodney Pitts

**Chief Executive:**
- Mr David Poynton (Acting Chief Executive to May 2003)
- Mr David Poynton (from 1st May 2003)

**Other Executive Directors:**
- Mr Chris Moore, Acting Finance Director (to 1st May 2003)
- Mr David Poynton, Finance Director (from 1st May to 15th December 2003)
- Ms Sheila Marriott, Director of Organisational Development and Learning (to June 2003)
- Mr Andrew Snowden, Director of Workforce and Human Resources Strategy (from 1st December 2003)
- Dr Tony Snell, Medical Director
- Mr Peter Spilsbury, Director of Health Policy and Strategy

Remuneration Committee

The Remuneration Committee, consisting of the Non-Executive Directors named here, sets the terms and conditions of the Chief Executive and Executive Directors.

- Mrs Elisabeth Buggins (Chairman)
- Ms Judy Foster
- Mr Donald McIntosh
- Mr Rodney Pitts

Declaration of Interests

| **Mr M Bailey** | Chief Executive, Murray Hall Community Trust; Chairman, Batman’s Hill Nursery; Member, Standards Committee, Nursing & Midwifery Council; Member, Sandwell Partnership |
| **Mrs E Buggins** | Freelance facilitator to the voluntary sector and NHS around patient and public involvement and board development; Project Worker with Public Health Resource Unit, Institute of Health Sciences, Oxford; Visiting Lecturer to Local Universities; Director, Engage 2 Excel Limited |
| **Prof J Brooks** | Vice-Chancellor, University of Wolverhampton; Trustee & Director, e-Learning Foundation; Member, Programme Monitoring Committee, GOWM; Member, AWM Rover Task Force & High Technology Corridor Steering Group; Board member, Regional Observatory; Chair, Wolverhampton Telford Technology Corridor; Board Member, Black Country Consortium. |
| **Prof W Doe** | Dean of the Medical School, University of Birmingham |
| **Ms J Foster** | Member, West Midlands Police Authority; Elected Member, Dudley MBC |
| **Ms S Marriott** | None |
| **Mr D McIntosh** | Director, Sickle Cell & Thalassaemia Support Project Ltd, Wolverhampton; Executive Director, Castle Vale Housing Action Trust; Director, Merlin Venture Ltd; Company Secretary, Castle Vale Enterprise Park Ltd |
| **Mr D Nicholson** | None |
| **Mrs B Nisbet** | None |
| **Mr J R G Pitts** | Non Executive Director, Leicester Housing Association Ltd; Chairman - Job’s Close Residential Home for the Elderly; Chairman - Fairways Residents Association Ltd; Hon. Treasurer - Arthritis Research Campaign, West Midlands; Member - Court of the University of Birmingham |
| **Mr D Poynton** | Director and Shareholder - Poynt One Enterprises Ltd; Director and Shareholder - Healthgain (UK) Ltd; Charity Trustee - Glaxo Renal Unit |
| **Dr T Snell** | Part owner of residential home for elderly people, Colchester; Consultancy advice, lectures, papers, etc for Hayward Medical Publications Ltd; Member, “NHS Board”, Eli Lilly Pharmaceuticals; Member, “NHS Board”, Altona Pharmaceuticals; Freelance lecturer and author, sponsored by pharmaceutical companies. |
| **Ms A Snowden** | Trustee, Concord College, Shrewsbury |
| **Mr P Spilsbury** | None |

Audit Committee

The Audit Committee consisted of the Non Executive Directors named below:

- Mr Rodney Pitts (Chairman)
- Mr Donald McIntosh
- Professor William Doe
Independent Auditor’s Report to Birmingham and The Black Country Strategic Health Authority on the Summary Financial Statements

I have examined the summary financial statements set out on pages 22 to 26.

This report is made solely to the Board of Birmingham and The Black Country Strategic Health Authority in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 54 of the Statement of Responsibilities of Auditors and of Audited Bodies, prepared by the Audit Commission.

Respective responsibilities of directors and auditors
The directors are responsible for preparing the Annual Report. My responsibility is to report to you my opinion on the consistency of the summary financial statements with the statutory financial statements. I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statements.

Basis of opinion
I conducted my work in accordance with Bulletin 1999/6 ‘The auditor’s statement on the summary financial statements’ issued by the Auditing Practices Board for use in the United Kingdom.

Opinion
In my opinion the summary financial statements are consistent with the statutory financial statements of the Strategic Health Authority for the year ended 31 March 2004 on which I have issued an unqualified opinion.

Signature:…………………………………..
Date: 10 September 2004
Name: Mark Stocks
Address: Audit Commission, 2nd Floor, No 1 Friarsgate, 1011 Stratford Road, Solihull, West Midlands B90 4EB

How the Strategic Health Authority handled complaints

During the year (2003/04) the Authority received 39 complaints, all of which were about Trusts and PCTs, and reflected a lack of understanding of the NHS complaints procedure or of confidence in the independence of the independent review stage. Following the national changes to the complaints procedure that place the second stage with the Healthcare Commission from 1 August 2004, the Authority might reasonably expect to receive fewer complaints. However, some complainants are still likely to refer their dissatisfaction to the SHA as the headquarters of the NHS locally.

Some of the complaints were inherited from the former health authorities, and involved ongoing matters that were also being dealt with in other ways, such as through different NHS bodies or employment tribunals. A few could be regarded as vexatious, and one of these complainants was prosecuted for harassment.

Most of the complaints about service providers were forwarded to the appropriate bodies for action. The guiding principle was to ensure that complaints were resolved as locally as possible. In some cases it was necessary to become more involved to ensure that the complaint was dealt with satisfactorily, and that performance management colleagues were informed of any significant issues. Complaints came from across the Authority’s area, although the majority were from Birmingham.

Birmingham 26
Dudley 5
Sandwell 2
Solihull 2
Walsall 2
Wolverhampton 2

Audit Fees
In 2003-04 the Authority paid £75,000 for the provision of audit services.

Disability and Equal Opportunities Policy
Birmingham and The Black Country Strategic Health Authority has adopted an Equal Opportunities Policy and continues to work to implement this.
Origin is situated by the Steg. Healt Autriniyty. The West Midlands Deanery, which employs 194 staff, makes a significant contribution to postgraduate medical education. Last year saw a large increase in the number of doctors training in the region.

The Pan Birmingham Cancer Network is a partnership of organisations in the eastern part of the SHA’s area with an interest in cancer which have come together to implement the Cancer Plan. The network, which employs 25 staff, is directed by a board comprising members from local acute trusts, PCTs, the voluntary sector and users. There is a separate network for the Black Country.

The West Midlands Specialised Services Agency employs 22 people who, on behalf of the 30 Primary Care Trusts across the West Midlands, commission around £170 million worth of services for patients requiring specialised care. The performance framework developed by the agency was recommended by the Department of Health as an example of best practice.

The West Midlands Perinatal Institute aims to establish the causes of adverse outcomes in pregnancy and childbirth, and works to develop evidence-based strategies for prevention. It runs a number of registers, audits and research projects, as well as educational and training workshops. It has approximately 30 staff on full or part-time contracts.

The Finance Staff Development Unit, which employs five staff, is responsible for the training and development of 1,702 finance staff across the West Midlands.

The Birmingham and The Black Country Workforce Development Confederation, which employs around 40 staff, aims to ensure that local health services have the trained staff they need to deliver improved services to patients. From April 2004, the Confederation has become part of the Strategic Health Authority.

MREC, OREC and LREC - The West Midlands Multi-Centre Research Ethics Committee (MREC), which employs two staff, is one of several throughout the country which provide ethical approval for proposed research projects. The Office of the Research Ethics Committees (OREC) is responsible for co-ordinating the work of local research ethics committees in the West Midlands and employs three staff. The South Birmingham LREC, which employs four staff and is responsible for providing ethical approval for research projects in that part of our patch, is also hosted by the SHA.
Birmingham and The Black Country Strategic Health Authority
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Web site: www.bbcha.nhs.uk