

ANNUAL REPORT 2013/14



Where
EVERYONE
Matters



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*Front cover images: Maternity patient (left), Steve Horton, Pharmacist (right).
Left: Our Cardiac Catheterisation Laboratory*



Sandwell and West Birmingham Hospitals NHS Trust

Annual Report

This annual report, comprising a Directors' Report, Remuneration Report and Strategic Report, is designed to give you an overview of Sandwell and West Birmingham Hospitals NHS Trust in 2013/14. It covers quality, performance, financial and environmental matters and looks ahead to planning for 2014/15.

More detail on the subjects discussed in this report can be found in the Trust's Quality Account, Full Financial Accounts and Annual Plan. Also available, is the annual report for the Sandwell and West Birmingham Hospitals NHS Trust Charities for the year 2013/14.

This report will be available on our website www.swbh.nhs.uk. If you would like to comment on our annual report, or would like a printed copy, please do not hesitate to contact Vanya Rogers, Press and PR Manager on 0121 507 4093, or email: vanya.rogers@nhs.net.

Introduction

Throughout this report, you will see evidence of how our organisation continues to develop. For example, an external review of our practices has commended as exemplary our infection control team and the rate of MRSA screening we provide for inpatients has risen by 20%. Similarly, the recent national survey of maternity care suggests that the huge progress made over the last five years in looking after local mums is reflected in the view of the six thousand families who have used Serenity or our complex labour ward. Finally, the NHS national staff survey, though illustrating room for improvement, shows that we have 7,500 colleagues who are largely engaged, motivated and enthused by how we work and what we do. We are especially pleased to report a 10% jump in the proportion of staff who tell us that care and safety is the number one priority of the Trust, and that they would recommend our care to their own family.

But as we develop, some change is necessary. Last winter we coped well - far better than in 2012. Waiting times were much shorter, we staffed our wards with more of our own employees not temporary staff, and infection rates were lower. The Trust won national recognition for its work in vaccinating staff and patients against flu. Looking forward, we want to sustain these successes. More than 90% of 10,000 respondents to our initial survey reported a positive experience from our clinics. But we want to see more than 98% of patients, and our referring GPs, telling us that our

services worked well for them. That is especially important as we try and develop different models of care. In diabetes, we have moved a large proportion of our long term clinics into GP practices. We have also begun to undertake clinics via Skype, so that patients can be at home or indeed abroad, while we provide expert help. More than 10% of the whole NHS budget is spent looking after people with diabetes, or diabetes combined other conditions, so it is crucial that we do this well.

As we went to press, government approval was given for the new Midland Metropolitan Hospital. This news has been in the making for ten years and many people in our community felt that it would never come. However, on July 14th 2014, the Chancellor of the Exchequer personally visited Rowley Regis Hospital to make the announcement. Undoubtedly, this is a major infrastructure project and the first in health under the PF2 banner. It also validates our Right Care, Right Here strategy which has always been about localising care, and providing services in community settings, as well as creating a single specialist acute hospital in Smethwick. In our annual reports in 2015, 2016, and 2017 we will update you on our preparations and whether we are 'on track' for the size, shape and scale of hospital that we now have permission to procure. It is very exciting and we hope you share our pride in the achievement.



Richard Samuda
Chairman



Toby Lewis
Chief Executive

Board of Directors (as at 1st April 2014)

Non-Executive Directors:

Chairman:	Richard Samuda
Vice-Chair:	Clare Robinson
Non-Executive Director:	Dr Sarindar Singh Sahota OBE
Non-Executive Director:	Gianjeet Hunjan
Non-Executive Director:	Professor Richard Lilford
Non Executive Director:	Olwen Dutton
Non Executive Director:	Harjinder Kang
Non Executive Director:	Mike Hoare

Trust Board Executive Management Team:

Chief Executive:	Toby Lewis
Director of Governance:	Kam Dhami
Chief Operating Officer:	Rachel Barlow
Chief Nurse (from December 2013):	Colin Ovington
Director of Finance and Performance:	Tony Waite
Medical Director:	Dr Roger Stedman

Trust Board Members who left during 2013/14:

Director of Strategy and Development:	Mike Sharon
Director of Finance and Performance:	Robert White
Chief Nurse (to September 2013):	Rachel Overfield

Acting members of the Trust Board during 2013/14:

Acting Chief Nurse (August to December 2013)	Linda Pascall
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On 5 June 2014, the Trust Board agreed that there was no relevant audit information of which the Trust's auditor was unaware, and that Directors have taken all the steps they ought in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of it.



Dr Rajai Ahmad, Consultant Cardiologist

1. Overview of the Trust

Sandwell and West Birmingham Hospitals NHS Trust is an integrated care organisation. We are dedicated to improving the lives of local people, to maintaining an outstanding reputation for teaching and education, and to embedding innovation and research. We employ around 7,500 people and spend around £430m of public money, largely drawn from our local Clinical Commissioning Group (CCG). That Group and this Trust are responsible for the care of 530,000 local people from across west Birmingham and all the towns within Sandwell.

Our teams are committed to providing compassionate, high quality care from City Hospital on Birmingham's Dudley Road, from Sandwell General Hospital in West Bromwich, and from our intermediate care hubs at Rowley Regis and at Leasowes in Smethwick (which is also our stand-alone birth centre's base). City Hospital dates back to 1887, when the foundations of an infirmary for the Birmingham Union Workhouse were laid in March of that year. Officially opened in 1889, the infirmary officially became a District General Hospital, funded exclusively by the City Council in 1920.

Sandwell General Hospital began life in 1884 when the West Bromwich Guardians built a new infirmary as an extension to the West Bromwich union workhouse on Hallam Street, later becoming Hallam Hospital in 1925. Several new buildings were constructed to improve services in the 1970s, leading to the facility being renamed Sandwell District General Hospital. The new and improved hospital was opened by HRH Princess Alexandra of Kent in 1978.

The Trust includes the Birmingham and Midland Eye Centre (a supra-regional eye hospital opened in 1996), as well as the Pan-Birmingham Gynae-Cancer Centre, our Sickle Cell and Thalassaemia Centre, and the regional base for the National Poisons Information Service – all based at City. Inpatient paediatrics, most general surgery, and our stroke specialist centre are located at Sandwell. We have significant academic departments in cardiology, rheumatology, ophthalmology and neurology. Our community teams deliver care across Sandwell, providing integrated services for children in schools, GP practices and at home, and offering both general and specialist home care for adults, in nursing homes and hospice locations.

In 2013/14, 5,586 women gave birth with our help. 564,395 people attended outpatient clinics and we delivered more than 736,852 community contacts. 176,496 attended our two A&Es and our eye casualty, of whom 38,479 were admitted to inpatient beds. We undertook 82,295 emergency and elective operations, of which 47,431 were on a day-case basis. From this work in 2013/4, 778 made first formal complaints and we received a large number of compliments for the work of our employees. In the 2013 national NHS staff survey, 59% of our staff would recommend or strongly recommend our services if a friend or relative needed treatment. Also 75% of our staff confirmed that care of patients is the organisation's top priority, placing our Trust above the national average.

Each year we publish a quality account to outline to local people how our services compare to our aims and to others. The latest data shows that:

- Outcome: Our 12-month cumulative standardised mortality rate was 87.8
This suggests that we had a slightly lower than expected mortality
- Infection: four patients contracted MRSA with us in the last 13 months and our C difficile rate was 39 for 2013/2014
- Harm-free care: We achieved 98.7% coverage for venous thromboembolism (VTE) assessment in March 2014 and during 2013-2014 had no avoidable grade 4 pressure sores
- Safe stays: Our overall readmission rate within 30-days of discharge during 2013 was 8.9%, and length of stay in our beds was 3.7 days, lower than the national average
- Waiting times: We were compliant with national standards for the care of stroke and cancer patients. Our A&E at Sandwell met the four hour standard and most specialties (and the Trust as a whole) met the 18-week standard for waits set out in the NHS Constitution. A number of specialties still need to achieve compliance and we have to consistently exceed the emergency care standard at both hospitals.

Committed to public health and local regeneration

We are a key partner in efforts to change the shape of care in our area. The Right Care, Right Here partnership has now run for nine years. Our intention is to provide substantially more care at home and rely less on acute hospitals. We aim to move 350,000 appointments out of traditional settings and close a further 20% of our hospital beds, as we have safely closed 25% over the last ten years. While most of the programme involves investment in GP surgeries and health centres, we still plan to relocate our acute care into a single purpose-built hospital. A site on Grove Lane in Smethwick has been purchased for this purpose, following public consultation in 2006. Now our plans are approved, we will open our new facility in 2018/19. The new hospital will act as a major employment opportunity for local people and is part of a wider scheme to develop the area adjacent to the site.





Our training and education team is outward facing in sourcing the workforce we need for the long term. We have a very active programme of apprentices and school experience joint working. We are partners in the Sandwell University Technical College development. More widely, we work closely with Birmingham City, Wolverhampton, Birmingham and Aston Universities. The Learning Works is our community-based recruitment and training resource.



The Trust Board is committed to developing ever more consistent links into our local communities, working with voluntary sector, faith and grassroots organisations. The development of our governing body and the expansion plans we have for our charitable foundation will also reinforce this work. During 2014/15 we published our Public Health and Community Development strategy, which outlines the contribution we currently make and plan to make, to tackle the underlying causes of ill-health in the communities that we serve.

Investing in the future

Each year, we spend around £25m on new equipment and expanding services. This is generated by the savings we make in how we provide care. This includes consistently meeting NHS-wide efficiency requirements. We report financial results annually and typically target a surplus of around 1.5% of turnover, which we reinvest in patient care. Over the next decade we will make major investments in three areas: the skills and training of our workforce; the technology we use to both care for and communicate with patients and partners; and our estate – in part through our plan to build the Midland Metropolitan Hospital (Midland Met) to rationalise acute care.

2. Year in review - 2013/14

Strategic Objective	Annual Priorities – 2013/14	Complete?
 <p>Safe, High Quality Care</p>	Deliver Year 2 of the Quality & Safety Strategy	✓
	Deliver all CQUINs	X
	Improve emergency readmission rates	✓
	Reduce rate of written complaints per 1000 episodes by 5%	X
	Achieve target for mortality reviews within 42 working days	✓
	No Never Events	X
	Attain national target of 95% for VTE risk assessment	✓
 <p>Accessible and Responsive</p>	Consistently achieve the national A&E targets	X
	Reduce A&E re-attendance	✓
	Improve our waiting times	✓
	Deliver Year 1 of our Dementia Strategy and support to carers	✓
	Increase our range of alternative models of face to face contact	✓
	Make improvements to our Emergency Departments through recruitment, new IT systems & establishment of GP service	✓
	 <p>Care Closer to Home</p>	Reconfigure a number of services across acute & community to provide integrated care
Implement a virtual ward in the community		✓
Establish 15 WTE Health Visitor posts and reduce caseload		✓
 <p>Good use of resources</p>	Deliver Year 2 of the Transformation Programme without compromising safety and quality of care	✓
	Deliver a 1-2% surplus	✓
	Enable clinically-led decision-making processes via Service Line Reporting (SLR)	✓

Strategic Objective	Annual Priorities – 2013/14	Complete?
 <p>21st Century Infrastructure</p>	Refresh financial modelling for Midland Metropolitan Hospital via PF2	✓
	Maintain estates compliance with CQC outcome 10 ('safety and suitability of premises') and 11 ('safety, availability and suitability of equipment')	✓
	Invest in the estate through capital schemes to support clinical strategy, in particular Pathology, Endoscopy and Stroke	✓
 <p>An effective organisation</p>	Deliver the milestones in the Foundation Trust programme	X
	Improve our performance in the national staff survey	✓
	Conduct a review of Health Informatics systems and capabilities	✓
	Attain 10% better than the national mean for sickness/absence rates	X
	Improve levels of mandatory training	✓
	Continue to implement the Trust's Leadership Framework/Talent Management programme	✓
	Identify 3 beacon services	✓

Priorities we didn't meet in 2013-14

Deliver all CQUINs

There are two Commissioning for Quality and Innovation (CQUIN) areas where we failed to meet the targets we set ourselves. These are - The Safe Storage of Medicines, where repeated audits have shown we are failing to reliably lock away unused medicines - And - The Maternity Friends and Family Test response rate. We will continue to drive improvements in these areas even though they are not CQUINs again this year.

Reduce rate of written complaints per 1000 episodes by 5%

In November 2013 the system for complaint handling changed so that complaint co-ordinators now assist staff within our services to address the complaints themselves and make any necessary amendments to services directly. We have also set ourselves a target of 30 working days to resolve complaints and early indications are that complainants are being responded to in a more timely manner. However, there is further work to do to ensure we can meet these requirements consistently.

No Never Events

Unfortunately last year we reported five never events, including one never event that occurred in the year before but was reported late. A never event is a serious untoward incident that has either caused or has the potential to cause serious harm that should never happen if the proper procedures are carried out to prevent them from happening.

Following the fifth never event we launched a major safety review of operating theatres across the Trust. We invited in external reviewers from the NHS Litigation Authority (NHSLA) to examine in detail our safety procedures, policies and culture. The recommendations from this review have been turned into a comprehensive plan of action for this year.

Consistently achieve the national A&E targets

SWBH has a target to ensure that 95% of our patients wait no more than 4 hours within Emergency Departments. We were able to achieve this target in 6 out of the 12 months and achieved an overall annual rate of 94.4% which is below the national target of 95%. The months where the target was achieved were June 13, August 13, November 13, December 13, January 14 and March 14.

Extensive redesign of urgent care pathways was undertaken throughout 2013/14. In addition there was work completed around timely and effective patient discharge (which included the establishment of two wards for patients who were Medically Fit for Discharge and further integration between health and social care teams). This work will be reviewed and refined over the course of 2014-15.

Deliver the milestones in the Foundation Trust programme

2013-14 saw the introduction of the Care Quality Commission's (CQC) Chief Inspector of Hospitals visit. This is a key milestone in the Foundation Trust application process and as such, the Trust's FT programme is dependent on successful completion of this inspection before progressing with additional external assessments integral to the FT process. The CIH visit has been confirmed for October 2014, and the Trust plans to submit the FT application to Monitor by Q1 of 2015/16.

Attain 10% better than the national mean for sickness/absence rates

Our sickness absence rate is currently above the Trust's target with the current year to date figure at 4.33%. Our approach to reducing sickness absence is integrated within our newly developed Public Health Strategy. Our aims for the next three years are as follows:

- We will have no higher than 3% sickness absence (2% long term and 1% short term)
- We will have a rate of work related illness that has fallen year on year
- We will have mental health training within the Trust for managers
- We will have developed a range of short interventions to support particular groups of employees at difficult times – e.g. when undergoing an investigation
- Health and Wellbeing training will be mandatory for employees



Anna Kipps, Midwifery Assistant

3. Our priorities for the year ahead - 2014/15

Our ambitions for 2014/15 are integral to our intention to become renowned as the best integrated care organisation in the NHS. Our six strategic objectives remain key drivers to meet this ambition:

- We will provide Safe, High Quality Care, putting in place controls and changed systems in response to Never Events to ensure harm free care for our patients
- We will be Accessible & Responsive to our patients, meeting all local and nationally set performance targets in every specialty
- We will provide Care Closer to Home, delivering multi-disciplinary care in more convenient locations for patients such as primary care
- We will ensure Good Use of Resources, delivering the savings and efficiencies identified in our long-term finance and workforce plans
- We will provide a 21st Century Infrastructure, investing in our estate and our IT systems
- We will support An Engaged & Effective Organisation through a more devolved model of decision making, empowering our staff to make decisions locally

Patient Safety Priorities

Safety culture or climate remains essential for the delivery of high quality care. The Trust continues to submit its incident data to the National Reporting & Learning System (NRLS) which provides comparative data with like sized Trusts. The comparative data shows that as at the September 2013 report, we remain in the highest 25% of Trusts with a reporting rate of 6.7 per 100 admissions.

Safe, High Quality Care



Ten out of ten (10/10)

During 2014/15 we will implement a programme aimed at ensuring that we do everything possible to prevent harm being experienced by any patient. The 'ten out of ten' approach is focused on the ten things we should do for every admitted patient: if these are completed we improve the individual patients experience throughout their stay with us. We want patients to know about these standards and will be placing a copy beside every bed in our hospitals and inform patients about them in our communications with them.



Senior Sister Kim Kaur with Kuldeep Singh, Patient Experience Project Manager



- We will use positive patient identification using three unique identifiers.
- We will assess every patient for their risk of developing a pressure ulcer and put in place the appropriate preventative measures.
- We will assess every patient for their risk of falling and ensure that the correct preventive measures are in place.
- We will assess every patient for the risk of developing venous thrombo-embolism and ensure the correct prophylaxis is prescribed where appropriate.
- We will ensure every patient has a base line set of observations carried out by a registered nurse including at least one record of height and weight.
- Every patient will have their medicines checked and reconciled against a definitive list and have any allergies clearly documented on their prescription chart.
- Every patient will have their mental capacity assessed and where required will be referred for further assessment.
- Every patient will have their pain assessed against a visual analogue scale and offered analgesia if required.
- Every patient will be screened for MRSA and given decolonisation treatment if required.
- Every patient will have their nutrition and fluid needs assessed and given access to appropriate nutritional advice.

Additional priorities for 2014/15

- Reducing preventable deaths, in particular by focusing on the **Sepsis Six Care Bundle**
- Reducing readmissions by 1%, through integrating care and better managing risk.
- Meeting the **emergency care waiting time** standard as we did in April 2014.
- Improving our Friends and Family results, towards being the best in the region.
- Implementing year one of our **Public Health Plan**, making every contact count.
- Reducing the number of complaints, especially repeat complaints.
- Delivering our **Year of Outpatient programme**

Working towards 25% reduction in deaths caused by sepsis

All patients seen within 4 hours

Focusing on the health of wellbeing of patients and staff

Achieving our target of 98% patient satisfaction



- No mixed sex breaches of our **privacy and dignity standard**
- By October 2014, specialty delivery of **18 week wait standards**, and introducing these standards into therapy services.
- Cutting cancelled operations numbers, and eliminating repeat cancellations.
- Delivering national cancer wait times, even where other Trusts deliver part of the care.
- Achieving the emergency care standard, and meeting our own ambitions around mental health care in an acute setting.
- Complying with both the letter and the spirit of the **Safe Staffing promise** made after the Francis Inquiry.

Male & female patients cared for on separate wards

Maximum waiting time of 18 weeks from GP referral to consultant appointment across all of our hospital specialties

Ensuring we have the right number of staff to meet the workflow requirements of each of our clinical areas



Taking time to chat with patients

Care Closer to Home



- Develop further our **model of intermediate care** at Leasowes, Rowley Regis and in Sheldon.
- Complete the transfer of 27 clinics into Rowley Regis
- Reform another long term conditions specialty into general practice, **year two of what we have achieved with diabetes.**
- Implement our **pacesetting project** to change the shape of district nursing delivery, making our services part of the primary health care team.
- Resolve the **long term configuration of midwifery services** for 2015-16, with our CCG partners, local families and the Local Authorities.
- Ensure that our plans for winter 2014 are supported by consistent models of out of hospital care in nursing homes and other settings of risk.

Integrated care delivered outside of acute hospital setting

Specialist diabetes services now delivered alongside your GP in primary care

Our District Nurses will be working more closely with GPs and their teams

We are going to check that our midwifery services suit the people who use them and change our model if we need to

Good Use of Resources



- Cut our reliance on agency, overtime and bank staffing, on which last year we spent over £25m.
- Standardise our equipment, especially in theatres to reduce the costs and safety risks of variation.
- Make sure that the way we work is productive and efficient, across the week and in every month of the year, making smarter use of technology.
- Reduce overheads in our system, so that more of every pound is spent on patient care.
- Eliminate the costs of poor quality care, where patients need more expensive treatment because of errors or omissions that we have contributed to.
- Improving our 'time to hire' from vacancy to recruitment.
- Introducing an **in-house medical bank.**
- Providing extra support to high- turnover departments and those with long-term vacancies.
- Investing in our occupational health services counselling teams to tackle workplace stress.
- Ensure that our training expenditure supports career and skill development.

An alternative model which will reduce locum costs

21st Century Infrastructure



- Invest in estate that we are keeping for the long-term including Sandwell General Hospital, Rowley Regis and Sheldon
- Resolve issues with the Birmingham Treatment Centre to ensure better staff and patient experience
- Proceed with **Midland Metropolitan Hospital (MMH)**

We will be going out to procurement & identifying two preferred bidders

An effective organisation



- Achieve 100% Personal Development Review (PDR) and mandatory training compliance by March 2015.
- Cut sickness rates from their current 4.5%, **by focusing on our fifty hot spots.**
- Improve employee wellbeing by implementing our Public Health Plan.
- Invest in our leaders, through our partnership with Hay Group and others.

The areas across the Trust where sickness/absence rates are above average



Scott Davie, Rotational Physiotherapist

4. How we govern ourselves?

Eight Groups form the structure of our Trust: Seven clinical groups and one which oversees all corporate services. Within that structure we have over thirty directorates who organise local service provision. We are determined, over time, to support the greater development and self-determination of those directorates to operate with autonomy, contingent upon performance.

This year, for the first time, our Annual Report is structured to provide a report back from each of the clinical groups which deliver care services. Those reports focus on NHS services, but in the future they will also be reporting back on research and development and on education. The three-fold mission that we have to provide services, developing at the same time the next generation of staff and the next generation of treatments, is an important feature of our organisation and one that will grow in time.

The work of the Board and its committees is explained below. The Board is concerned not only with the day by day work of the organisation but also our long term plans. The executive group focuses on this year and the year after. Clinical groups hold the primary responsibility for the quality of what we do in and out of hours each week.

The governance systems that we operate are intended to ensure not only that basic standards are always exceeded, but that variation in quality is eliminated where we can, with standards being improved through learning from the best of what we already do, as well as what is done better elsewhere.

We have engaged in discussions during 2013/14 about our journey to a Foundation Trust model of governance. This in particular involves public and staff representation through an elected Governing Body. We have developed our thoughts about how such a programme could be constructive and have impact rather than being simply symbolic. Engagement with constituency members has been active during the year and we expect to create some indicative structures to begin to make use of this energy and perspective during 2015.



Our nursing team in the Rowley Regis Day Hospital

Board Governance Diagram



Chairman
Richard Samuda



Chief Executive
Toby Lewis



Vice Chair
Clare Robinson



Non-Executive Director
Olwen Dutton



Non-Executive Director
Harjinder Kang



Non-Executive Director
Gianjeet Hunjan



Non-Executive Director
Dr Sarindar
Singh Sahota OBE



Non-Executive Director
Mike Hoare



Non-Executive Director
Parmajit Gill



Medical Director
Dr Roger Stedman



Chief Operating Officer
Rachel Barlow



Chief Nurse
Colin Ovington



Director of Finance & Performance Management
Tony Waite



Director of Governance
Kam Dhami



We value greatly the partnerships we have outside the Trust. Some of those are partnerships to provide care, and some are commissioning or assurance relationships designed to ensure that we meet core standards and that the public can be advised of our quality in comparison to others.

Healthwatch England – both Sandwell and Birmingham

The Trust is committed to putting feedback from patients and the wider public into the heart of how we work. We have some examples of very good practice in maternity, outpatient and therapy services. There is more we can do to act on feedback and provide tailored, personalised services, including ensuring we make reasonable adjustments.

We were pleased to place the feedback widget for Birmingham Healthwatch onto our website, and be invited to their annual meeting to reflect on the future care models in West Birmingham. A representative from Sandwell Healthwatch joins each of our Board meetings, and we have now commenced an active Enter and View programme.

Sandwell and West Birmingham Clinical Commissioning Group (CCG)

With our principle commissioner of services, we have worked to re-design nursing services in the community. This project goes into operation during 2014/15 and reflects our determination to help build primary health care teams as a base model of local care.

In October 2013, the whole Board of the Trust met with the CCG to discuss mutual concerns over data quality. The CCG joined our data quality taskforce which operated from October to April 2014. Our new DQ kitemark is intended to provide clarity on the confidence we have in the data item under consideration.

During the year, the Trust was successful in receiving commissions for several new services, including early supported discharge for stroke patients, and the transfer of the GP 'front end' in A&E into Trust responsibility.

Birmingham and the Black Country Local Area Team (LAT)

We worked closely with specialist commissioners, as around a tenth of the Trust's income for care, comes through that route. 2013-14 was a start-up year for these arrangements and we worked with partners to try to ensure a smooth transition to NHS England.

The LAT also coordinated the system wide response to emergency care pressures across the West Midlands. The Trust was very involved in that work as we sought to ensure that we could play a part alongside colleagues in ending very long waits for care. There is more to do for mental health patients in this regard, and that issue remains reflected in our corporate risk register.

Trust Development Authority – NHS Midlands and East (TDA)

The Trust, as a non-Foundation Trust, is regulated through the TDA. Monthly scrutiny of our performance is conducted across issues of safety, workforce, finance and national standards. We have benefitted from TDA support around urgent care and also had a review of our infection control practices, the extremely positive outcome of which is included elsewhere in this report.

The TDA undertook extensive scrutiny of our long term financial and workforce plans, initially in assessing the Midland Met Business Case, but latterly in considering our Five Year Plan submissions. The TDA local and national teams approved the new hospital business case in January 2014.

Health Education West Midlands (HEWM)

Students and postgraduate trainees rate very highly the teaching provided for doctors in our Trust. Likewise nursing and therapy students are positive about our placements. Two weaker areas identified during 2013/14, hand surgery and emergency care, are the subject of sustained improvement work. We recognise that teaching and training are changing, and were pleased to achieve 100% compliance in the initial General Medical Council (GMC) trainer's appraisal submission.

We also partner with HEWM around innovation. They have invested in our apprentice programme. We are working with them on new roles and ways of working. Because we have a long-term workforce plan we are now better able to specify the kind of training support that we need to develop individuals who can work across community and acute boundaries, operate comfortably with technology, and function in an inter-disciplinary manner.

The HEWM visits are vitally important in the ongoing development of good training practice we provide at Sandwell and West Birmingham Hospitals. Training undergraduate and post graduate staff plays a big part in developing staff to be kind and compassionate as well as efficient and effective within their role.

HEWM visited the Trust seven times within the last year, looking into areas such as the medical training provided in Plastic Surgery, Emergency Medicine and Obstetrics and Gynecology. Below is a selection of the positive feedback we received during these visits.

“ **The Clinical Tutor involvement in exploring issues/identifying possible areas of concern from the GMC NTS and JEST is commended.**

Following previous concerns raised with regard to the collaborative working with nursing staff, the overall opinion of Trainees is that once trust is gained by the nursing staff, the interaction and team work is good.

Trainees commend the support provided by the middle grade, with the exception of locum cover. In particular, one consultant was clearly identified by Trainees as an enthusiastic and passionate about education and training within the Emergency Medicine Department.

Care Quality Commission (CQC) registration

The Care Quality Commission is an independent regulator of all health and social care services in England. The Commission checks all hospitals in England to ensure they are meeting national standards and they share their findings with the public.

What are the national standards?

The national standards cover all aspects of care including:

- Treating people with dignity and respect
- Making sure that the environment is clean and safe
- Making sure food and drink meets people's needs
- Managing and staffing services

All health and social care services in England have to be registered with the Care Quality Commission (CQC). Our hospital is registered with no conditions, meaning we are safe to practice and our patients are in good care. The CQC regularly inspect Trusts without or with very little warning to ensure the standards listed above are met. The table below details our 2013 inspection and the findings.

Aims	Site	Actions	Rate	Outcome
June 2013	Sandwell General Hospital	Respecting and involving people who use services	✓	Met this standard
		Consent to care and treatment	✓	Met this standard
		Care and welfare of people who use services	✓	Met this standard
		Assessing and monitoring the quality of service provision	✓	Met this standard
June 2013	City Hospital	Respecting and involving people who use services	✓	Met this standard
		Consent to care and treatment	✓	Met this standard
		Care and welfare of people who use services	✓	Met this standard
		Assessing and monitoring the quality of service provision	✓	Met this standard

Feedback

“ The overwhelming majority of people that we spoke with during the inspection, told us that they were happy with the quality of service they received. One person said “I don’t think that anything could be done better.”

During this inspection we found that there had been significant improvements in this area. Whilst we acknowledge that there were on-going areas for improvements, such as staffing and completing the reorganisation of the complaints process, the Trust had plans in place to support this. We therefore found that there was an effective system to regularly assess and monitor the quality of service that people received.

All the people who were in patients and their relatives that we spoke with told us that their medical and nursing needs were being met. One person told us, “They really look after you, more than fit for purpose.” On all the wards that we visited, we saw that staff were generally caring and committed to their work. We found that people experienced care, treatment and support that met their needs and protected their rights.

”

5. Highlights and lessons from 2013/14

Service developments

The Trust is a very large organisation. We provide care from over 150 locations and offer all sorts of different services. Increasingly, we want to manage services at the most local level possible. Teams are managed through directorates, and those directorates are brought together in seven clinical groups. The success and lessons learned by those groups form the basis for our forward plans as a single Trust. We are especially proud during the last year of our success in achieving the lowest possible risk rating for our maternity and obstetric services (CNST Level 3). Our community specialist team, iCares, entered its second year and achieved national recognition as a role model service for NHS providers across the country in the view of the King's Fund.

If you would like more information about their achievements, please follow the contact details at the end of the annual report in the first instance.

Community & Therapies

During October 2013, Sandwell Community Adult Health and Therapies, merged with the Trust. The Community and Therapies group was established which is a diverse group of around 600 staff who are a mix of registered and non-registered employees. The group, which includes District Nurses, Community Nurses, Physiotherapists, Occupational Therapists, Speech and Language Therapists, Dieticians, Nutrition Nurses and Podiatrists, provided a broad range of services across secondary care and in the community.

Group Director

Fiona Shorney

Workforce

– 616 people

Budget –

£27,394,000



Our community services demonstrate our commitment to becoming the best integrated care organisation in the UK, seamlessly linking up care for patients from community to hospital. During the year, the group has been developing its teams into three directorates as follows:

The Sandwell Integrated Care Services Team (iCares) offers one single point of access, seven days a week, for primary, hospital, mental health or social care professionals or concerned older people or carers. The team incorporates a range of disciplines, including nurse specialists in case management/disease management and nurse practitioners skilled in Hospital at Home interventions, therapists, rehabilitation assistants, social workers, care assistants and night sitters. It also has easy access to local GPs and to voluntary sector organisations.

On receipt of a referral, they assess urgency of need and guarantee to begin assessment and support in the person's own home within three hours of referral (for urgent cases) and within two days (for subacute cases). They are then able to arrange 'wraparound' services as required to help the person remain at home, unless hospital admission is necessary. The service also supports care home residents in crisis in the same way.

The work of iCares has attracted national interest and was commended by the King's Fund as an example of good practice in their 2014 thought-leading publication, "Making our health and care systems fit for an ageing population." It has also been cited as good practice by NHS England in the NHS Improving Quality publication, "Improving Adult Rehabilitation Services in England: Sharing best practice in acute and community care."

Our leading edge Primary Care Assessment and Treatment Centre (PCAT) saw 311 more patients in the first seven months of the service than the same period the previous year. 93% of those patients were able to stay at home with the right support rather than being sent into hospital by their GP.

ICARES also set up a new community service for deep vein thrombosis (DVT), preventing patients with a suspected DVT from having to come into hospital, assisting 590 patients in the first eight months.

- Integrated Bed Services (Ibeds), covering all secondary care provision, intermediate care beds, Rapid Response Therapy Service and Interim community beds
- Ambulatory Therapy Services, covering all outpatient services including spinal clinics, pain management, diabetic foot clinic, nail surgery and Occupational Health Physiotherapy.

We have worked closely with our GP colleagues to integrate our services, in particular the iCares and District Nursing teams and are continuing to develop our integration.

During the year we have also:

- Redesigned the management roles that support the new directorates
- Promoted multi-professional joint working across the directorates to support all services, avoiding duplication of assessments and handovers
- Expanded our admission avoidance services in the community and in our emergency departments and admission units
- Expanded our early supported discharge service to facilitate shorter lengths of stay.

One of our key challenges for the future will be, in liaison and partnership with other clinical groups, to challenge, revise and expand traditional clinical pathways across Medicine, Surgery and Trauma and Orthopaedic to deliver services, historically in an acute bed, in community locations. An example is the delivery of IV services.

It is our intention to optimise use of Rowley Regis Day Hospital to deliver a broad range of outpatient services and clinics - the likelihood is that the name will change, as 'Day Hospital' does not reflect what the facility will provide.

In acute services, we are working towards delivering a seven day service in Physiotherapy and Occupational Therapy ahead of winter 2014. In Physiotherapy this is becoming the norm but for other services, such as Occupational Therapy, this will be more challenging to implement as historically, the acute service runs Monday – Friday during core hours.

Lastly, the Year of Outpatients is high on our agenda particularly in the Ambulatory Therapies directorate to ensure we comply with Trust standards.



Imaging

With a focus on integrating our services and improving efficiencies, the Imaging group has made some considerable achievements, including:

- Cutting the time it takes us to turn around reports
- Reviewing the staffing establishment required to support seven day working
- Establishing a Directorate model with the appointment of
- Clinical Directors for General Diagnostics, Interventional Radiology, Breast Screening and Nuclear Medicine
- Achieving a financial surplus and our savings plan
- Supporting the seven day Metastatic Spinal Cord Compression pathway
- Supporting Clinical Groups to achieve improved performance, such as our Winter Must Be Better Project
- Maintaining our waiting time performance to less than 5 weeks (with the exception of Cardiac CT)
- Improving Emergency Department report turnaround despite increasing demand

Group Director

Dr Jonathan Benham

Workforce
– 332 people
Budget –
£11,244,000



ED Report Turnaround Feb 2013 - Feb 2014

Mobility	February		March		April		May		June		July		August	
	% < 24hrs or next working day	Total	% < 24hrs or next working day	Total	% < 24hrs or next working day	Total	% < 24hrs or next working day	Total	% < 24hrs or next working day	Total	% < 24hrs or next working day	Total	% < 24hrs or next working day	Total
CT	100	513	99	622	99	678	99	1014	97	818	99	1023	99	1030
MR	57	21	84	19	79	24	88	40	90	32	70	30	84	25
Radiology	100	5918	99	6718	99	6714	100	9467	99	7249	99	7736	99	9290
US	100	75	100	99	100	86	100	198	95	90	100	115	100	103

Mobility	September		October		November		December		January		February	
	% < 24hrs or next working day	Total	% < 24hrs or next working day	Total	% < 24hrs or next working day	Total	% < 24hrs or next working day	Total	% < 24hrs or next working day	Total	% < 24hrs or next working day	Total
CT	99	827	99	1055	100	1102	99	1142	99	974	100	1051
MR	65	51	100	19	99	46	81	41	77	26	93	54
Radiology	98	7514	99	8166	100	8152	99	9659	100	7625	100	6627
US	100	94	100	194	100	142	100	127	100	106	100	116



Our new MRI scanner at Sandwell General Hospital

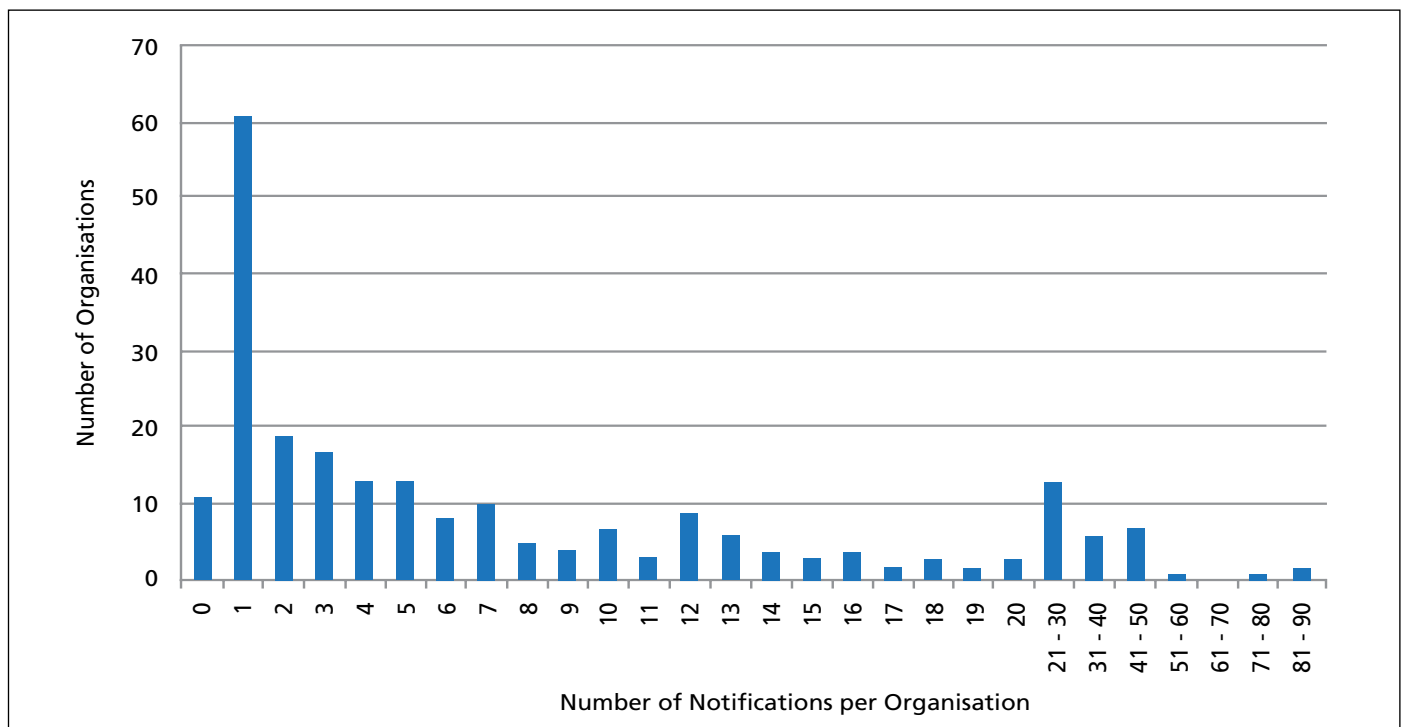
We have been working on a number of other projects that we haven't achieved during the year but we are continuing to work towards, including:

- Seven day working has taken longer to fully implement than anticipated, mostly because E-Rostering only became available to us in early 2014
- Right Test Every Time has not resulted in any measureable decrease in demand, and we would welcome a move to service line reporting in order to support this initiative internally
- Externally the change to a block contract for General Practitioners (GP) has had a significant impact on our ability to meet our future savings targets
- Direct Access work gives motivation to managing the demand from GPs – particularly for Magnetic Resonance Imaging (MRI)
- Beginning to audit GP requests.

How we compare to others

The Imaging group took part in the national Radiology benchmarking exercise in 2013, which produced comparative data around service models, modalities, equipment and capital, access activity, reporting, workforce, costs, quality and outcomes. The full report is available publicly and is helping to inform our future plans.

Reviewing incidents



The review of Ionising Radiation Medical Exposure Regulations (IRMER) incidents from our Trusts compared with other organisations up to 2012 shows 20 reported incidents.

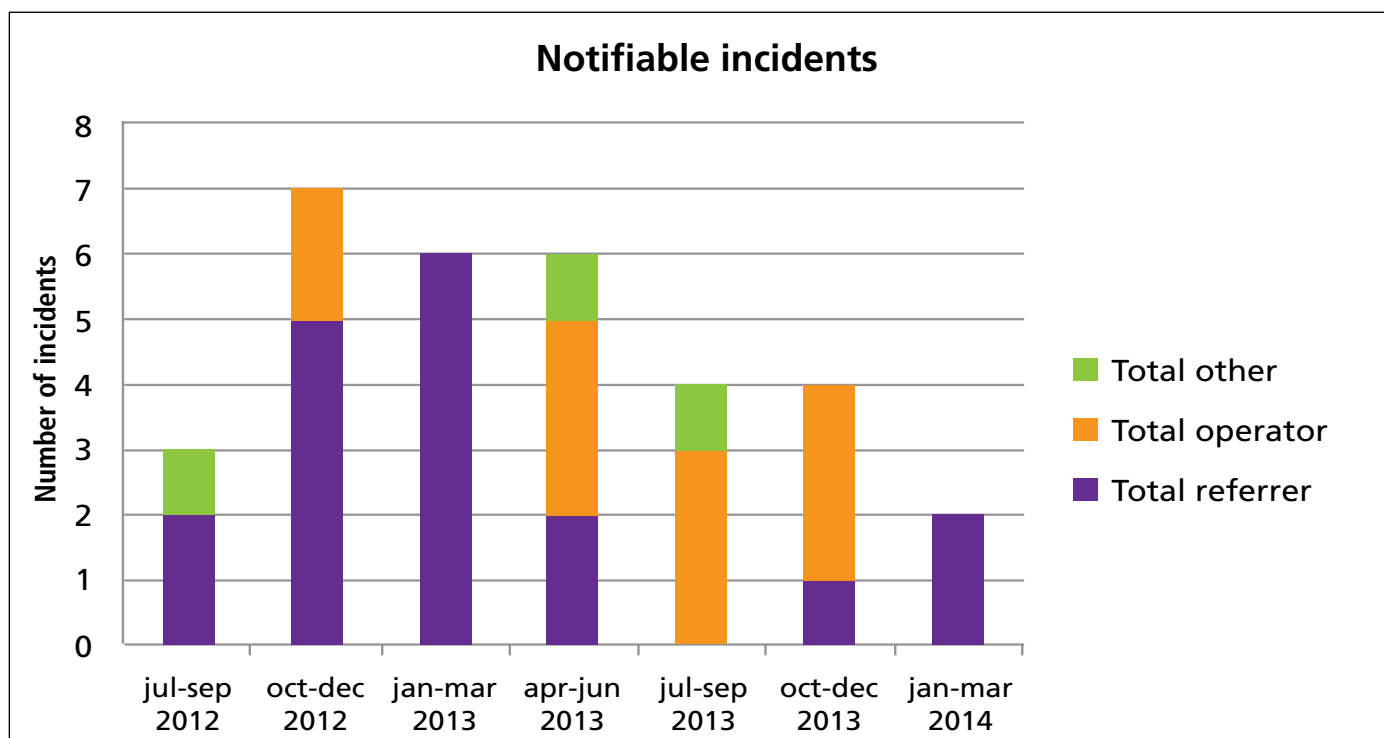
2012: 13

2013: 12

2014: 14

With total number of notifiable incidents since 2010 being 47.

We are committed to reducing the number of IRMER incidents and we carry out table top reviews of incidents where appropriate.



Reducing notifiable incidents

We are raising awareness of issues with referrers through Trust-wide and specific communications, with the referrer's Group Director taking responsibility for the investigation of referrer notifiable incidents. We will support groups to put preventative measures in place.

We have implemented a range of improvements to iCM, the clinical results, ordering and reporting system including:

- Patient sex now appears on the printed request form
- A message is displayed when MRI and CT requests are placed, explaining how to cancel the request
- A duplicate request alert is displayed if a request is placed for a CT scan that has already been performed in the past three months

Using the Trust's Medical Physics mailbase we have begun Benchmarking with other Trusts to identify areas of good practice to improve our service.

Priorities for Imaging in 2014/15

- We intend to work with commissioners on referral pathways for direct access imaging in order to provide our patients with integrated care
- Seven day services are to be embedded, with development of the reporting radiographer role to support with reporting efficiency
- Investment in new Picture Archiving and Communication System (PACS), Vendor Neutral Archive & Voice Recognition systems will bring efficiencies and provide our commissioners with a means of accessing patient reports more easily.
- Novel ways of procuring and maintaining equipment are being investigated
- The Group supports the Year Of Outpatients Project – and in particular is investigating the use of check-in desks where possible.



Kulvir Chana, Biomedical Scientist

Pathology

In the last year, the Pathology department has undergone major re-organisation with the move of hub laboratories from City to Sandwell. Our blood sciences laboratory officially opened on the first floor of the former Pathology building at Sandwell Hospital in January 2014.

Our new laboratory was produced on time and at very modest cost with a huge effort involving large numbers of pathology staff working with the Trusts Capital Projects team. The Blood Sciences facility sees a number of departments working much more closely together using common robotics and sample reception areas and focussing on increasing the efficiency of the department.

Continued growth from Primary Care

Our overall increase in work from our Community General Practitioners is between 10-30% depending on tests. We have prioritised ensuring that we have the right staff in place to receive and handle this work appropriately. Test turnaround times are an important aspect of the pathology service and we are working hard to ensure that samples are collected and treated within the optimum time in order that results are true and meaningful. Audits have indicated that some samples received from General Practitioners are well beyond the optimum time. The transportation of samples plays a crucial part in our service and we are increasingly aware that the existing transport systems in the community need to be reviewed and updated.

The anticoagulant service in Haematology is also seeing an increase in demand due to the successful tendering and award of any qualified provider (AQP) for their services by Walsall CCG and also services managed by GPs moving back to us.

Group Director
Dr Jonathan Berg
Workforce
– 331 people
Budget –
£12,943,000



Innovation in the laboratory

We have continued to innovate in all areas of our work. Our Microbiology department sees the routine use of mass spectrometry techniques known as Maldi-TOF, to report the cause of infections much faster than in our previous traditional methods. In our Immunology department, we are working on a number of new services that help categorise and monitor treatment of patients with immune disease.

Our direct to the public Vitamin D service has continued to be very well received and is used by members of the public concerned about their vitamin D levels right across the United Kingdom.

We are currently implementing new tests as identified by National Institute for Health and Care Excellence (NICE) guidelines. These new tests include faecal calprotectin for studying patients with intestinal disease and the rather expensive but potentially effective BNP test for use in stratifying patients with heart failure.

We are continuing to introduce new ways of providing patient access to results. Using post, sms text and online access, we are now providing results to our Diabetic, Rheumatology and Immunology patients more readily.

Our staff

We put a great emphasis on communication and team building in the Pathology department. Communication, both internal and also with our users is vital. Follow the Pathology department on the Twitter accounts @City Assays and @fitpathlab to see more.

Future Plans

One of the major tasks in the coming years is moving to the next phase of our Pathology redevelopment. Planning for the Microbiology and Histopathology departments to move to Sandwell needs to progress from the drawing board to reality. This redevelopment phase will be closely integrated with the Midland Metropolitan Hospital build.



Our Chairman and colleagues are shown the new blood sciences laboratory at Sandwell

Surgery A



Sandwell's new Surgical Assessment Unit

Group Director
Mr Misra Budhoo
Workforce
– 1,034 people
Budget –
£69,321,000



In 2013/14, the Group's highlights included:

- Theatre annualisation to improve staffing and more effective use of services
- Many group representatives honoured at the Staff Awards

In November 2013, the new Sandwell Surgical Assessment Unit (SSAU) opened to provide comprehensive, high quality care to patients aged 16 and over who present with an acute general trauma or orthopaedic problem from the Emergency Department (ED) or General Practitioner (GP) referral. Patients now follow an agreed pathway from the front door to SSAU to allow a rapid assessment, diagnosis, stabilisation and treatment of their condition within eight hours of attending the hospital. The SSAU is open 24/7, 365 days a year and treats around 60-80 patients per week.

- Key staff member Helen Shoker leaving to be chief nurse at Royal Orthopaedic Hospital
- Maintaining quality standard measures such as MRSA and venous thrombo-embolism
- Achievement of Beacon status for breast services
- Complete restructure of the group
- Significant improvement in sickness absences.

In 2013, Surgery A inpatient areas completed a 6Cs campaign, which saw the Group adopt a different 'C' for each month as follows:

- June – Care
- July – Compassion
- August – Competence
- September – Communication
- October – Courage
- November - Commitment.

Staff demonstrated their awareness of the 6C's in Practice strategy on memo boards and external ward displays. They also invited patient involvement through nominating a member of staff that they felt most upheld the value of the month.

In January 2014, Surgery A launched its new "Theatre Standards" agreement, which was created to ensure all theatre users understand the importance of dress code and expectations on entering the theatre suites. The key outcome for the agreement was to both improve infection control and deliver excellent patient care. Regular visitor to theatres such as surgeons, anaesthetists and theatre staff were fully briefed on the standards which have become an integral part of Surgery A operations.



Priorities for the Group in 2014/15:

- Ongoing work in demand capacity to meet 18 weeks Referral to Treatment Time (RTT)
- Continuing with the programme of theatre refurbishment
- Never events in theatre – a theatre review with recommendations
- Working towards delivering transformation plans
- Further development of Sandwell SAU to ensure that it is fully staffed.

Surgery B

In 2013/14, the Group's highlights included:

- A formal presentation was made to Audiology by the Chief Executive in recognition of it becoming one of six national providers on whom accreditation by UKAS (United Kingdom Accreditation Service) was conferred under the Improving Quality in Physiological Sciences
- Standard (IQIPS) for adult care. The team was also the first within the region to become accredited for its Paediatric services
- The Mayor of Sandwell selected Birmingham Midland Eye Centre (BMEC) as her Charity of the Year. During the course of the year, the Trust has participated in a number of events to optimise fundraising to patients benefit
- BMEC expanded on its social media information exchange potential through supplementing its website <https://bmec.swbh.nhs.uk> with a Twitter account @swbh_BMEC
- In commemoration of a colleague who died in 2012, but both supported training and inspired generations of Ophthalmologists and Optometrists, BMEC received a commemorative bench
- Mr Kale (ENT consultant) was commended by the Medical School for his revised teaching methods in both clinic and theatre
- Undertaken by Mr Imran Masood, (Glaucoma Consultant), BMEC was the first to host the Glukos Suprachoroidal Stent Procedure as part of an international study
- To reduce queue waits at outpatients reception in BMEC, self-check in units were installed. Within the first week they were used by 75% of our patients. To further improve patient flow, the Reception desk was moved closer to the main entrance
- As part of National Eye Health Week, BMEC colleagues participated in the inaugural Birmingham Carrot Walk - a charitable event (organised by Fight for Sight) aimed at raising donations for UK ophthalmic research

Group Director
Mr Ajai Tyagi
Workforce
 – 404 people
Budget –
 £46,050,000



To support transition between paediatric and adult services for adolescent patients, BMEC and Birmingham Children's hospital agreed care pathways for those with long term conditions. These pathways included the delivery of joint provider clinics as the adolescent prepares to transition between services facilitating better communication between them and their new doctor.

Key learnings for the Group

From a number of serious, untoward patient incidents in the year to March 2014, the following learnings and improvements to processes were put into effect. These included:

- The use of video reflective practice to ensure that agreed surgical processes are both standardised and adhered to
- The use of random patient surveys to ensure that both identification and procedure check processes are embedded
- Improvement of both key protocols and education related to them.

In terms of measurable outputs, the Group achieved:

- Financial underspend of £522k against plan
- The maintenance of BMEC Casualty waiting times below four hours for 98.8% of attendees
- RTT within 18 Weeks for 89.9% of admitted patients and 98.6% of non-admitted patients
- Development reviews for all staff within the year.



Care in the Birmingham and Midland Eye Centre

Medicine and Emergency Care

The Medicine and Emergency Care Group has worked hard through the year to improve patient care.

During 2013/14 we have:

- Put new structures in place with many new roles and appointments
- Improved our 95% performance through better coordination of activity at the front door and wards
- Introduced Board Rounds which are a new way of conducting a brief multidisciplinary discussion of all ward patients each morning, with data logged on the electronic Bed Management System Established two Medically Fit For Discharge Wards (one at City, one at Rowley Regis), dedicated to providing nurse-led care for patients no longer requiring an acute hospital bed
- Supported seven-day working with an additional General Medicine consultant on-call at weekends to review recent admissions, sick patients and potential discharges on the wards

Group Director
Dr Matthew Lewis
Workforce
– 1,677 people
Budget –
£151,348,000



At the Trust's annual Staff Awards in October 2013, three groups were awarded Beacon status, including Medicine & Emergency Care for its gastroenterology services. To win this award, consultants and specialist nurses all contributed different examples of innovations, research, patient engagement and public health. With a strong focus on its patients, the Gastroenterology department has worked towards empowering people to manage their conditions at home, whilst also providing quick and easy access to clinical nurse specialists via dedicated phone lines and nurse led clinics. In doing so, the department has increased efficiency by reducing weekly outpatient clinics by 25 per cent.

The scope of the Trust's Gastroenterology service extends well beyond the boundaries of Sandwell and western Birmingham to provide services for the whole of the West Midlands. Specialists from the Trust currently manage and run University Hospitals Birmingham's bowel cancer screening programme and support specialist transition clinics at Birmingham Children's Hospital.

- We are working on creation of a regional Behcet's service in Rheumatology as well as establishing a trust-led community Diabetes service
- Made improvements in appraisal, mandatory training and job planning.

Priorities for the Group in 2014/15:

- 18 week referral to treat performance is being closely reviewed within the Group
- Our biggest challenges are delivering our savings plans and controlling our overspend in Nursing Initiatives to improve in patient provision, including FrailSafe and Home for Lunch



Rev. Everton Harrison, Chaplaincy Visitor

- Continue to improve our performance in appraisals, PDRs, job planning, and mandatory training
- We are expecting a decision on the configuration of strokes services across the West Midlands within the next few months.

As a Group, we believe that the balance between delivering high quality care while controlling our expenditure can only be achieved by implementing radical new processes. We will require our staff, and the people that we work with outside our Group, to be open to innovative new approaches in the way that we care for our patients. Good financial management at all levels in the group is essential to making sure that we use our resources effectively.

Women's & Child Health

During 2013/14 the Group made significant improvements to the range of services we provide including:

Group Director
 Professor
 David Luesley
Workforce
 – 1,020 people
Budget –
 £77,738,000



Maternity directorate

In February 2014 our Maternity Services were awarded Level 3 CNST accreditation which is the highest possible safety and risk management standard, awarded by the NHS Litigation Authority following a thorough assessment process. The accreditation aims to promote effective risk management and minimise harm to patients. This significant achievement was possible through the hard work and dedication of the teams within maternity services and demonstrates an improvement on the previous year, when Level 2 was awarded.

- Awarded Baby Friendly Level 2
- Implementing BadgerNet – an IT system for complete electronic data records of maternity activity

Gynaecology directorate

- Opening of the Emergency Gynaecology assessment unit (with Rapid Hydration for hyperemesis and Hot clinics) reconfiguring gynaecology inpatient services
- Redesigning the community gynaecology and scanning service into six community venues seeing over 50% of general gynaecology outpatients in this one stop service becoming one of the first three Beacon services
- Achieving an excellent Gynaecology Peer Review and Obstetrics & Gynaecology Deanery review.

Community Children's directorate

- Progressing our plans to deliver the Department of Health's health visiting three year strategy "Delivering the Future"

Pediatric directorate

- Focussing on activity for the Keep it Moving project to streamline discharges from the unit
- Achieving excellent results from Diabetes Peer Review and Deanery review

In terms of measurable outputs, the Group achieved:

- Major and/or sustained improvement/achievement on venous thrombo-embolism assessment, MRSA screening, colposcopy standards, Genito-Urinary Medicine (GUM) targets and 18 weeks referral to treatment time RTT
- Conversion of three day case theatre lists to Local Anaesthetic procedures undertaken in a bespoke outpatient facility
- No never events, ward closures, MRSA bacteraemia, unavoidable pressures sores, mixed sex breaches, orfalls resulting in serious injuries
- Delivery of service specific Commissioning for Quality and Innovation framework goals
- Evidence of well engaged workforce from 'Your Voice' survey and we are working on increasing the number of participants
- Good Friends and Family Test results in gynaecology.

What the Group didn't quite achieve but is working towards:

- Sustained improvement for non-clinical on the day cancellations, compliance to all sections of the WHO checklist, sickness reduction, 95% mandatory training compliance, readmission rates
- Consistent achievement of 62 day standard in gynaecology oncology driven predominantly by late referrals from the units. We are continuing to work with the units to provide support.
- Maternity Friends and Family Test – compliance and scores remain an issue
- Retention of the School Health Nursing service – work on going to reduce the fragmentation of care with the new provider.
- The retained immunisation service has received additional income to expand
- Improvement to the Autism Spectrum disorder pathway through planned investment in 2014/15.

Priorities for the Group in 2014/15:

- Realisation of benefits of the new BadgerNet system – paper light records, activity monitoring, KPI monitoring, antenatal screening risk reduction
- 'Go live' with the newly installed baby tagging system
- Aim for Baby Friendly Level 3
- Integrate the GUM and Family Planning services and remodel community service provision
- Extensive marketing of both the Community Midwifery and Health Visiting services increasing engagement with key stakeholders
- Redesign of City Paediatric Assessment Unit with A&E and Medicine
- Streamline all Outpatient services (acute and community) in line with Year of the Outpatient programme
- Realise benefits from newly invested obstetric cover on labour ward
- Development of a centralised health visiting call centre.



Maternity Unit, City Hospital

6. Our financial performance in 2013/14

The performance of NHS Trusts is measured against four primary financial objectives:

- i. the delivery of an income and expenditure position consistent with the target set by the Department of Health (the breakeven target);
- ii. not exceeding its capital resource limit;
- iii. not exceeding its external financing limit; and
- iv. delivering a capital cost absorption rate of 3.5%.

For 2013/14, the Trust was set an amended income and expenditure target surplus of £6,736,000, increased from an original target of £4,600,000. Against this target, the Trust met its main budgetary objective by delivering an underlying surplus of £6,751,000.

For the purpose of measuring statutory accounts performance, the Trust generated a deficit in year of (£2,505,000). This deficit is primarily the result of the downward movement in the value of Trust property, mainly land, and the charge of this downward valuation to in year expenditure.

As has been the case in previous years, the presentation of financial results requires additional explanation owing to adjustments generated by valuation updates to the Trust's assets as well as changes to the accounting for donated and grant funded capital assets. These technicalities are explained in the detailed notes to the accounts (separate document).

The Trust's property assets (land and buildings) are professionally valued annually by the District Valuer. In 2013/14, this exercise resulted in a general increase in the value of the Trust's buildings but a decrease in the value of land, primarily land held for the construction of the Midland Metropolitan Hospital. The downward change in the value of assets is reflected as expenditure in the accounts but, for the purpose of measuring performance against the DoH target, this expenditure is removed as a technical adjustment. The table below shows how the Trust's underlying performance is made up. The deficit in the statutory published accounts is, in part, technical and does not affect the assessment of the Trust's performance against the duties summarised above (e.g. breakeven, CRL, EFL, capital absorption).

Budgetary/Accounts Performance	2013/14	2012/13
	£000s	£000s
Income for Patient Care Activities	396,256	391,875
Income for Training, Education, Research & Other	42,766	41,132
Total Income	439,022	433,007
Pay Expenditure	(291,589)	(284,797)
Non Pay Expenditure Including Capital Charges & Interest	(149,938)	(151,651)
Total Expenditure (including impairments & IFRIC12 adjustment)	(441,527)	(436,448)
Surplus/(Deficit) per Statutory Accounts	(2,505)	(3,441)
Exclude: All Impairments, Reversals and Other Adjustments to Non Pay Expenditure	9,256	9,964
Surplus/(Deficit) for DoH Monitoring (Target Performance)	6,751	6,523

Although impairments and reversals are not counted towards measuring budgetary performance, they must be included in the statutory accounts and on the face of the Statement of Comprehensive Income. Impairment transactions are non-cash in nature and do not affect patient care budgets. However, it is important that the Trust's assets are carried at their proper values so that users of its financial statements receive a fair and accurate view of the financial position. The Department of Health holds allocations centrally for the impact of impairments.

During the year, a number of the Trust's operating groups experienced significant budgetary pressures as a result of higher than planned patient activity levels in key areas, pressure on emergency services, increased dependency of some patients and the impact of a number of unforeseen events. In overall terms, however, the Trust was able to offset these pressures with contingency reserves as well as injecting additional resources into key operational areas to assist in maintaining or improving service levels. There was again a strong performance in the delivery of the transformation plan (nationally viewed as the cost improvement programme) both the Trust as a whole and the majority of divisions met their delivery targets in full. Both during 2013/14 and in plans for subsequent years, the Trust continues to concentrate on changes that improve processes and secure savings without compromising patient care.

More detailed information on capital spend is shown later in this report. The capital resource limit (CRL) sets a maximum amount of capital expenditure a trust may incur in a year. Trusts are not permitted to exceed this limit but may spend less than the limit. Against its CRL of £21,815,000 for 2013/14, the Trust charged £21,224,000 and so met this financial duty.

The external financing limit (EFL) is a control on the amount a trust may borrow and also determines the amount of cash which must be held at the end of the financial year. Trusts are not allowed to exceed or overshoot the limit but are permitted to undershoot. Against its EFL of £3,015,000, the Trust undershot by £3,930,000.

The capital cost absorption rate is a rate of return on the capital employed by the Trust which is set nationally at 3.5%. The value of this rate of return is reflected in the Statement of Comprehensive Income below as PDC dividend, an amount which trusts pay back to the Department of Health to reflect a 3.5% return. The value of the dividend/rate of return is calculated at the end of the year on actual capital employed so is set automatically at 3.5%.



Lynda Jones, Senior Sister

Income from Commissioners and other sources

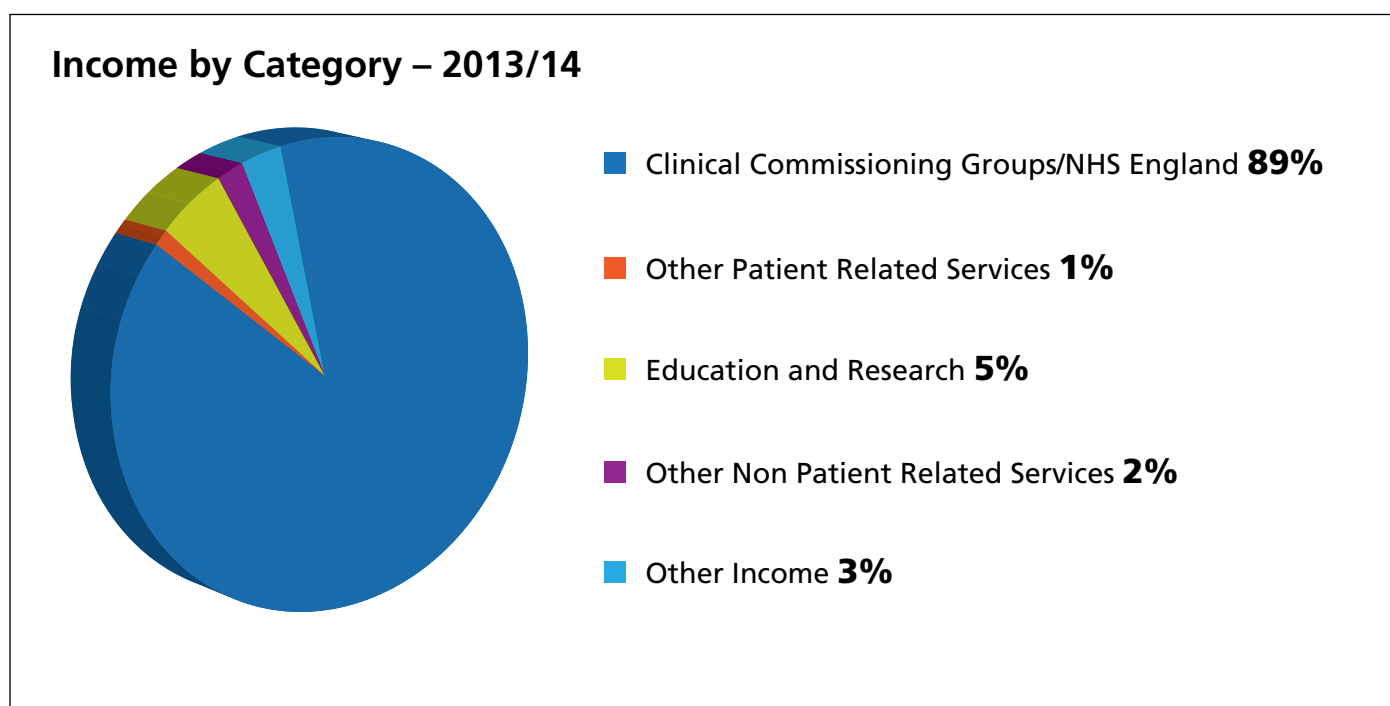
The Trust received the majority of its income from Clinical Commissioning Groups (CCGs) as the table below shows. CCGs replaced Primary Care Trusts (PCTs) on 1st April 2013 and the equivalent income stream for 12/13 was from PCTs.

The main components of the Trust's £439,022,000 income are shown below. Income increased from Clinical Commissioning Groups/Primary Care Trusts in respect of direct patient care whilst other income sources were broadly stable and/or are too small to have a material impact on the financial performance of the Trust. A pattern of broadly similar year on year income is expected for the future especially given the ongoing need to meet rising healthcare demands from within static or reducing resources.

Sources of Income £000s	2013/14	2012/13
NHS England/DoH/Strategic Health Authorities/Other NHS *	53,311	1,491
NHS and Foundation Trusts	1,380	972
Clinical Commissioning Groups/Primary Care Trusts *	338,768	385,823
Non NHS Patient Income	2,797	3,589
Education & Research	21,754	20,866
Other Non Patient Related Services	9,678	9,163
Other Income	11,334	11,103
Total Income	439,022	433,007

Income relating to specialised services was received in 13/14 from NHS England. For 12/13, this was included within the Primary Care Trust category.

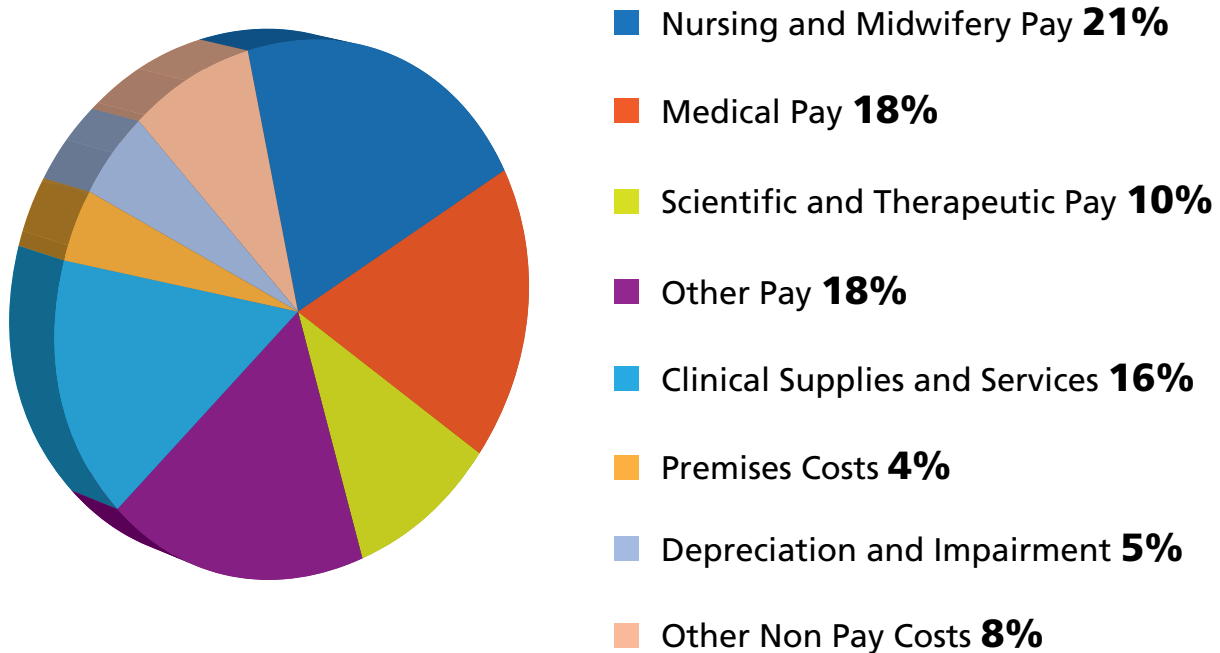
Within the pie chart below, the largest element (89.1%) of the Trust's resources flow directly from Clinical Commissioning Groups/NHS England with the next most significant element (4.8%) being education, training and research funds. The Trust is an accredited body for the purposes of training undergraduate medical students, postgraduate doctors and other clinical trainees. It also has an active and successful research community.



Expenditure

The chart below shows that 67% of the Trust's costs are pay and within this, the three largest groups are nursing and midwifery (21%), medical staff (18%) and scientific and therapeutic (10%). The remaining 33% of operational expenditure is non pay, the largest element of which is clinical supplies and services which includes drug costs at 16%.

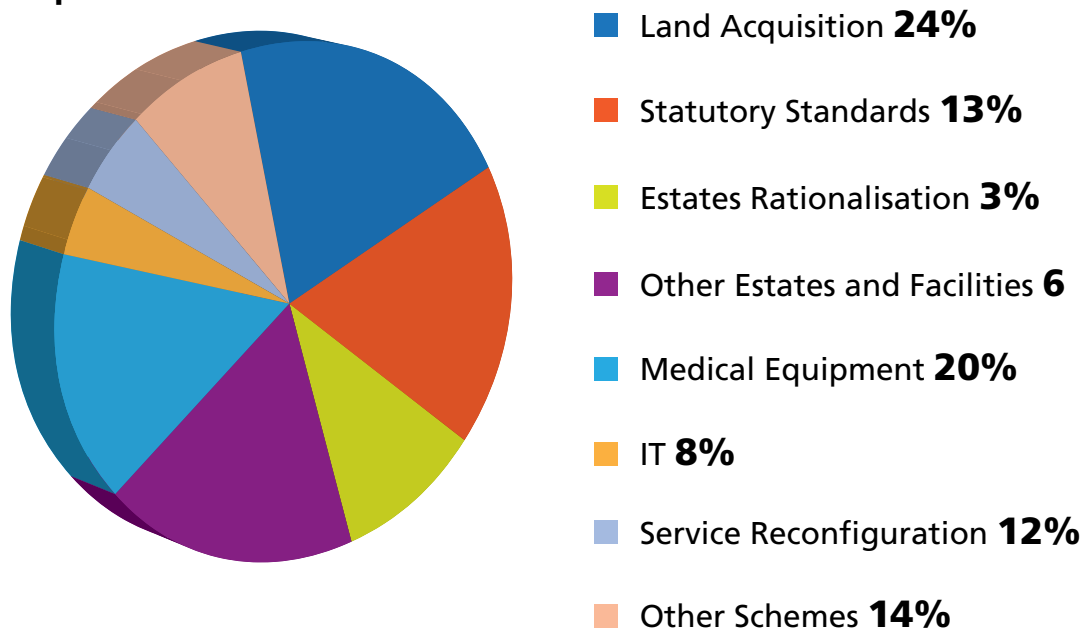
Expenditure by Category – 2013/14



Use of capital resources

Capital expenditure differs from day to day operational budgets and involves tangible items costing more than £5,000 and having an expected life of more than one year. In total, the Trust spent approximately £21.7m on capital items during 2013/14. A breakdown of this expenditure is shown in the chart below.

Capital Spend 2013/14



The Trust spent a significant proportion of its capital budget updating its facilities and medical equipment. Specifically, £7.1m was spent on upgrading the Trust's estate, including ensuring compliance with statutory standards (£2.6m), rationalising the number of buildings in use (£0.7m) and reconfiguration of blood sciences and stroke services (£2.6m). Medical equipment accounted for £4.3m including £1.1m on imaging diagnostic facilities.

Other developments included further acquisition of land at Grove Lane (part of the development of the Midland Metropolitan Hospital) costing £5.0m and £1.7m on replacement and upgraded IT systems.

Sickness absence

Staff Sickness Absence	2013/14	2012/13
Total Days Lost	64,130	64,353
Total Staff Years	6,526	6,575
Average Working Days Lost	9.8	9.8

Staff sickness data is provided on a national basis by the Department of Health and covers the calendar year ended 31st December 2013 (31st December 2012 for prior year comparative data).

Audit

The Trust's external auditor is KPMG LLP.

The cost of the work undertaken by the auditor in 2013/14 was £140,000 including VAT. The fee in respect of auditing charitable fund accounts is excluded from this sum. In addition, a quality review of the Trust's Long Term Financial Model was undertaken outside the audit at a cost of £12,000.

As far as the directors are aware, there is no relevant audit information of which the Trust's auditors are unaware and the directors have taken all of the steps they ought to have taken as directors to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

The members of the Audit Committee at 31 March 2014 are Gianjeet Hunjan (Chair), Sarindar Singh Sahota, Olwen Dutton, Clare Robinson and Harjinder Kang.



Members of the Cardiology team

6a. Remuneration Report

Remuneration Report for the Financial Year Ending 31 March 2014

The Trust has a Remuneration and Terms of Service Committee, whose role is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors. Membership of the Committee is comprised of the Trust's Chair and all Non-Executive Directors. As at 31st March 2014, these were:

- Richard Samuda (Chair)
- Gianjeet Hunjan
- Sarindar Singh Sahota
- Olwen Dutton
- Clare Robinson
- Harjinder Kang
- Michael Hoare (non executive director designate)

Remuneration for the Trust's Executive Directors is set by reference to job scope, personal responsibility and performance, and taking into account comparison with remuneration levels for similar posts, both within the National Health Service and the local economy. Whilst performance is taken into account in setting and reviewing remuneration, there are currently no arrangements in place for 'performance related pay'. The granting of annual inflationary increases are considered and determined by the remuneration committee on an annual basis.

It is not the Trust's policy to employ Executive Directors on 'rolling' or 'fixed term' contracts; all Directors' contracts conform to NHS Standards for Directors, with arrangements for termination in normal circumstances by either party with written notice of 6 months. The salaries and allowances of senior managers cover both pensionable and non pensionable amounts.

A number of changes were made during 2013/2014 in the composition of the Board. Professor Richard Lilford left the Board in January 2014. Michael Hoare joined the Trust in February 2014 as a non executive director designate without voting rights at the Board. Robert White, Director of Finance and Performance Management left in February 2014 and was replaced in January 2014 (with a period of overlap) by Antony Waite and Rachel Overfield, Chief Nurse, left in September 2013 and was replaced on a temporary basis by Linda Pascall from September to December 2013 and then on a permanent basis by Colin Ovington from December 2013.

Items contained within the tables Salaries and Allowances of Senior Managers and Pension Benefits and the section on pay multiples are auditable and are referred to in the audit opinion.

SALARIES AND ALLOWANCES OF SENIOR MANAGERS

Name and Title	2013-14							2012-13						
	(a) Salary (bands of £5000) £000	b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) Total Payments Made by Trust (bands of £5000)	(f) All pension related benefits (bands of £2500)	(g) Total all payments and benefits (bands of £5000)	(a) Salary (bands of £5000) £000	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) Total Payments Made by Trust (bands of £5000)	(f) All pension related benefits (bands of £2500)	(g) Total all payments and benefits (bands of £5000)
Richard Samuda, Chair	20-25	39	0	0	25-30	0	25-30	20-25	0	0	0	20-25	0	20-25
Clare Robinson, Non Executive Director and Vice Chair (from 20 November 2012)	5-10	4	0	0	5-10	0	5-10	0-5	0	0	0	0-5	0	0-5
Gianjeet Hunjan, Non Executive Director	5-10	0	0	0	5-10	0	5-10	5-10	0	0	0	5-10	0	5-10
Sarindar Singh Sahota, Non Executive Director	5-10	0	0	0	5-10	0	5-10	5-10	0	0	0	5-10	0	5-10
Derek Alderson, Non Executive Director	0	0	0	0	0	0	0	0-5	0	0	0	0-5	0	0-5
Olwen Dutton, Non Executive	5-10	0	0	0	5-10	0	5-10	5-10	0	0	0	5-10	0	5-10

SALARIES AND ALLOWANCES OF SENIOR MANAGERS														
Name and Title	2013-14							2012-13						
	(a) Salary (bands of £5000) £000	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) Total Payments Made by Trust (bands of £5000)	(f) All pension related benefits (bands of £2500)	(g) Total all payments and benefits (bands of £5000)	(a) Salary (bands of £5000) £000	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) Total Payments Made by Trust (bands of £5000)	(f) All pension related benefits (bands of £2500)	(g) Total all payments and benefits (bands of £5000)
Director														
Richard Lilford, Non Executive Director (to 31 January 2014)	5-10	0	0	0	5-10	0	5-10	0-5	0	0	0	0-5	0	0-5
Harjinder Kang, Non Executive Director (from 20 November 2012)	5-10	1	0	0	5-10	0	5-10	0-5	0	0	0	0-5	0	0-5
Michael Hoare, Non Executive Director Designate (from 1 February 2014)	0-5	0	0	0	0-5	0	0-5	0	0	0	0	0	0	0
Toby Lewis, Chief Executive	180 - 185	0	0	0	180 - 185	27.5 - 30	205 - 210	0	0	0	0	0	0	0
John Adler, Chief Executive	0	0	0	0	0	0	0	120 - 125	4	0	0	120 - 125	47.5 - 50	120 - 125

SALARIES AND ALLOWANCES OF SENIOR MANAGERS

Name and Title	2013-14							2012-13						
	(a) Salary (bands of £5000) £000	b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) Total Payments Made by Trust (bands of £5000)	(f) All pension related benefits (bands of £2500)	(g) Total all payments and benefits (bands of £5000)	(a) Salary (bands of £5000) £000	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) Total Payments Made by Trust (bands of £5000)	(f) All pension related benefits (bands of £2500)	(g) Total all payments and benefits (bands of £5000)
Robert White, Director of Finance & Performance Management (to 16 February 2014)	110 - 115	0	0	0	110 - 115	0 - 2.5	110 - 115	125 - 130	2	0	0	125 - 130	5 - 7.5	125 - 130
Antony Waite, Director of Finance & Performance Management (from 6 January 2014)	30 - 35	0	0	0	30 - 35	5 - 7.5	35 - 40	0	0	0	0	0	0	0
Rachel Overfield, Chief Nurse (to 8 September 2013)	45 - 50	0	0	0	45 - 50	157.5 - 160	205 - 210	110 - 115	3	0	0	110 - 115	12.5 - 15	110 - 115
Linda Pascal, Acting Chief Nurse (9 September to 1 January 2014)	20 - 25	1	0	0	20 - 25	52.5 - 55	75 - 80	0	0	0	0	0	0	0

SALARIES AND ALLOWANCES OF SENIOR MANAGERS														
Name and Title	2013-14							2012-13						
	(a) Salary (bands of £5000) £000	b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) Total Payments Made by Trust (bands of £5000)	(f) All pension related benefits (bands of £2500)	(g) Total all payments and benefits (bands of £5000)	(a) Salary (bands of £5000) £000	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) Total Payments Made by Trust (bands of £5000)	(f) All pension related benefits (bands of £2500)	(g) Total all payments and benefits (bands of £5000)
Colin Ovington, Chief Nurse (from 9 December 2013)	35 - 40	0	0	0	35 - 40	32.5 - 35	70 - 75	0	0	0	0	0	0	0
Roger Stedman, Medical Director (from August 2012)	170 - 175	0	0	0	170 - 175	40 - 42.5	210 - 215	110 - 115	1	0	0	110 - 115	140 - 142.5	110 - 115
Rachel Barlow, Chief Operating Officer	110 - 115	3	0	0	110 - 115	2.5 - 3	110 - 115	110 - 115	0	0	0	110 - 115	27.5 - 30	110 - 115
Mike Sharon, Director of Strategy	110 - 115	0	0	0	110 - 115	(25 - 27.5)	80 - 85	120 - 125	2	0	0	120 - 125	42.5 - 45	120 - 125



Care in a community setting

SALARIES AND ALLOWANCES OF SENIOR MANAGERS														
Name and Title	2013-14							2012-13						
	(a) Salary (bands of £5000) £000	b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) Total Payments Made by Trust (bands of £5000)	(f) All pension related benefits (bands of £2500)	(g) Total all payments and benefits (bands of £5000)	(a) Salary (bands of £5000) £000	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) Total Payments Made by Trust (bands of £5000)	(f) All pension related benefits (bands of £2500)	(g) Total all payments and benefits (bands of £5000)
& Organisational Development (Acting Chief Executive January – March 2013)														
Kam Dhami, Director of Governance	95 - 100	0	0	0	95 - 100	0 - 2.5	95 - 100	95 - 100	0	0	0	95 - 100	75 - 77.5	175 - 180

Notes

Non Executive Directors do not receive pensionable remuneration and therefore do not accrue any pension related benefits. Figures in brackets () represent negative values.

Pension Related Benefits are a nationally determined calculation designed to show the in year increase in notional pension benefits, excluding employee contributions, which have accrued to the individual. Changes in benefits will be dependent on the particular circumstances of each individual.

Pensions

The pension information in the table on page 46 contains entries for Executive Directors only as Non Executive Directors do not receive pensionable remuneration.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pensions payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figure and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

PENSION BENEFITS								
Name and Title	Real increase in pension at age 60	Lump sum at aged 60 related to real increase in pension	Total accrued pension at age 60 at 31 March 2014	Lump sum at aged 60 related to accrued pension at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2013	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Toby Lewis, Chief Executive	0-2.5	5-7.5	35-40	110-115	518	463	44	0
John Adler, Chief Executive	-	-	-	-	-	972	-	0
Robert White, Director of Finance & Performance Management	0-2.5	0-2.5	30-35	100-105	644	602	26	0
Antony Waite, Director of Finance & Performance Management	0-2.5	0-2.5	40-45	130-135	744	699	7	0
Rachel Overfield, Chief Nurse	2.5-5	7.5-10	50-55	150-155	895	729	66	0
Linda Pascall, Acting Chief Nurse	0-2.5	0-2.5	40-45	125-130	909	811	25	0
Colin Ovington, Chief Nurse	0-2.5	0-2.5	45-50	140-145	927	849	18	0
Roger Stedman, Medical Director	2.5-5	7.5-10	35-40	110-115	599	529	59	0
Rachel Barlow, Chief Operating Officer	0-2.5	2.5-5	25-30	85-90	435	403	23	0
Mike Sharon, Director of Strategy & Organisational Development	(0-2.5)	(0-2.5)	35-40	115-120	800	771	12	0
Kam Dhani, Director of Governance	0-2.5	0-2.5	30-35	90-95	476	444	22	0

Figures shown in brackets () represent real decreases in value.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The annualised remuneration of the highest paid director in Sandwell & West Birmingham Hospitals in the financial year 2013-14 was £187,255 (2012-13, £170,152). This was 6.55 times (2012-13, 5.95) the median annualised remuneration of the workforce, which was £28,568 (2012-13, £28,596). Annualised remuneration may not reflect actual remuneration in year, for example where an individual was in post for only part of the year.

In 2013-14, 11 (2012-13, 19) employees received remuneration in excess of the highest-paid director. Annual remuneration on a whole time equivalent basis ranged from £14,294 to £311,048 (2012-13, £14,153-£266,793). Total remuneration includes salary and any additional payments for overtime, additional activities and enhancements and any severance pay but excludes employer pension and national insurance contributions. Employees of the Trust do not receive performance related pay nor benefits in kind.

There has been a small overall increase in the workforce numbers of the Trust during the financial year 2013-14, in part as a consequence of the need to open additional capacity to meet demand as well as positive decisions to make service improvements in key areas, for example the Emergency Department. This has not resulted in any material changes to the composition of the workforce.

The basic pay of the Trust's most highly paid individual has increased between 2012-13 and 2013-14 as a result of an increase in payments for additional activity undertaken outside contracted employment. These payments are wholly variable and may change significantly from one year to another for this and any other individuals in receipt of them.

The vast majority of Trust employees are subject to national pay settlements and have, in accordance with those national settlements, received an inflationary increase in pay in 2013-14 of 1%. Where applicable, employees have continued to make incremental progression within existing pay scales. Pay settlements have not had a material effect on the calculation of the pay multiple above.

Off payroll engagements

For all off payroll engagements as of 31st March 2014, for more than £220 per day and that last longer than six months.

	Number
Number of existing engagements as at 31st March 2014	18
Of which, the number that have existed:	
for less than 1 year at the time of reporting	13
for between 1 and 2 years at the time of reporting	4
for between 2 and 3 years at the time of reporting	1

Off payroll engagements are subject to risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and where appropriate, that assurance has been sought and received.

For all off payroll engagements as of 31st March 2014, for more than £220 per day and that last longer than six months, new Engagements Between 1st April 2013 and 31st March 2014.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	15
Number of new engagements which include contractual clauses giving Sandwell & West Birmingham Hospitals the right to request assurance in relation to income tax and National Insurance obligations	15
Number for whom assurance has been requested	15
Of which:	
assurance has been received	15
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

There were no off payroll engagements of board members or senior officials with significant financial responsibility between 1st April 2013 and 31st March 2014.

The Trust is making significant efforts to reduce the number of non substantive (agency, bank and other off payroll engagements) staff it uses with specific targets for reductions incorporated within its cost improvement programme. Of the 15 new engagements identified above, 11 relate to the provision of additional capacity and the need to ensure the delivery of safe services within the Trust's emergency services functions. Positive action is being taken as part of additional investment in these areas to ensure that permanent staff are recruited into vacant posts.

7. Our safety and quality of care 2013/14

Overview

Over the last two years, we have completely overhauled how we manage and govern safety in our Trust. This is now the 'core business' of our Clinical Groups. Meanwhile, a significant infrastructure of audit, assurance, support, and challenge exists – with peers tackling peers, an executive function focused on risk and care, and a monthly Board discussion about Quality and Safety. There is more to do and during 2014/15 we will complete the review of our long term strategy in each area – to make sure that our goals are very specific and ambitious.

In 2013/14 the Trust Board, and wider leadership, reflected on the reports from Sir Robert Francis into the unacceptable care provided at Mid Staffordshire. This gave rise to the completion of our 'Francis Report Response', a series of eight goals for long term improvement. They are listed below, and the overarching goal is to achieve patient satisfaction with our care that is better than is the norm in the West Midlands. We have services that are leading the way in that journey, notably maternity care and children's services. Our own study of outpatient care suggests high rates of satisfaction but with room for improvement. It is our inpatient services for emergency patients where change is most pressing.

Creating the right culture with values that put patients first

Our patient promises are consistently delivered across all our services and our staff report that ours is a safe organisation in which they would choose to be treated, within a health and social care system that is integrated.

Effective complaints handling

All feedback from patients, whether it is concerns voiced on the ward at the time, or complaints made once they are back home, will make a difference. These will be taken seriously and lessons learned.

Openness, transparency and candour

Everyone working in the Trust will be honest, open and truthful in all their dealings with patients and the public. Organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.

Caring for the elderly

A culture where older patients are valued and listened to and are treated with compassion, dignity and respect.

Getting fundamental standards right

Through an accountability framework ensure fundamental standards are delivered in a standardised way, reducing variability in practice. Through a culture and behaviour which strives for best practice, service development improvement plans will be in place to ensure best practice.

Medical education and training

Hearing the voice of doctors in training at every level of the organisation for improving the learning from complaints and incidents, ensuring they have the knowledge, skills and attitudes that equip them as champions for safety throughout their career.

Compassionate, caring and committed nursing

Patients can be confident of receiving the highest quality, knowledge based care, delivered consistently with compassion by caring and competent nurses.

Accurate, useful and relevant information

Ensuring culture where the quality of data is viewed as important by all staff providing as well as those using data with a known framework and assurance systems in place for delivering accuracy.

In support of that work, we worked through the year to refine our patient experience plans. Our Patient Knows Best strategy is an important interim step. The real focus is on ensuring that our nine Care Promises happen consistently across our organisation. They are well known to local residents, visible inside the Trust, and form the basis for our commitment to deliver.

Based on a view about the source of most complaints that we considered preventable, we have launched an inpatient set of commitments. These are promises about what we will do for everyone admitted into our care inside their first 24 hours within a ward. We began to deploy this plan in practice in August 2014. Ten Out Of Ten is the title for a series of actions that, currently, we know that we do usually. But we want to be sure and want our patients to be sure that we do them everytime. Ten Out Of Ten tries to ensure that we offer truly interdisciplinary care at a local level. It also tries to alert families and friends to our promises and asks them to warn us if they are concerned that something has been missed. We see this participation as an important step in tilting the balance of power in our care model – towards our strategic ambition to integrated care framed around the outcomes important to the patient and their carers.

The accompanying Quality Account provides significant detail on our performance, including data that compares our Trust to peers and norms. That document also sets out some forward ambitions, which are reflected in our Annual Priorities and Plans. This chapter outlines some of the key achievements and issues that we have to tackle and continue to tackle.

We are committed to delivering the best possible experience of the services used by patients, their families and their carers, being mindful that this can only be achieved by ensuring this commitment is shared by everyone employed at the Trust. To this end, we have developed a strategy that brings together these simple truths based on an important belief: that our patients know best ie. they have knowledge that we do not, because they know themselves better than we can.

We know that across the Trust, there are areas where we achieve the best and others where we could do better. We want our best to be the consistent standard across SWBH. We know that we don't always get it right but it is our intention to implement a culture where we continually listen and learn from patients, staff and carer feedback so that we work together to achieve sustainable service improvement and thereby deliver the best care possible.

We recognise that staff are our biggest asset and in order to deliver a good patient experience, we need to ensure a good staff experience. All staff have a responsibility to work in a way that ensures that 'the patient's voice is heard at every level of the organisation.' We expect staff to let us know when they feel unable to do this, either due to personal circumstances, lack of resources or inadequate systems and processes.

When a patient, resident, relative, carer, friend or visitor leaves a service we need only simply, humbly and sincerely ask; 'Are you happy with the way you've been treated today?' and when we go home, ask ourselves; 'Is everything I've done today what I'd do for my family?'

To achieve this, service delivery will focus upon the following key themes:

- Give patients, carers and colleagues the same respect that we would want for ourselves or a member of our family
- Patients, their families and carers feeling informed, being involved and given options
- Staff who listen and spend time with their patient
- Being treated as a person and not a number
- The value of support services
- Consistent efficient processes.

Improvement in responsiveness to personal needs of patients

Involving our patients, relatives, carers and community in improving patient experience is central to our success as an organisation. It is at the heart of the NHS Constitution (DH, 2009) and increasingly is also a key indicator of a performing NHS.

The Trust seeks patient views in a variety of ways including the national patient inpatient and outpatient surveys, and a Trust-generated internal inpatient survey. The internal survey generates around 1,000 replies every month which is in excess of 10% of inpatient admissions. This survey is given out to patients when they are discharged and is available in easy read format and other languages. What we find out from these surveys really does help us to shape the services we deliver.

Everyone can contribute, everyone matters and it is everyone's business to help us improve care for our patients, carers and relatives. Increasingly, there is evidence that patients who enjoy a positive experience feel better, sooner. Patients often remember the little things – a smile, a kind tone of voice, kind words and someone there to hold a hand. This is what matters to us all.

Patient experience will improve if Trust staff are motivated to do everything they can to make patients feel cared for. Paying attention to equality and diversity is also an essential requirement to be able to achieve good patient experience and good outcomes.

The Trust is fully committed to developing and supporting patients, carers and relatives to play an active role in all aspects of the planning, delivery and evaluation of its acute and community health care services.

In early 2013, the Trust produced its first Patient Experience Strategy in which the key challenge is for all staff to constantly question "How does this practice, information or change affect patients, carers and relatives? Does it improve the experience?" The only way to know the answer is to ask and to listen.

2013/14 was the first full year of the Patient Experience Strategy in use. All staff have welcomed the Strategy, allowing all patients to fully benefit from improved care and services as a result.

Last year we set out our priorities in improving the patient experience:

Aims	Actions	Did we do what we said we would do
Implement the patient experience strategy as detailed in the implementation plan	Completed	✓
Friends and Family Test milestone delivery	<ul style="list-style-type: none"> Increasing the response rate in the acute inpatients and A&E areas. Achieving a response rate within the top 50% of trusts nationally, showing an improvement; Phased expansion of the FFT to Maternity by the end of Oct 2013 and additional services by the end of March 2014; Increase the FFT score within the 2013/14 staff survey compared to 2012/13. 	✓ ✗ ✓
National and local patient survey to improve services based on the findings	Completed the Inpatient Survey, A&E survey, Maternity Survey, Outpatient Survey, Cancer Patient Experience Survey and Chemotherapy Patient Experience Survey	✓
Patient Engagement Programme	An ongoing programme of events built to expand and increase the opportunities available for regular patient engagement	✓
Patient Stories	Patient stories collected as a learning tool for training and events as well as opportunity to share patient experience with the Trust Board	✓
Volunteers	Overall number of volunteer recruits from a wide age group	✓

Patient Knows Best

We believe our patients know best, and that belief drives our commitment to ensuring that the services we deliver provide the best possible experience for every patient. To this end we have developed a joint patient experience and staff engagement strategy, because we recognise that for staff to deliver good patient experience, our staff must be engaged with their responsibility to deliver outstanding service.

While we do not suggest that patients can advise on treatment choice or are experts on service configuration, we know that they have knowledge that we do not, because they know themselves better than we can. They are witness to the healthcare we provide and participate in the care we propose.

Time and again, whether in national enquiries into error, or local evaluations of our incidents or complaints, it is evident that our patients tell us far more than we choose to hear. And that if we heard and acted on what we hear, we would provide better and safer services.

Our ability to hear and act is composed of three things:

1. The behaviour of individuals – the quality of our people.
2. The systematic way in which we make sure that what we hear is handed over from shift to shift, clinician to clinician, porter to nurse, therapist to pharmacist, trainee to GP – our quality of teamwork.
3. Our organisation has to learn from what works well and is appreciated by patients, as well as where we err, and need to do better – the quality of our culture.

We are passionate about our services and care deeply about the quality of care our service users, their carer's and families receive. We know that we don't always get it right but it is our intention to implement a culture where we continually listen and learn from patient, staff and carer feedback so that we work together to achieve sustainable service improvement.

In keeping with a simple philosophy that the 'Patient Knows Best', our strategy is shaped around the 9 promises that every member of our organisation makes to patients in our care. Put simply, by working to keep our promises we will be doing the best we can to ensure the best experience possible. You will see our 9 promises displayed at key locations across our sites, and behind each one lies the detail about how we expect to deliver it:

1. I will make you feel welcome

We intend to improve patient experience from first contact to exit from the 'building.' So you should expect:

- To always be welcomed with a smile.
- That everyone involved in your care will play their part to ensure that you get what you need when you need it and to the best of their ability.
- That everyone involved in your carer will communicate with you in a way that is consistent, timely and in a manner that suits you.

2. I will make time to listen to you

We intend to ensure that when we communicate with patients and their families/carer's that they are involved, informed and responded to. So you should expect:

- Every time you share information with us it will be managed in a consistent way with minimum duplication and we will make sure you have understood what has been said.
- When we develop new services we will actively seek your views and take them into account.
- We will always make time to tell you and your carer's what they can expect to happen along your pathway

3. I will keep you involved

We will improve communication with patients, so you should expect:

- That information is always available in different formats to meet your needs.
- We will always listen to you and answer their questions in a way you can understand.
- Make sure you know what you can expect from us.

4. I will be caring and kind

Patient's physical comfort needs will be met, so you should expect:

- That meeting your physical needs and comfort is given the highest priority at all times.
- That you are cared for in clean and comfortable surroundings.
- That there is always someone available to talk to you, your carers or family should they have any worries or fears.

5. I will be polite, courteous and respectful

We will respect the needs of patients and recognise their individuality, so you should expect:

- That we will respect and recognise your cultural, religious or diversity needs.
- That we will make every effort to communicate with you in the language you are familiar with using any means of interpretation that are required.
- We will always introduce ourselves to you and ask you how you wish to be addressed.
- We will ensure that privacy and dignity is considered at all times, and in particular when discussing condition or treatment.

6. I will keep you informed and explain what is happening

We will improve engagement of patients and carers, so you should expect:

- That you will be involved as much as you want to be, in decisions about your care and treatment
- That we engage with, and involve, the diverse community of users of Trust services when developing services or facilities so that service developments are informed by and respond to patient feedback

7. I will admit to mistakes and do all I can to put them right

We will foster a 'no blame' culture, making it easier for staff to understand how to make an apology and learn from mistakes. So, you should expect:

- That we are consistent, open and supportive across the whole organisation when needed by staff to talk to patients and relatives in difficult situations.
- We will actively encourage patients and carers to ask for information and to know that we will keep them informed of all events good and bad in an open and honest way.
- That we continuously assess people's satisfaction with our complaint's handling process.

8. I will value your point of view

We will engage with patients and carer's when delivering or developing services so that your needs are taken into account. So you should expect:

- That we will tell patients and carers what they can expect to happen along a patient pathway
- We will make sure patients and carers have understood and are on board with what we have communicated to them
- We will listen to patients and answer their questions in a way they can easily understand
- We will ask patients their personal preferences while caring for them, for example, how they wish to be addressed.

9. I will go the extra mile

We will think holistically and 'outside the box' to meet every patient's needs. So you should expect:

- That we spend more time with patients and carers, explaining the reasons for the hospital processes that affect them and which they may not necessarily understand i.e. visiting hours and no visiting at lunch time.
- We will encourage employees to volunteer for 'experience enhancing' tasks like way-finding and continuing beyond shifts to finish caring for a dying patient and their family.
- We will be willing to 'bend the rules' when necessary, for example, allowing visitors to come onto a ward outside of visiting hours.

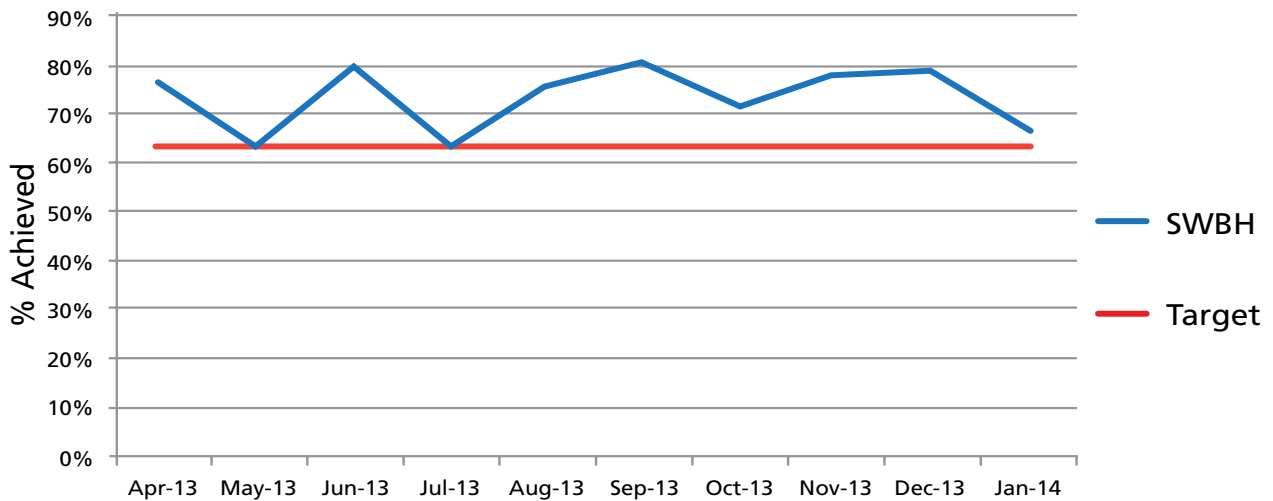
The 2013/14 CQUIN measures agreed were as followed, the CQUIN contract value was £8.97m. As a result of not achieving and delivering Medicine Management, Friends and Family Test (FFT) roll out in Maternity and Sepsis bundle use, the total of withheld funding was £0.9105m. These non-achieving areas are explained in the table below. Final data is awaited for the following schemes; VTE RCA, Staff FFT, Use of Sepsis Care Bundles and Recording Do Not Attempt Resuscitation (DNAR) Decisions.

		Measure	2013/14
	Commissioning for Quality & Innovation (CQUIN)		
National	VTE Risk Assessment (Adult IP)	%	98.7
National	VTE Root Cause Analysis	%	100
National	NHS Safety Thermometer - Reduction in Pressure Sores	No	On Track
National	Dementia - Find, Investigate and Refer	No	Met
National	Dementia - Clinical Leadership		In Place
National	Dementia - Supporting Carers of People with Dementia		Monthly Surveys in Place
National	Friends and Family Test - Phased Data Collection Expansion	%	16.4
National	Friends and Family Test - Increase Response Rate (Emergency Care and Wards)	%	20.3
National	Friends and Family Test - Improve Performance on Staff FFT	Score	
Local	Safe Storage of Medicines	%	81
Local	Dementia Patient Stimulation		In Place
Local	Use of Pain Care Bundles	%	Met
Local	Use of Sepsis Care Bundles	%	Off Trajectory
Local	Community Risk Assessment & Advice	%	Met
Local	Recording DNAR Decisions	%	On Track
Specialised	Clinical Quality Dashboards		Fully Compliant
Specialised	Bechets Highly Specialised Service		Fully Compliant
Specialised	HIV - Communication with GPs		Fully Compliant
Specialised	Neonatal - Retinopathy of Prematurity Screening	%	Met

Improvement in experience of patients at the end of life

We said we would increase by a further 10%, the number of patients known to the specialist palliative care team achieving their preferred place of care/death in both the acute hospitals and the community. This means that patients and their families have been involved in discussions about their condition and have talked about what is important to them including where they want to be cared for and where they want to die. The 63% target has been exceeded every month since April 2013 with an overall achievement of 74%.

Mortality 2013/14



The specialist palliative care service has been developing over the past few years and is now delivering a seven day visiting service and advice out of hours in both the acute hospitals and community. This service focuses on ensuring that people who have an advanced, life limiting illness are supported to improve or maintain their quality of life.

“ Just a note to say thank you for all you did for my dad through such a difficult, painful period at the end of his life. You got to know he was a proud, independent man but he trusted you completely and took real comfort and reassurance from your kind, practical care. Personally I would also like to say just how much your professionalism, combined with genuine compassion helped me care for Dad and grant his final wish to be at home.

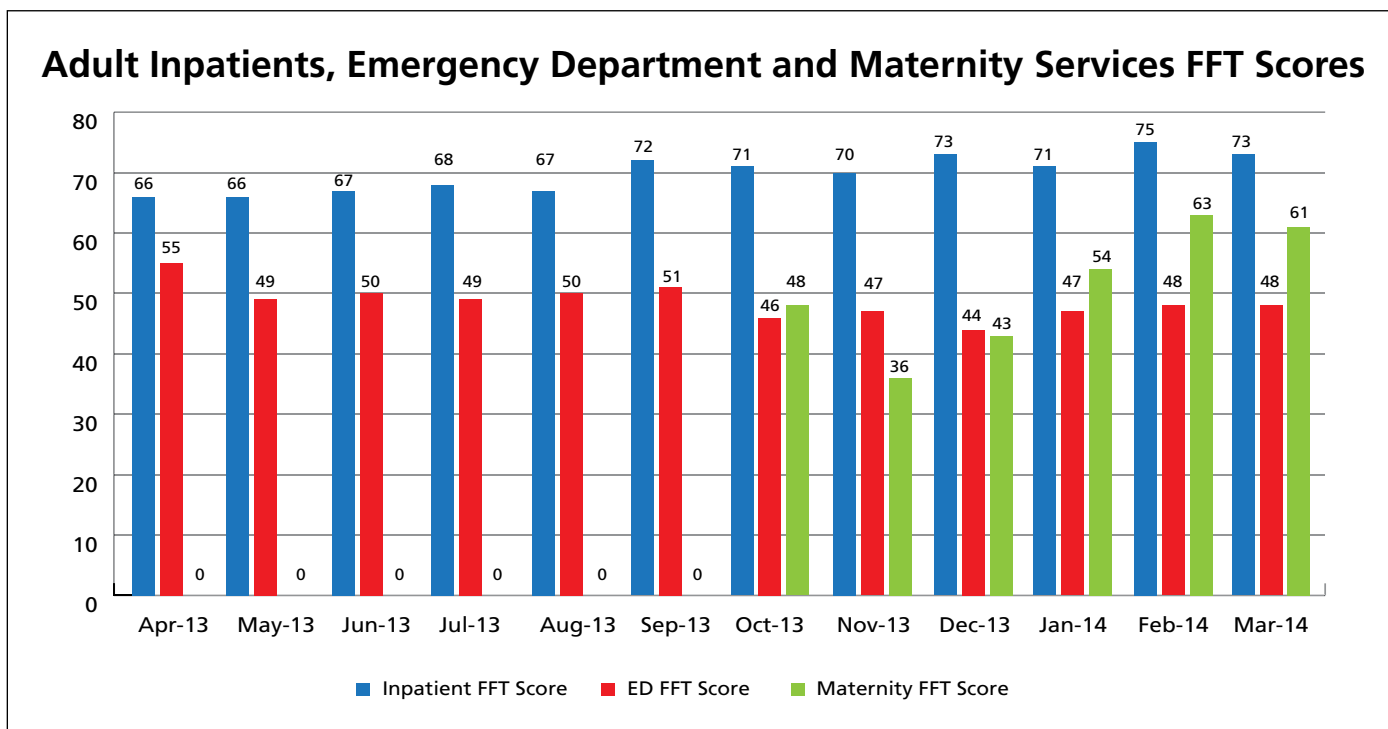
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“ I would like to take this opportunity to thank you for the support and compassion which your team afforded my late husband and I. Throughout the last days of his life the care was exemplary. I thank you for your openness when conveying difficult information regarding my husband's health. Your professionalism and respect will never be forgotten.

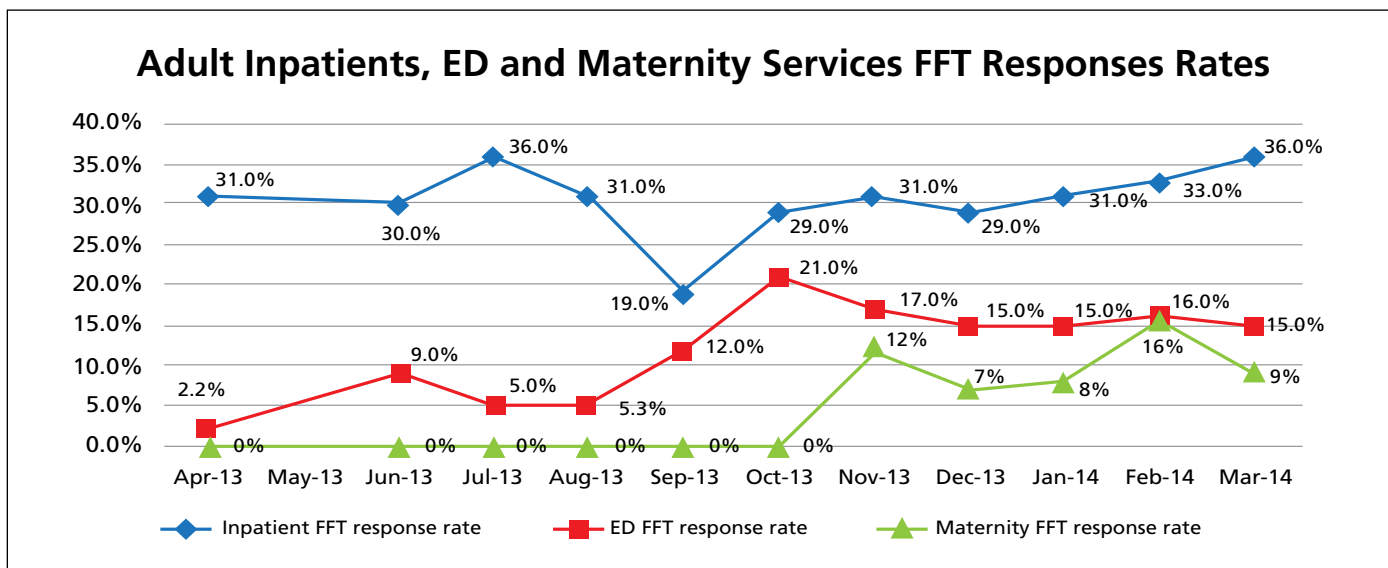
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Introduction of the 'Friends and Family Test'

The Trust is part of the national Friends and Family Test (FFT) programme and has made good improvements in its FFT scores and response rates over the last year. Under the FFT, we ask all inpatients, A&E and Maternity service users to answer the question: "How likely are you to recommend our service to friends and family if they needed similar care or treatment?" Results of the test, down to the level of individual wards and units, are made available locally within the Trust and also published online every month on the NHS England and NHS Choices websites.



Note: The Maternity Services joined the FFT survey programme from October 2013.



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The strength of the Friends and Family Test is its power to trigger hospitals and individual teams to take immediate action on real-time feedback. Based on recent patient feedback, an initiative called 'The Quiet Protocol' which helps patients to have a good night's sleep on the wards was launched. Other improvement initiatives include: 'Hello my name is' campaign, NHS Change day pledges, Patient Stories to the Trust Board, league tables of staff members named by patient as giving exceptional care, Dementia environment improvement programme for wards.

10 top comments by patients:

- Ward staff were very friendly and helpful
- Patients felt that staff were informative and efficient
- The wards generally very tidy and clean
- Patients felt that staff were kind and caring
- Most patients liked the food
- Patients felt that doctors and nurses were mostly attentive and polite
- Long waiting time (A&E)
- Communication between doctors, nurses and patients can be improved
- Ward toilets/bathrooms need more frequent checking and cleaning
- Night staff need more training.

This Word Cloud is based on patient comments and shows in largest type the phrases most commonly used:



Improving 'Patient Reported Outcomes' in hips, knees, hernias and varicose veins

PROMs assess the quality of care delivered to NHS patients from the patient perspective. Currently these cover four clinical procedures where the health gains following surgical treatment is measured using pre- and post-operative surveys. The Health & Social Care Information Centre publish PROMs national-level headline data every month with additional organisation-level data made available each quarter. Data is provisional until a final annual publication is released each year.

The tables below shows the percentage of patients reporting an improvement in their health status following the procedure and the average adjusted health gain achieved compared against the average for England.

Percentage reporting improvement

	Health Status Questionnaire Percentage improving			
	Finalised data for April 11 – March 12 (Published October 13)		Provisional data for April 12- March 13 (Published February 14)	
	National	SWBH	National	SWBH
Hernia repairs	51.0%	40.2%	50.2 %	50.0%
Hip replacement	87.5%	88.4%	89.7%	88.2%
Knee replacement	78.8%	71.8%	80.7%	72.7%
Varicose vein surgery	53.6%	61.0%	52.7%	43.8%

Average adjusted health gain

	Health Status Questionnaire Percentage improving			
	Finalised data for April 11 – March 12 (Published October 13)		Provisional data for April 12- March 13 (Published February 14)	
	National	SWBH	National	SWBH
Hernia repairs	0.087	0.047	0.085	0.088
Hip replacement	0.416	0.405	0.438	0.369
Knee replacement	0.302	0.247	0.319	0.271
Varicose vein surgery	0.095	0.100	0.093	0.053

	SWBH average below England
	SWBH average above England

The finalised data for 2011/12 and the provisional data for 2012/13 shows that there are areas where the reported outcome is below the average for England.

In response, the Trust has taken action the following action:

	Action taken
Hernia repairs	Work to ensure 80% questionnaires handed out. All patients seen and listed have been audited to ensure cases listed are symptomatic and have copies of letters, consented appropriately. Risk and benefits explained. Introduction of Hernia clinic and listed, piloted and gradual roll-out from Feb 2014.
Hip & knee replacement	Streamline questionnaire hand out process to ensure >80% uptake. A joint club in place and information leaflets given. Discussion with patients so they are fully aware of the risk and benefit as well as expected outcome. Audit of listing of cases to ensure meets criteria consistently for replacement and meets the current CCG guidance. A contact point after discharge if there are any problems. A six month follow up and review of performance after surgery.
Varicose vein surgery	Most varicose veins are now done by radiofrequency ablation here. Questionnaire given on the day seen. Current wait times mean many of these are invalid and process has to be repeated. Current work is being undertaken to reduce wait time to ensure consistency. All patients have discussion regarding risk and benefits.

Hip fractures – operation within 24 hours

In 2013/14 we have seen a substantial rise in the volume of patients coming through our A&E department with hip fractures. This, along with a lack of resources, has had a negative effect on our performance.

Our high volume, when compared with the National Standard, shows the bar is raised much higher. As a result of this, we need to establish a streamline service and pathway to use every minute as critical time to ensure we stay on target.

Actions we will undertake:

- Extend our trauma clinic, which operates seven days a week to support some of the extra load
- Look into putting in a dedicated fracture list to support this with extra staffing
- Audit the high volumes for patterns, trends and how this affects our target and performance
- Evaluate the operational structure to free-up staffing resources at times of increased volume of patients.

Coronary Heart Disease – Rapid Access Chest Pain (<2 weeks)

A shortfall of three consultants resulted in an overwhelming capacity on the remaining service providers. Although Rapid Access Chest Pain (RACP) clinics were maintained during this period, the demand for these was not met in a timely way by the capacity available.

To rectify this, the three vacant posts were filled by April 2014. We will now be able to offer an additional RACP clinic to improve the throughput of cases. Although the process by which we monitor and escalate RACP cases which are of potential long waits has been assessed and improved, further work has been outlined to analyse the type of cases which are referred to us, ensuring our patients are being seen through the optimal pathway.

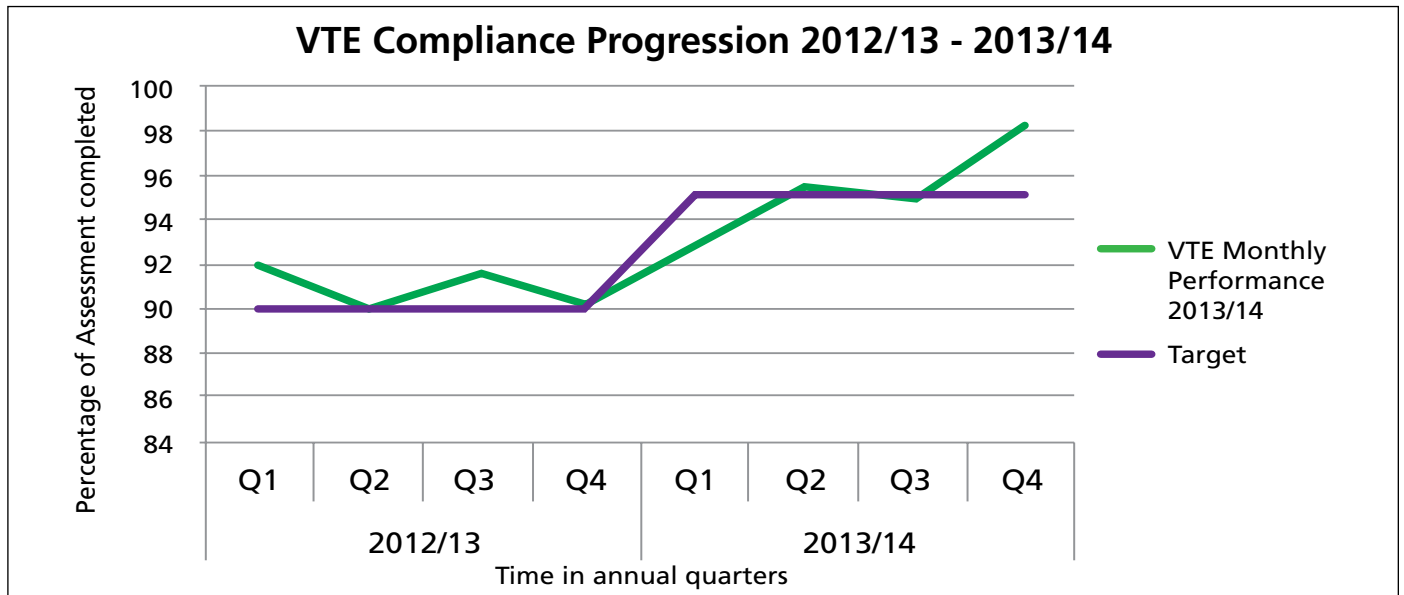
More detail on our performance against quality targets can be found in appendix 1.

Clinical Effectiveness Priorities

Performing risk assessments for the development of VTE on 90% hospital in-patients

VTE is the term used to describe deep vein thrombosis (clots in the leg) and pulmonary embolism (where clots can break off and block the lung). This has long been recognised as a major problem that can affect patients whose mobility is impaired either by illness or following certain types of surgery. Doctors have, for many decades, included an estimate of the risk of developing deep vein thrombosis in certain patients and provided preventive treatment where the risk was deemed to be high.

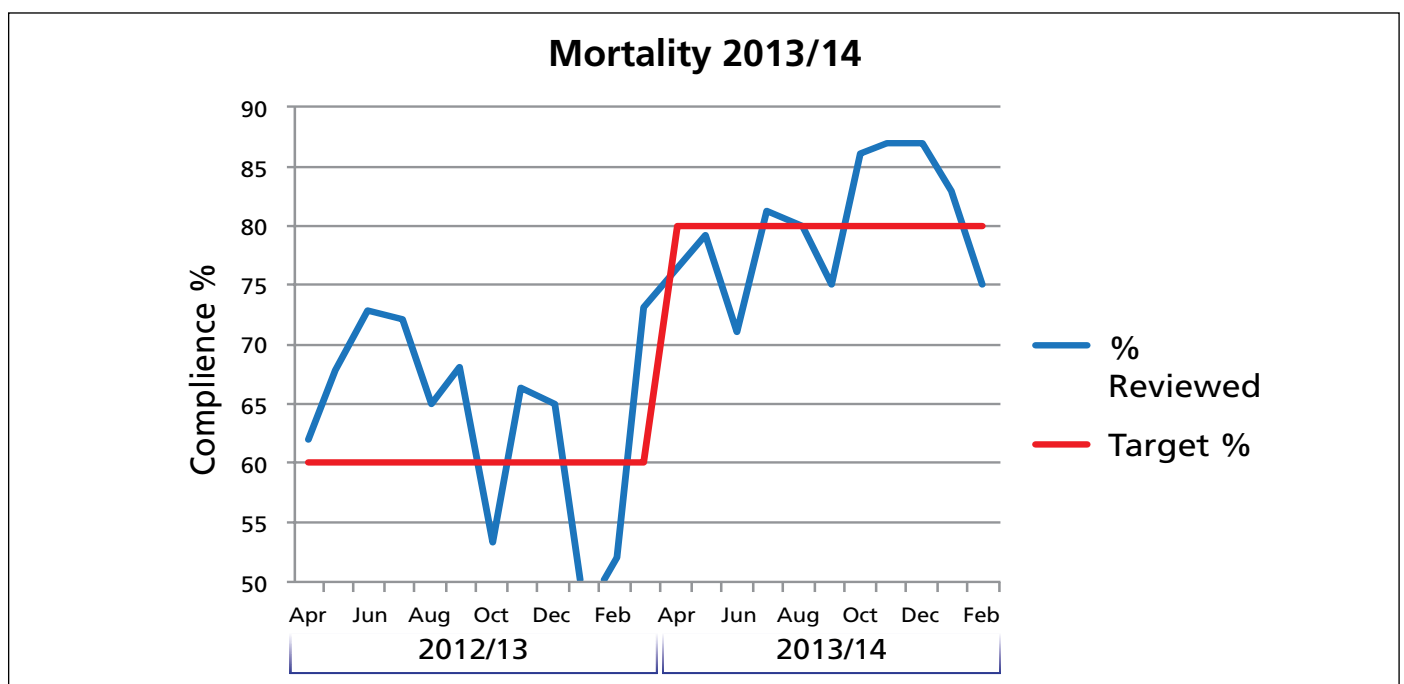
This CQUIN target has been carried on from 2010/11 through to 2012/13 but with a more stringent target of an assessment rate of 95% in admitted patients. The Trust met the 95% VTE target in eight out of the 12 months. However, 95% of admitted patients did receive a VTE risk assessment across the year. Over 98% has been met consistently since December 2013, with significantly improved performance.



Conducting reviews on 80% of all deaths that occurred in hospital

In 2012/13 we were successful in increasing the percentage of deaths that were reviewed by senior doctors to above 60%. However, we highlighted this as a continual high priority to improve further in 2013/14 and increased the target further to 80% of all patients who were reviewed within 42 days of death.

We have continued to apply great efforts to achieving our motility goals and this has been demonstrated with our 82% annual compliance, further to that, quarter 3 alone saw a rise to 88.9%. Quarter 4 data is awaited.



Reducing Hospital Standardised Mortality Ratio and Standardised Hospital Mortality Index

We continue to make progress in reducing our mortality rates. This has been through a relentless focus on examining the causes of death through the mortality review system, where we have exceeded our target of reviewing 80% of all deaths in hospital. In addition, we have improved our performance in the prevention of hospital acquired venous thrombo-embolism (VTE) by exceeding our target of 95% of patients being risk assessed. Last year we set out our priorities in reducing mortality rates:

Aims	Actions	Did we do what we said we would do?
In 2012/13 we have increased the percentage of deaths that have been reviewed by senior doctors. However, we are committed to reviewing at least 80% of all deaths within 42 days of death	Increased the number of doctors conducting mortality reviews	✓
Feedback to consultants regularly on deaths identified as preventable to aid lessons learnt	Held number of meetings and presentations of outcomes and Grand rounds	✓
Ensure that 95% of admitted patients have a VTE risk assessment carried out	Introduced mandatory use of electronic bed management system to carry out assessments before discharge	✓
Carry out root-cause analysis of confirmed cases of hospital associated thrombosis	Conducted detailed review of all cases of hospital acquired thrombosis by quarter	✓
Set up a small, clinically-led group by the end of June 2013 to look at mortality difference	Looking into deaths within the Trust and will identify themes which may need addressing to improve outcomes for patients	✓
We will improve our mortality performance to be better than the England average by March 2014	SWBH HSMR 2013/14 = 92.5 England average = 100.3	✓

Use of Hospital Standardised Mortality Ratio (HSMR) & Summary Hospital – Level Mortality Indicator (SHMI)

We said we would use a range of tools to analyse mortality. We use HSMR and SHMI. It is reported every month to the Quality & Safety Committee, the Commissioners, and is discussed in detail at the MQuAC (Mortality and Quality Alerts Committee). We also carry out in-depth reviews of any diagnostic code that has shown that our incidence of disease seems higher than expected.

HSMR is a standardised measure of hospital mortality and is an expression of the relative risk of mortality. It is the observed number of in-hospital spells resulting in death divided by an expected figure.

The Trust's 12-month cumulative HSMR (87.8) remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the SHA Peer (96.7). The in-month (January 13) HSMR for the Trust has decreased to 81.4

The 12 month cumulative site specific HSMRs are 76.2 and 99.7 for City and Sandwell respectively, neither of which are currently in excess of upper statistical confidence limits.

Investigation into differences in mortality across the two hospital sites

As a result of the difference in mortality ratios between the main hospital sites, the MQuAC commissioned a 'Task and Finish' Group to examine the data behind this difference in more detail. The interim report details the findings from the work undertaken to date and it makes a number of recommendations including those to further the investigation going forward.

The HSMR at Trust level has, over recent years, been below that expected. This is explained in part by City Hospital experiencing significantly less deaths than would be expected (according to Dr Foster's statistical methodology), whereas Sandwell Hospital has demonstrated a number of deaths in excess of that which could have been expected.

As a result of the difference in mortality ratios between the main hospital sites, the Mortality and Quality Alerts Committee commissioned a 'Task and Finish' Group to examine the data behind this difference in more detail. The interim report details the findings from the work undertaken to date and it makes a number of recommendations including those to further the investigation going forward. The report's conclusion indicates the difference in ratio has many causal factors:

- Risk adjustment relies on accurate coding of reasons for admission and co-morbidities. Detailed analysis demonstrates that our coding practice is not consistent between the two hospitals. Work is underway to improve this
- Diagnosis on admission is not always the cause of death - we don't always have cause of death available at the time of review or coding
- There are differences in case mix between the two sites, with Sandwell having a more elderly population and in addition hosting Trauma and Stroke services and City having a younger population but with a higher deprivation index
- Coding for palliative care has increased in the last few years - this is due to the successful development of palliative care services. There are slight differences in the palliative care coding rates between the two hospitals - this impacts on HSMR but not on SHMI
- Our mortality review system has indicated a slightly higher number of adverse triggers for patients at Sandwell Hospital - this has not reached a statistically significant level, but could be suggestive of quality of care issues being a contributing factor. However the vast majority of deaths on both sites do not have any adverse triggers.

The work on site differences in mortality continues to form part of the mortality programme this year.

Improvements in dementia care

2013/14 has seen many developments to improve the care of patients with dementia and their relatives. The organisation was successful in bidding for funding from the Department of Health to 'enhance the healing environment' and this had led to structural and visual improvements in wards to support the care of patients with dementia.

We screen patients to determine risk of dementia which may lead the patient to undergo a further assessment. We have supported the training of staff at university to increase knowledge of the signs and symptoms, treatment and care of patients with dementia and the needs of their carers. We have recently employed three staff to provide activities and therapy to this group of patients. The above strategies aim to improve patient and carer experience and reduce harm to patients.

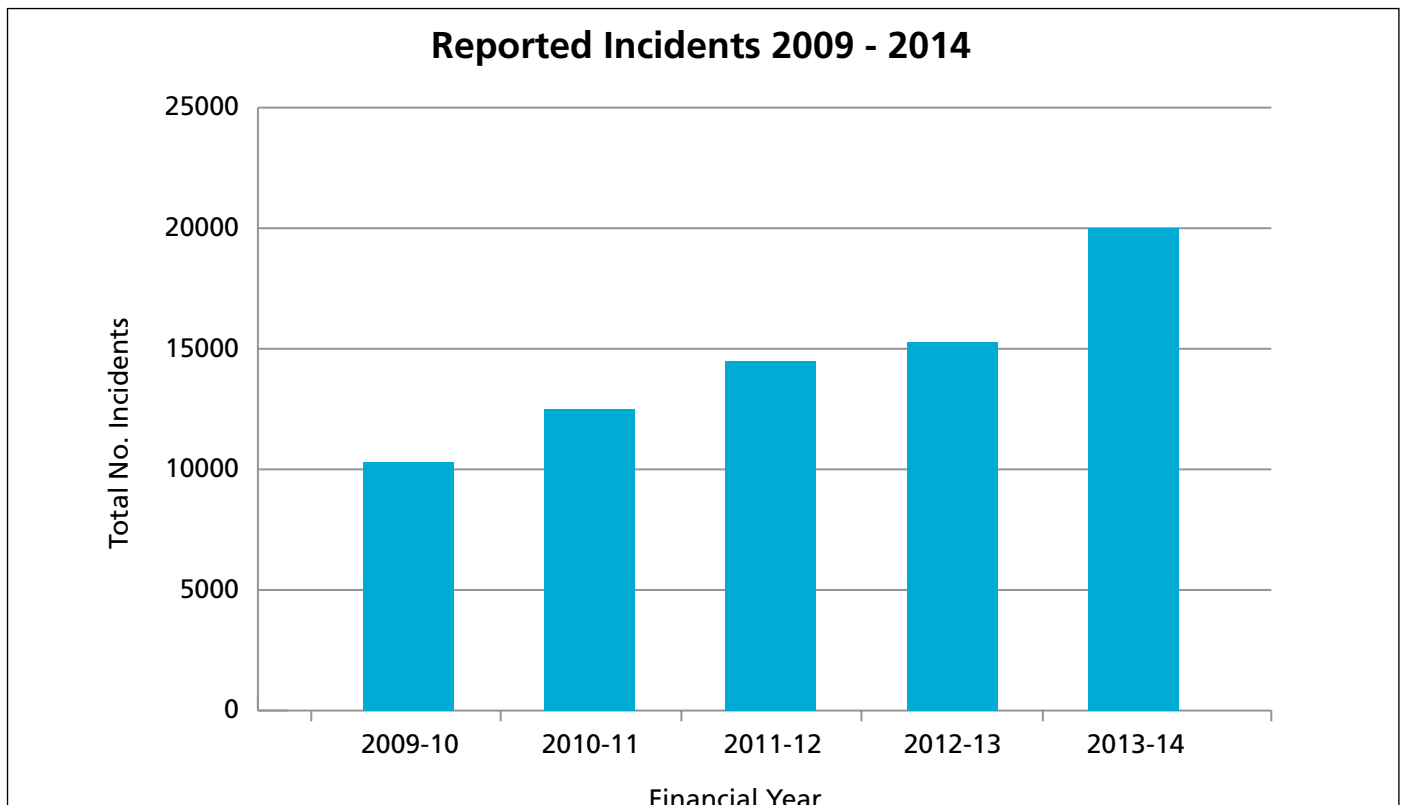
Roll out of alcohol prevention strategy to a number of outpatient specialities

We agreed with the commissioners to carry out screening of patients to check if they are at risk of harm from alcohol. It is very important to assess alcohol risk to ensure that patients are treated appropriately and also to be able to advise them on health issues if appropriate. This is now one of our key objectives in our Public Health Strategy.

Patient Safety Priorities

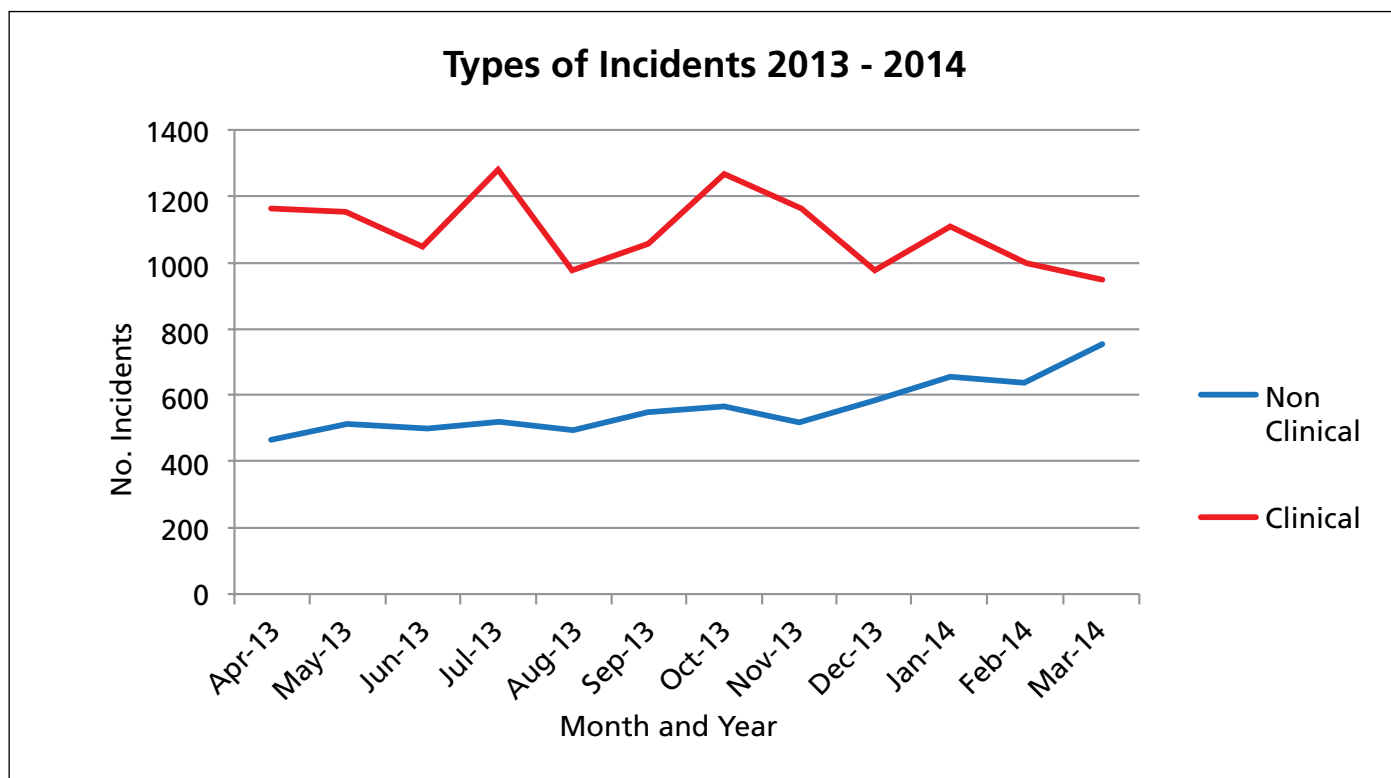
Safety culture or climate remains essential for the delivery of high quality care. The Trust continues to submit its incident data to the National Reporting & Learning System (NRLS) which provides comparative data with like sized Trusts. The comparative data shows that as at the September 2013 report, we remain in the highest 25% of Trusts with a reporting rate of 6.7 per 100 admissions.

To further promote patient safety, a Patient Safety Summit was held in February 2014. The focus of the summit was to launch the use of MaPSaF, (The Manchester Patient Safety Framework). Those who attended used the tool to define where they thought both the organisation and their team were on the safety maturity matrix. The Trust Board underwent a similar exercise in March 2014. Our clinical teams have been asked to undertake "culture checks" within their areas of responsibility.



Incidents are generally categorised into clinical (patient safety) and non clinical and then further categorised dependent upon their causative factor.





The chart above shows the data for the main types of incidents throughout the year, month on month. Serious incidents continue to be reported to the CCG and investigations for these are facilitated by the corporate Risk team. Those incidents designated as 'amber' are investigated at clinical group or corporate directorate level.

The number of serious incidents reported in 2013/14 is shown in the following table. This does not include pressure sores, fractures or serious injuries resulting from falls, ward closures, some infection control issues or health and safety incidents.

Month 2103/14	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
No. serious incidents reported	9	3	4	6	4	3	3	3	7	3	1	2

Never Events

Unfortunately last year we reported five never events, including one never event that occurred in the year before but was reported late. A never event is a serious untoward incident that has either caused or has the potential to cause serious harm that should never happen if the proper procedures are carried out to prevent them from happening. There is a list published by NHS England of 26 possible never events which include incidents such as 'Wrong Site Surgery', 'Retained Instruments or Swabs' and 'Wrong Implant'. The following table gives an overview of the never events that we reported with the key actions and learning points from each:

INCIDENT	What Happened	Where it happened	What we learned
Wrong Site Surgery December 2012 (reported July 2013)	A patient received an operation on their wrist instead of their elbow. This error was only detected when the patient returned for their outpatient follow up appointment	This incident occurred in the Plastic surgery service at Sandwell Hospital	The process for obtaining consent from patients should start in clinic at the time of decision to operate. In this case consent was obtained on the day of surgery and a failure to check the notes resulted in the wrong operation being done.
Wrong Implant June 2013	A patient having an intraocular lens implant for the treatment of cataract received the wrong strength lens	Operating theatres in the Birmingham Midland Eye Centre	Strengthening of the final step of the implant checking procedure. A change and reinforcement of the theatre visitor policy
Wrong Implant November 2013	During a total hip replacement operation the wrong size femoral head implant was selected for the acetabular cup size that had been implanted	Orthopaedic theatres Sandwell Hospital	A rationalisation and reorganisation of implants available in orthopaedic theatres. Reinforcement of the responsibility of the consultant in charge of the operation. A written implant selection procedure.
Wrong Site Surgery November 2013	A patient received the wrong laser procedure to their eye due to an error in identifying the patient	Outpatients department Birmingham Midland Eye Centre	A Trust wide learning alert on positive identification of patients in all settings. A review of never event risks in outpatient procedure areas.
Wrong Implant January 2014	A patient received the wrong strength intra-ocular lens due to a same name error resulting in the wrong electronic record being accessed	Theatres Birmingham Midland Eye centre	Operating in BMEC was suspended for three days whilst an investigation was undertaken. Reinforcement of the importance of team brief for catching unforeseen changes to the operating list. Locking down of operating lists 24 hours before. Video reflexivity exercise to reinforce safety behaviours. Identification of risks of partial EPR implementation.

Following this final never event we launched a major safety review of operating theatres across the Trust. We invited in external reviewers from the NHSLA to examine in detail our safety procedures, policies and culture. The recommendations from this review have been turned into a comprehensive plan of action for this year. This includes:

- Strengthening of our WHO Checklist steering group to look at all potential never events and gain assurance on control measures to prevent them
- A program of safety culture assessment using the MaPSAF tool
- A review and update of policies and procedures in theatres
- Incorporation of never events assurance audit as a CQUIN.

Improving Stroke and Transient Ischaemic Attack (TIA) services

Stroke care – admissions to acute stroke unit within four hours

In some months of 2013/14 we were not able to meet this target which relates to the increased number of stroke admissions, together with difficult discharge of some of the complex stroke patients. Despite this, our overall performance of 76.4% has been one of the best in the country, compared to overall 51.2% nationally.

We plan to address this to streamline the Stroke Pathway and remove all bottle necks with the following measures:

- Two beds to be kept free at any time – one of these beds to be a side-room to ensure timely admission of stroke patients from A&E to the stroke unit
- Continue Board rounds every morning and invite the ESD (Early Supported Discharge) team to attend once weekly. This should help to ensure two beds are free and also identify patients who could be discharged early with rehabilitation at home
- When there is no identified plan and/or when only one bed available, the Ward Co-ordinator will now alert Consultants and Matron
- To improve earlier recognition of stroke and quicker transfer we are currently exploring the possibility of the routine stroke being scanned and transferred directly to the stroke unit
- Group establishing in June 2014 to address the complex discharge for the cohort of patient with increased length of stay.

Stroke Care – Admission to Thrombolysis Time (% within 60 minutes)

In November 2013, we established a negative impact of the target with A&E Departments. Meetings were held throughout December and the Stroke Pathway was changed to visualise a better incorporation of all services to be more efficient and timely for the patient, including colleagues in A&E and imaging. This has had great impact on the patient care in our A&E and we have increased our thrombolysis rate to more than 13% of our stroke patients. We achieved more than 95% in less than 60 minutes and in fact, most of our patients were thrombolysed in less than 45 minutes. We hope that in 2013/14 we can share a 95% achievement across the year.

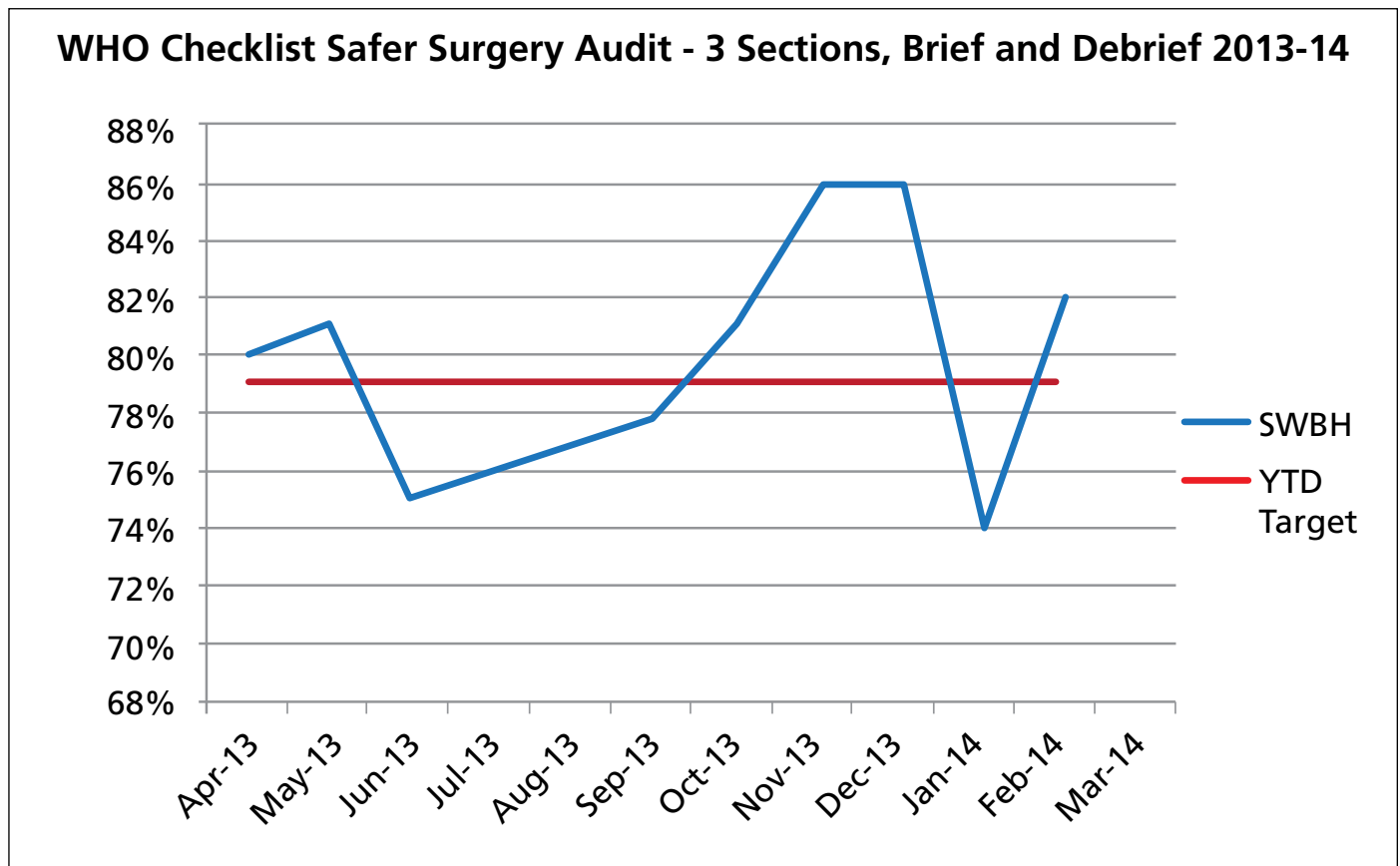
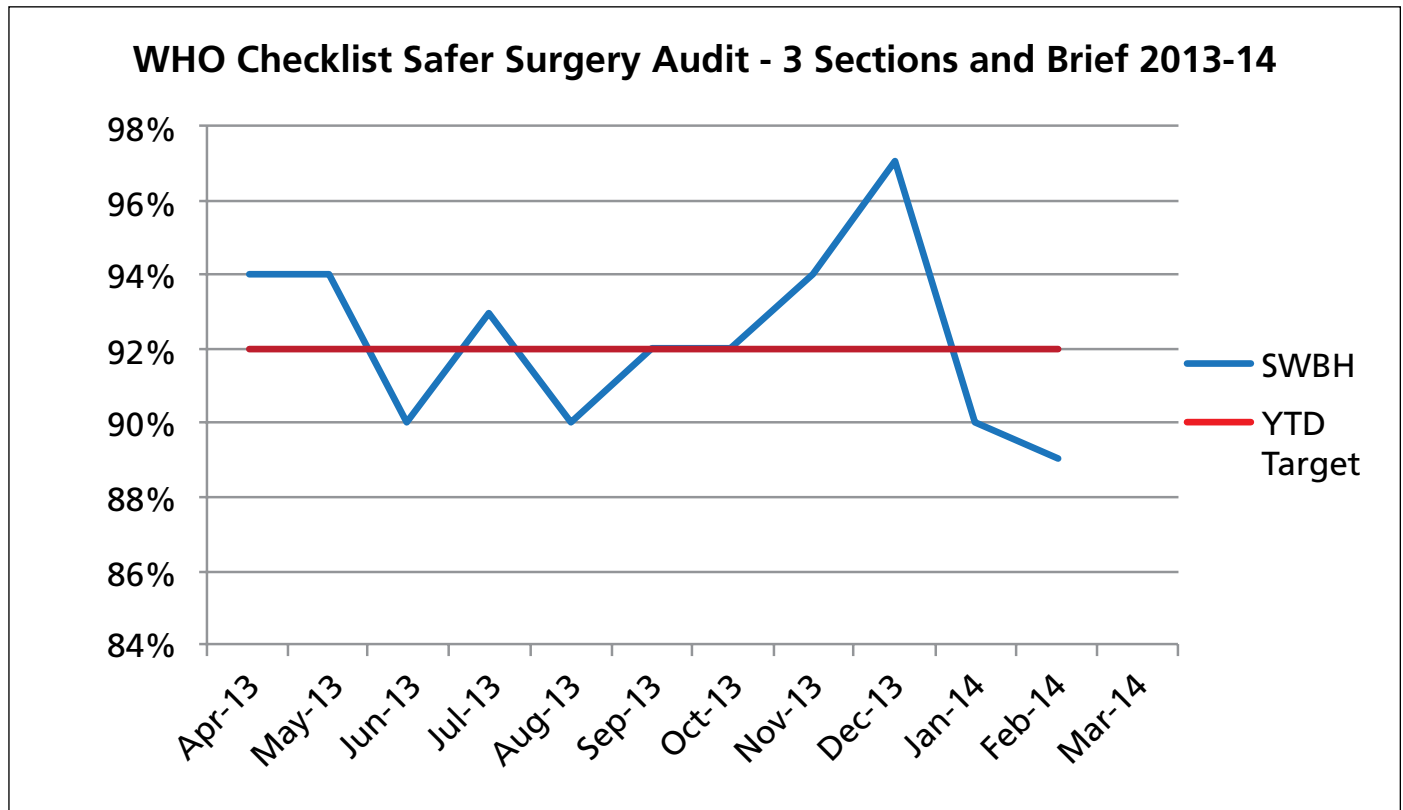
Implementing the Five Steps to Safer Surgery

Last year we identified that we needed to improve our use of the WHO Surgical Safety Checklist. During the year, we have continued to have regular WHO checklist committee meetings to monitor compliance with the checklist. Monthly compliance of completion of all five components of the checklist in all areas is monitored.

There remains a high standard of completion in all areas, with debrief being marginally lower than other sections. Intermittent notes based audit cross-checks against this data to ensure recording accuracy. We have focused on quality of completion ensuring it does not become a tick box exercise, and regular qualitative reviews by observers of the checklist process is conducted at intervals, giving instant feedback to teams. We have approved several updated versions of the checklist for specific areas, following on from review of incidents or locally differing requirements.

In February 2014, we introduced a compulsory check on ORMIS (operating theatre computer system) to highlight the completion of three areas of the checklist. This will make the collection/entering of audit data less onerous for staff. However, during the changeover period there will be difficulty in data collection as the team brief/debrief components are recorded separately per list, leading to some short term data inaccuracy.

The reported compliance with the three sections in the checklist over the past year is shown in the following table:



Reducing hospital acquired infections

Standards and targets for infection control are set nationally and include the following:

- Meeting targets set for C. Diff
- Meeting targets for Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia
- Monitoring and recording Meticillin Sensitive Staphylococcus Aureus (MSSA) and E. coli cases
- Monitoring 30 day mortality for Clostridium difficile (C. Diff)
- Reducing the use of antibiotic associated with C. Diff
- Maintaining PEAT scores at good or excellent
- Achieving hand hygiene standards
- Achieving MRSA screening targets

Element	Performance and Action
C Diff	39 cases for the year against a target of no more than 46 cases.
MRSA blood stream infections	Four cases for the year against a zero tolerance target.
MRSA screening	Elective - 78% against target of 80%. Non Elective - 78% against target of 80%.
Antibiotic Stewardship Programme	Improved access to antibiotics guidelines ('Microguide' application accessible on mobile phone devices). Achievements this year include allergy status above 97% and prescribing compliance above 90%. Redesign of hospital drug-charts in progress to improve documentation targets.

C. Diff incidences

In 2013/14 we have been very successful in keeping well below the number of occurrences agreed by the Department of Health, with only 39 occurrences of C. Diff. against a trajectory of 46 during the past year.

Actions to achieve this good performance included hand hygiene audits, a reduction in the use of antibiotics and maintaining a high level of environmental cleanliness.

MRSA screening & bacteraemia

Our target was to maintain a screening rate of 85% of all eligible patients by March 2014. We achieved this by February 2014. We will continue to work together to achieve our ultimate goal of a screening rate of 100% and to improve on our rates of elective screening.

We are working with teams to improve their focus on carrying out screening on all patients, and we are striving to ensure that we capture the data in the most timely and complete way possible.

Across the whole of 2013/14 there was a total number four MRSA bacteraemias (one post 48hr and three pre 48hrs) against a target of zero. Of these, the post 48 hour bacteraemia was deemed to be a contaminant and was attributable to our Trust. Two of the three pre 48 hour bacteraemias were also attributed to our Trust, two being contaminants and one being post procedure, although deemed to be unavoidable.

Work is currently being undertaken to address the issue of blood culture contamination at a ward level.

PEAT Score

The Trust's PEAT score for national standards of cleanliness has an average for Very High Risk Areas of 97% and High Risk Areas of 96%.

PEAT audits have now been superseded by PLACE which stands for Patient-led Assessments of the Care Environment. PLACE was introduced in April 2013, and is the new system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments will apply to hospitals, hospices and day treatment centres providing NHS funded care.

The assessments will see local groups/ex-patients go into hospitals. The Trust group consists of the Facilities PPI Group members and a member of the local Healthwatch. The teams assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job.

The assessments will take place every year, and results will be reported publicly to help drive improvements in the care environment.

Reduction of antibiotic usage

The Trust continued to improve on the antimicrobial stewardship toolkit score, scoring 97 this year, up from 83 at baseline in March 2013.

Delivering harm-free care in four key areas

The 'Safety Thermometer' tool which was introduced by the Department of Health enhances the understanding of harm free care experience by our patients in four specific areas:

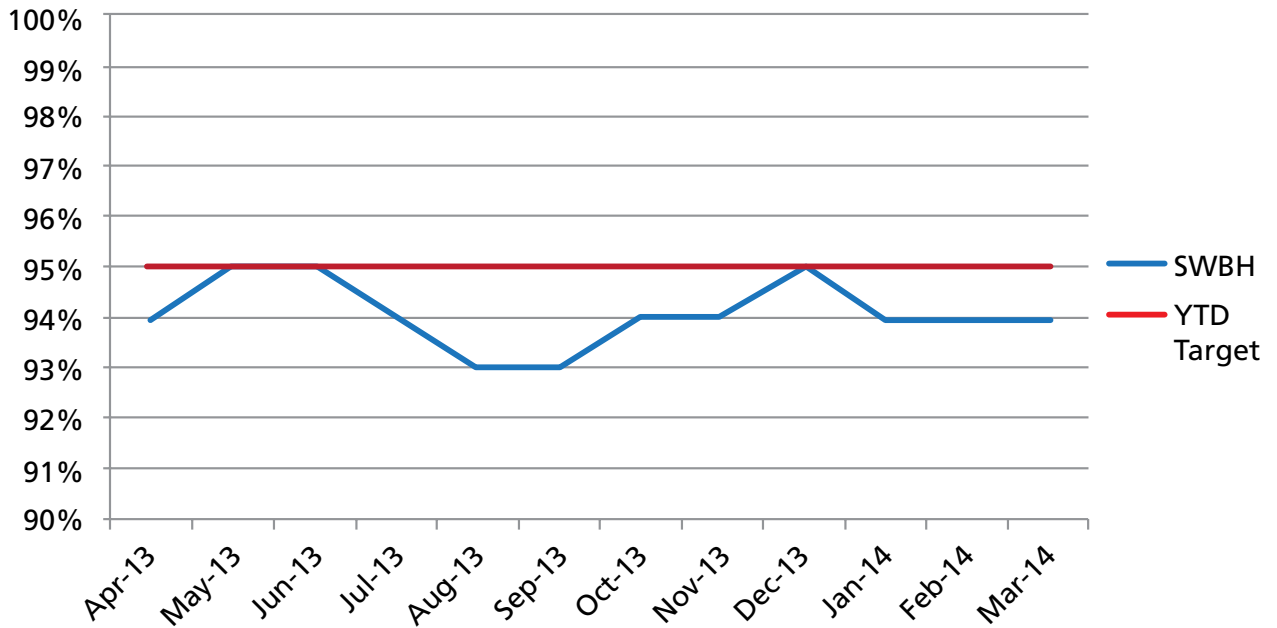
1. Pressure Ulcers
2. Falls
3. Catheter-associated Urinary Tract Infections
4. VTE (venous thrombo-embolism)

We intended to continue to improve the safety and enhance patient experience through specific attention to the reduction of harm events and through efforts to measurably improve care delivered. The Safety Thermometer audit is completed trust wide including Community services on a pre-prescribed day, once a month. The data is then submitted to the NHS Information Centre which is then published nationally.

The monthly whole Trust audit of patients for three harm-free events has been accepted very positively with good engagement of nursing staff.

The Trust harm-free percentage for 2013-/2014 dipped mid-year, but it has improved to 94% which is just below the target.

SWBH Safety Thermometer: Harm-Free Care (2013-14)

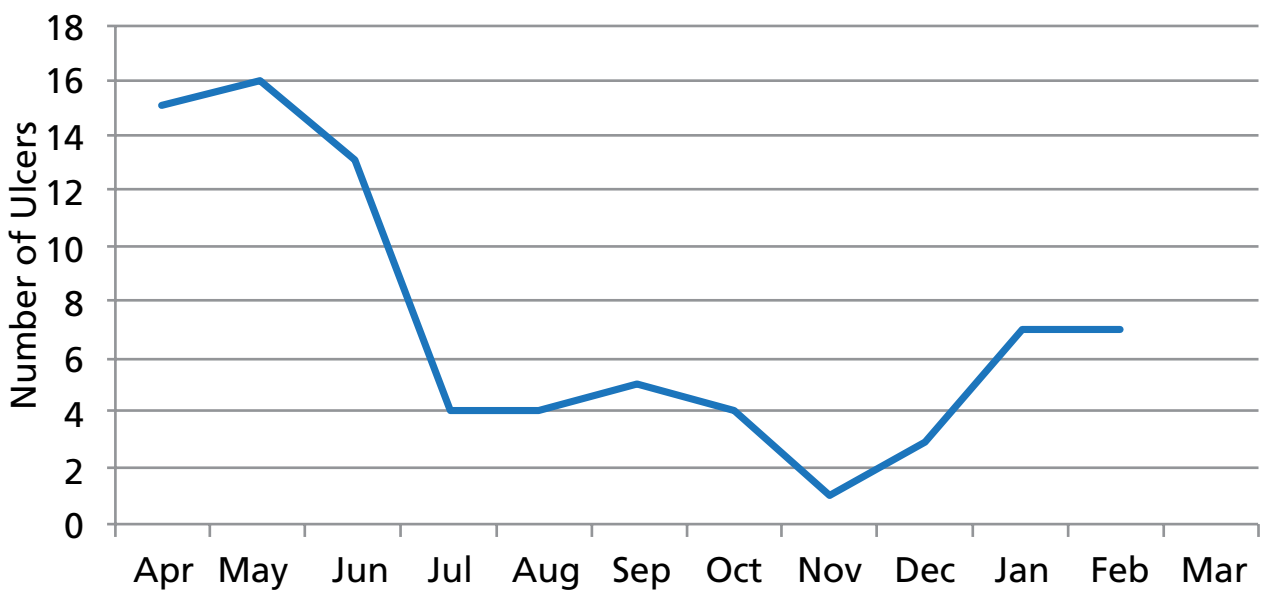


Eradication of grade 2, 3 and 4 hospital acquired pressure ulcers

Following the implementation of a focussed pressure ulcer reduction campaign, the incidence of avoidable hospital acquired pressure ulcers has been reduced by 54% during the last twelve months. Many of our wards have achieved sustained elimination of pressure ulcers with the highest celebrating 600 days pressure ulcer free.

All severe pressure damage is reviewed to identify the cause and implement local actions reflecting the lessons learnt. Following the success in reducing pressure ulcer incidences within the Hospital setting, the focus of the pressure ulcer reduction campaign will be placed on reducing incidences within Sandwell Community and patients under the care of our District Nursing teams.

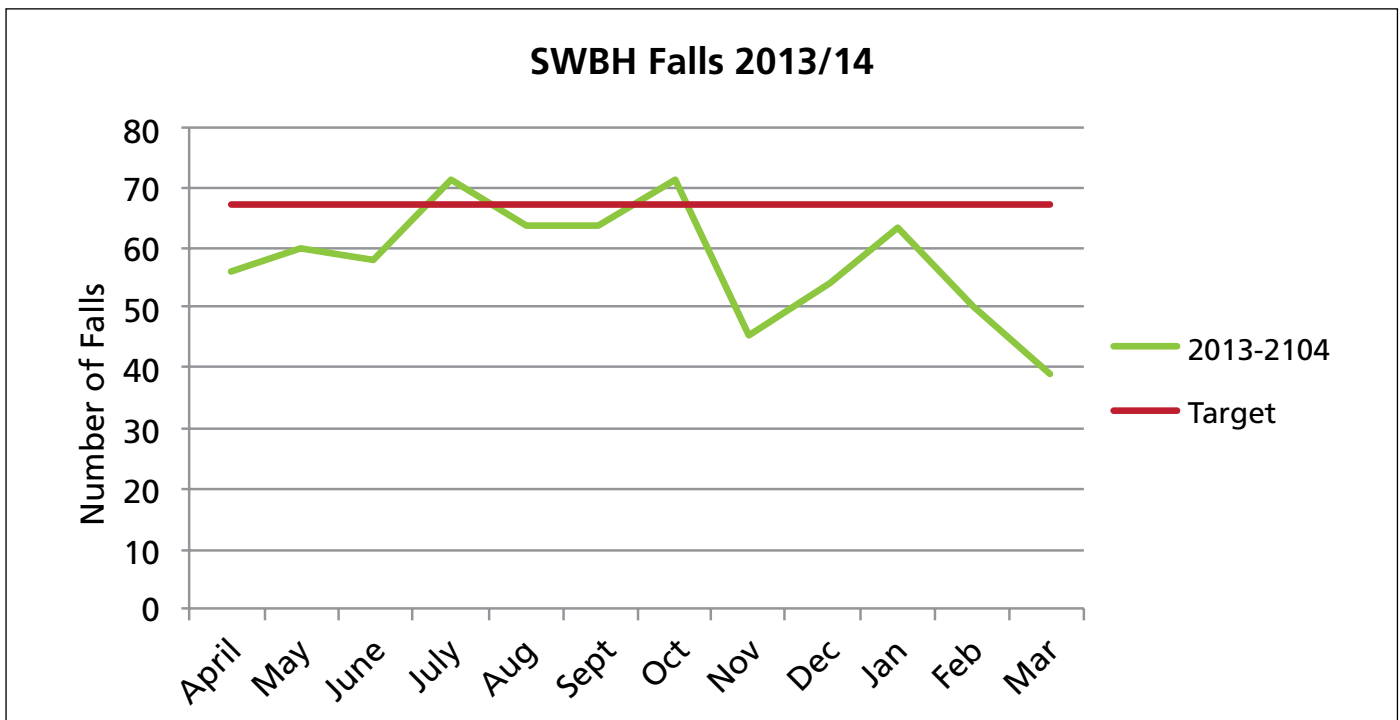
SWBH Hospital Acquired Pressure Ulcers 13-14



Patient falls

We continued to reduce the overall number of falls in 2013/14 by over 10%, however there has been an increase in the number of falls resulting in harm to our patients (for example a hip fracture /head injury) from 17 in 2012/13 to 30 in 2013/14. We investigate and review each one of these serious incidents and determine whether different actions could have reduced the risk of the fall happening. Out of the 27 reviewed to date, it was determined that in 13 incidents the organisation believes it could have reduced the risk of the patient falling. For example, we have determined that on some occasions the patient required a higher level of supervision by nursing staff or that greater accuracy of transferring information from one department to another was required.

We continue to invest in equipment and training – all staff receive prevention of falls on induction and annual mandatory training. Fallsafe, a new initiative recommended nationally will be implemented this year to co-ordinate the best practice in reducing the risk of falls - this includes a detailed review of medication and the use of specific care bundles (plans of care).



Visitors to Rowley Regis Hospital

Improvement in the safety and performance of our Accident & Emergency Departments

The A&E Department is the place many local people, many of them very unwell, frail and elderly, first come into contact with our hospitals. Last year, we set out some priorities to improve the patient experience in A&E:

Aims	Actions	Did we do what we said we would do?
Delivery of investment plans and recruitment in A&E	Structural change to A&E in order to improve flow and patient experience. Fully recruited to middle grades and nursing staff	✓
Implementation of a new informatics system in A&E	Implemented MSS Patient First IT system in A&E	✓
Development of our acute assessment and elderly care models in both hospitals	<ul style="list-style-type: none"> altering our surgical flow changing our elderly care ward model introducing more step down capability for those patients requiring help to get home 	✓
Establishment of joint health and social care team to include both Birmingham and Sandwell Social Services		✓
Improving the profile of discharges to precede admissions	<ul style="list-style-type: none"> building on the developments of the Transformation Plan with daily early senior ward reviews transport and pharmacy projects to expedite early discharge 	✓
Establishment of a 7 day capacity team with an Operational Centre to determine a better predictive emergency care flow and planning		✓

Accident & Emergency performance against the national four hour wait standard

For 2013/14, our aim remained for patients to get the appropriate care within as short a time as possible and that no one should wait more than four hours to get the care they need in A&E.

Our hospitals are targeted to ensure that 95% of our patients wait no more than four hours within A&E. We were able to achieve this target in six out of the 12 months and achieved an overall annual rate of 94.4%. The months where the target was achieved were June 13, August 13, November 13, December 13, January 14 and March 14.

In the summer of 2013, we launched the 'Winter Must be Better' (WMBB) 2013 Transformation Programme which encompassed a re-design of Emergency Care Pathways. The Patient experience in Winter 2012 had been poor with many patients waiting longer than four hours in A&E; ambulances frequently waited longer than 60 minutes to handover patients and those needing admission experienced long trolley waits due to a lack of beds on the Acute Medical Units. The WMBB 2013 Programme set out to establish a new service model which encompassed the establishment of dedicated Ambulance Assessment areas in A&E and an increase in total funded medical beds from 452 to 494. The specialty allocation of the 494 beds changed from 60 - 120 Acute Medical Unit beds operating with a maximum length of stay of 48 hours and two dedicated nurse-led Medically Fit for Discharge wards comprising of 48 beds.

Alongside the 'structural' service model changes, all departments involved in the delivery of emergency care are now engaged in new ways of working such as the rapid assessment of frail elderly patients in A&E by therapies staff to prevent unnecessary admissions, the rapid turnaround of diagnostic tests in A&E and acute wards, seven day working in Pharmacy and Radiology and weekend consultant reviews on the Acute Medical Wards. The Trust also introduced a Community Intravenous Antibiotic Therapy Service which both prevented admissions and enabled earlier discharges of patients.

The Trust is determined, and has renewed that commitment during 2013-14, to be actively working for the wider benefit of the communities that we operate within, that we work for, and that many of our staff live within. We already do a great deal of work that contributes positively to that ambition. We set that work out in this section of our Annual Report.

We know that there is always more that we could do. That is why the Board has created a dedicated committee with a focus on Public Health, Equality and Community Development. We have published our first Public Health Plan and will approve revised Equality objectives during 2014/15. Our work on community development will take place with partners and the test for the management is to persuade the full Board that our plans are ambitious and comprehensive across communities that we serve, both large communities and those that are especially vulnerable.

Public Health Strategy

The people in our catchment area suffer deprivation amongst the worst in the country. The likelihood of death under the age of 75 and chronic ill health from multiple long term conditions is extremely high. The causes of this include high levels of poor mental health, smoking, alcohol and substance misuse, poor diet, obesity and limited physical activity.

More than half of the contacts we make are with people with two or more long term conditions. It makes sense to reduce the number of people requiring interventions by addressing the causes not the consequences of poor health. Hospitals are well placed to deliver health promotion around recognised risk factors, and contribute to the health of their local community. Our first Public Health Plan describes how we will do this.

First we will make it clear in our mission, goals and communications that Public Health is central to what we do every day. Policies and programmes are being established with resources to ensure delivery of health promotion, and progress will be monitored by the Trust Board. These programmes will be developed and carried out in partnership with local agencies, and community groups, but SWBH will be in the lead.

Secondly, we will ensure that all our contacts with patients, relatives, carers, and the public will include an element of evidence-based health promotion. This includes outpatient visits, planned interventions, ambulatory care attendances, emergency admissions and rehabilitation visits with any of our staff. We will ensure that we are 'Making Every Contact Count'. There are benefits in smoking cessation, alcohol reduction and improved physical activity which can be demonstrated in the short, medium and long term. This will involve an overhaul of clinical pathways, so that prevention assessment and interventions are mandated, as well as training all our staff who interact with patients to give health promoting messages. Our evidence based screening and early treatment programmes will be increased.

Thirdly, we will improve the health of our workforce. Training to give messages to patients will be backed up with engagement in healthy activities, including help to stop smoking, improve diet and fitness, and support a stress reduction and mental health improvement programme. The goal is happier, healthier, more productive staff members who feel confident to promote these changes to others.

Fourthly, we will communicate our vision to our members and the local community. As one of the largest employers in the area, we actively contribute to local regeneration projects and particularly programmes which focus on getting unemployed people into training or work. The programmes we have already started will increase in scope through partnership and sponsorship. Building a local consensus about health will be achieved through volunteering, support to local charities and working with social enterprises.

Finally, we will reach beyond the local community to find clinical and academic partners regionally, nationally and internationally. We know that interventions will take time, focus and persistence, and as the evidence base grows we wish to both contribute to and benefit from innovation in effective health promotion.

Our 13 public health objectives

Objective 1

Objective: 80% of Trust staff to be trained in Making Every Contact Count and confident in making very brief interventions

Delivery deadline: October 2015

Expert lead: Doug Robertson

Responsible Board member:
Director of Organisational Development

Objective 2

Objective: For all pregnant women to receive carbon monoxide monitoring and, as required, intensive smoking cessation support, whilst improving breast feeding later

Delivery deadline: October 2015

Expert lead: Elaine Newell

Responsible Board member:
Chief Operating Officer

Objective 3

Objective: All of our community nurses, and nurses working for others in the community, to be delivering audited asthma advice to prevent acute admissions and to improve self management habits

Delivery deadline: April 2016

Expert lead: Sandra Fitzpatrick

Responsible Board member:
Chief Operating Officer

Objective 4

Objective: All Trust sites to be smoke-free by 2018, supported by an extensive and effective programme of cessation advice and nicotine replacement therapy for both staff and patients

Delivery deadline: October 2018

Expert lead: Hatem Abusriwil

Responsible Board member:
Chief Nurse

Objective 5

Objective: Reduce alcohol related admissions by at least a fifth against 2013-14 baseline, with a 50% increase in referrals from the Trust to partner alcohol support agencies by the end of 2015

Delivery deadline: October 2016

Expert lead: Ed Fogden

Responsible Board member:
Medical Director

Objective 6

Objective: The Trust can evidence that the food we serve and others serve on our sites actively and successfully promotes healthy choices, appropriate portions, and is consistent with nutritional advice

Delivery deadline: April 2016

Expert lead: Steve Clarke

Responsible Board member:
Chief Nurse

Objective 7

Objective: All new employees joining our Trust, and existing staff who choose to do so, will provide health data to us, which we will use to offer tailored support with risk issues including weight management, smoking, and alcohol consumption

Delivery deadline: April 2015

Expert lead: Tamsin Radford

Responsible Board member:
Director of Organisational Development

Objective 8

Objective: We will deliver our 'strand one' health promotion priorities, including extensive nicotine replacement therapy for staff, gym facilities on our Sandwell site, and out of hours access for night-workers to healthy food options

Delivery deadline: April 2016

Expert lead: Jenny Wright

Responsible Board member:
Director of Organisational Development

Objective 9

Objective: We will be recognised as a leader in workplace mental health provision and support for our teams. This will support our drive to cut sickness absence below 3%

Delivery deadline: April 2016

Expert lead: Tamsin Radford

Responsible Board member:
Director of Organisational Development

Objective 10

Objective: Our Trust is recognised as the youth employer of choice in our region, because we have doubled the number of apprenticeships we offer and have a work experience programme embedded in all local schools

Delivery deadline: October 2016

Expert lead: Jim Pollitt

Responsible Board member:
Director of Organisational Development

Objective 11

Objective: The Trust tackles the number one priority of local Health and Wellbeing Boards by delivering outstanding services for homeless people in partnership with the third sector and others - both as a care provider and as an employer

Delivery deadline: April 2016

Expert lead: Jo Wakeman / Jim Pollitt

Responsible Board member:
Chief Executive

Objective 12

Objective: We will select our new hospital partner in accordance with our regeneration obligations, and will shift by at least 10% the proportion of type B goods and services purchased locally

Delivery deadline: April 2016

Expert lead: Jenny Marshall

Responsible Board member: Director of Finance and Performance Management

Objective 13

Objective: We will deliver our sustainability action plan, which will cut landfill use by 5% and stabilise our energy usage at current levels, and therefore improve our NHS good corporate citizen assessment score by 10% or better

Delivery deadline: April 2017

Expert lead: Fran Silcocks

Responsible Board member:
Director of Estates and New Hospitals

To read our Public Health Plan in full visit the About Us section of our website (www.swbh.nhs.uk) and click on Trust Publications.

Our commitment to sustainability

As with previous years, our Trust has continued to demonstrate its commitment to sustainability, minimising our impact on the environment and climate change and working to reduce carbon emissions.

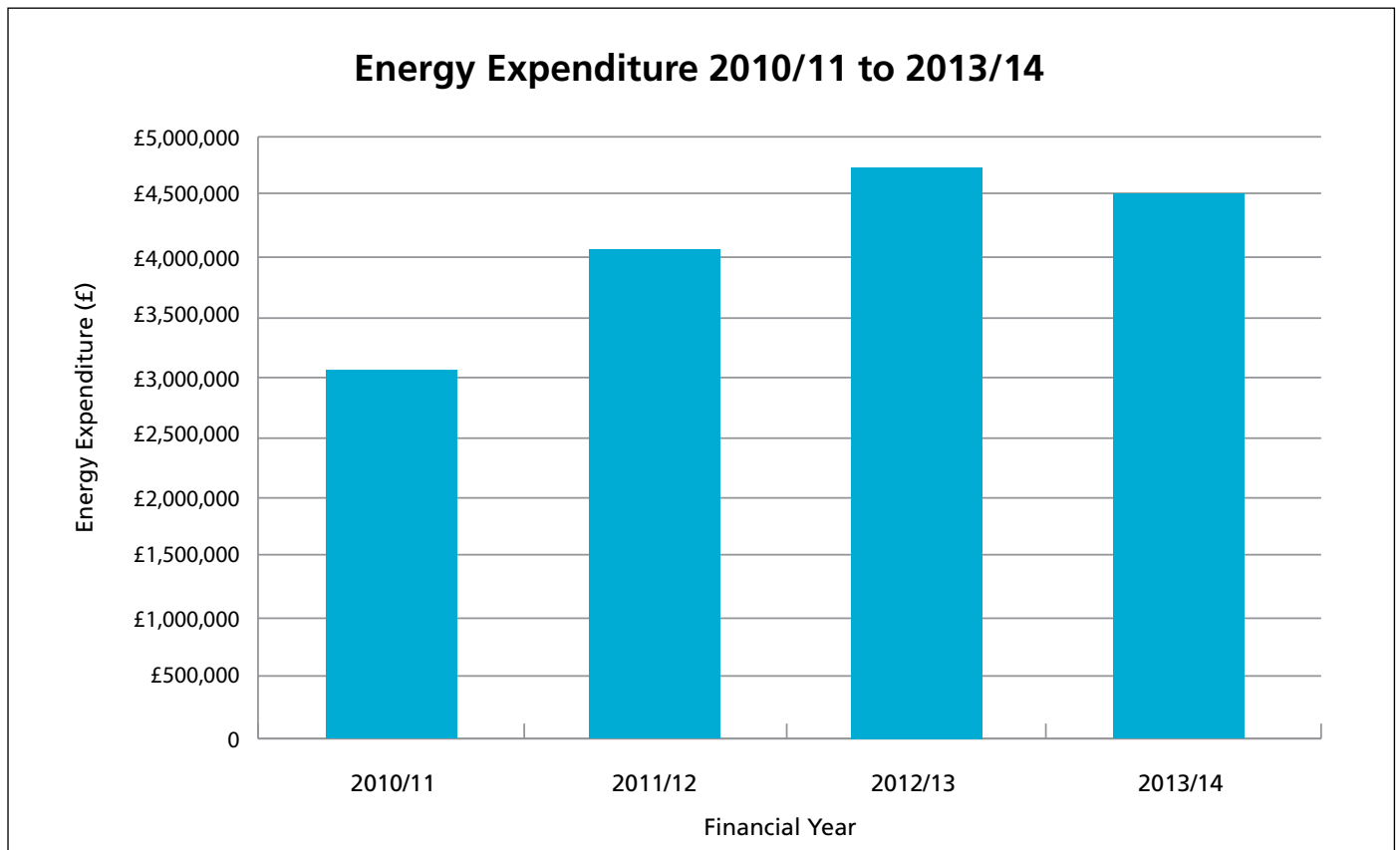
Our Trust has robust governance for sustainability with a well-established Sustainability Action Plan, Environment and Sustainability Policy, and Carbon Management Plan in place. The Trust also has a Sustainability Working Group with key managers across the Trust that meet monthly to discuss sustainability and monitor progress towards the Sustainability Action Plan. We also have a Board Level lead to ensure that sustainability issues have visibility and ownership at a high level in the organisation. Alongside the Sustainability Action Plan, the Trust has a Sustainable Travel Plan which focuses on staff travel to and from work and across our sites.

Our Trust believes that staff engagement is vital and that an environmentally sustainable NHS can only be delivered through the efforts of staff. We encourage staff to become Sustainability Champions to help us disseminate information, run campaigns and also feedback ideas. Our Sustainability Champions help us towards energy saving and waste reduction targets, reducing our environmental impact whilst also saving money.

The Trust believes that sustainability should be engrained within the organisation. Providing health care that won't cost the Earth is our mission.

Expenditure on energy

The Trust's total expenditure on energy has reduced slightly since 2012/13 which is reflected by a reduction in energy consumption. With increasing energy prices, it is vital that the Trust reduces the amount of energy it consumes from an environmental and costs perspective. We are currently working on plans to stabilise our energy consumption at 2013/14 levels up to 2017.

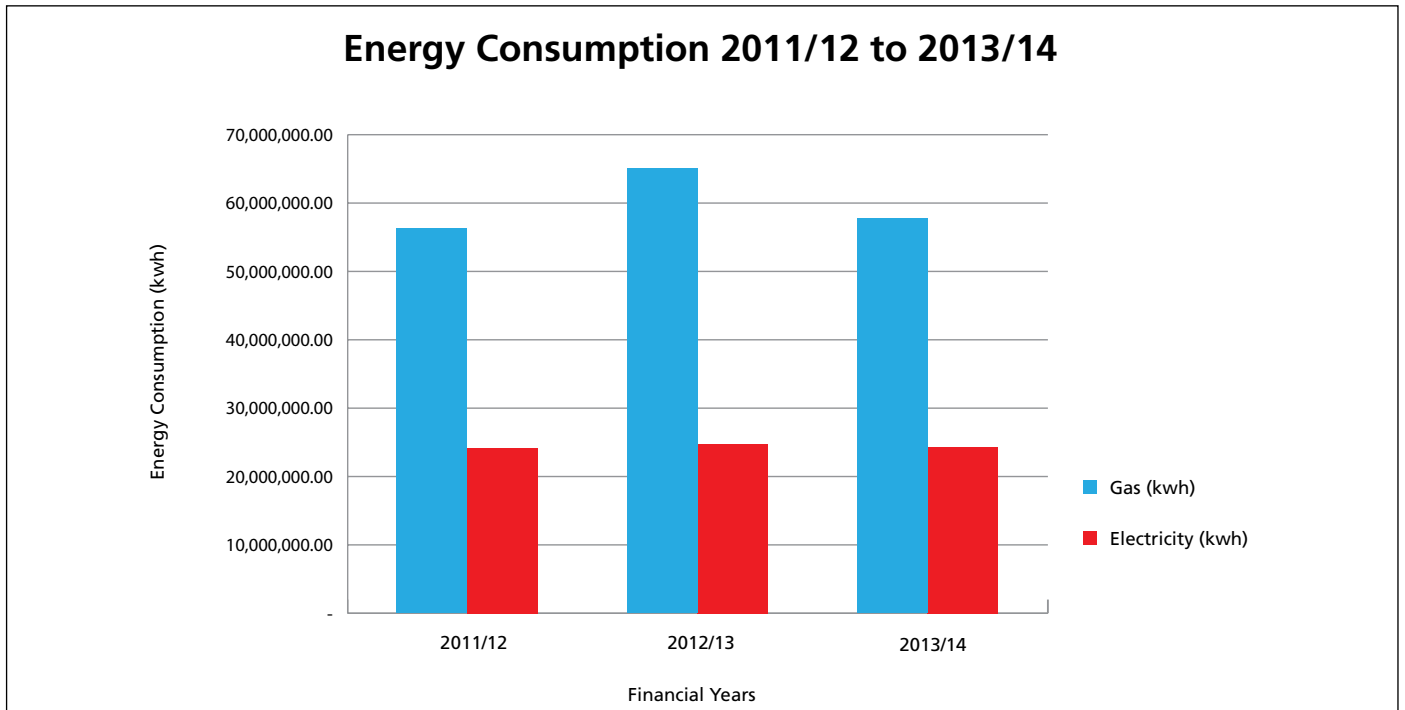


Note: From 2012/13, Leasowes Intermediate Care Centre energy expenditure data has been included in the Trust total.

Energy consumption

The Trust's gas consumption has reduced and electricity consumption has stabilised since the previous financial year (2012/13), resulting in an overall reduction in energy consumption. This is despite the Trust taking on Leasowes Intermediate Care Centre in April 2013. To achieve this overall reduction in energy consumption, the Trust has implemented some significant projects, including:

- Estates rationalisation programme, closing buildings and reducing the size of the estate which has saved energy and costs
- LED lighting and controls installed across the Trust to reduce electricity consumption, whilst also improving the patient and staff environment
- Replacement of boilers for more energy efficient models to reduce gas consumption
- Photovoltaic solar panels installed on roofs of the Birmingham Midland Eye Centre (City Hospital) and Rowley Regis to generate renewable electricity and reduce consumption from the national grid
- Staff engagement



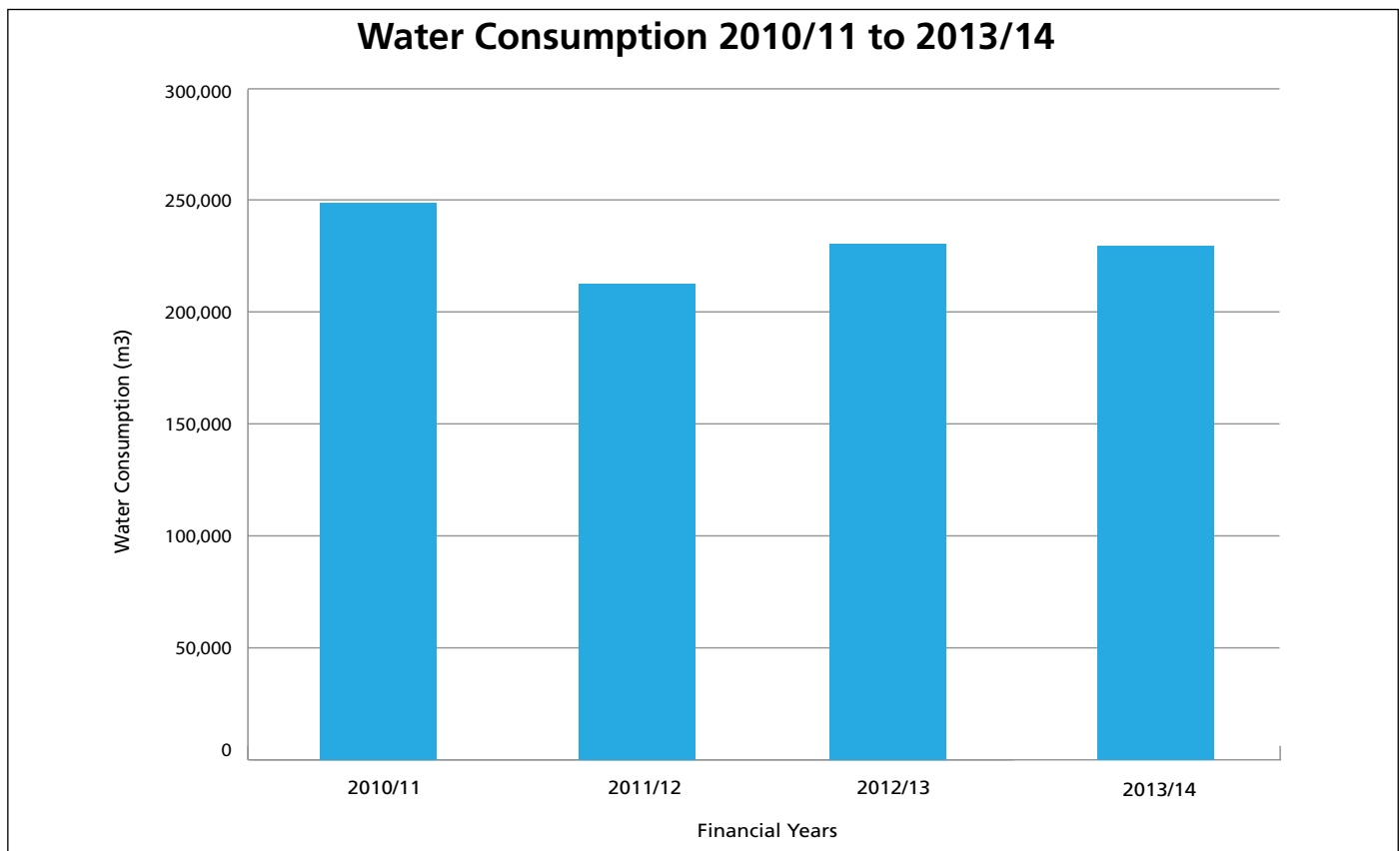
Note: 2013/14 data includes Leasowes Intermediate Care Centre energy consumption data from April 2013.



Best practice hand washing at the Trust

Water

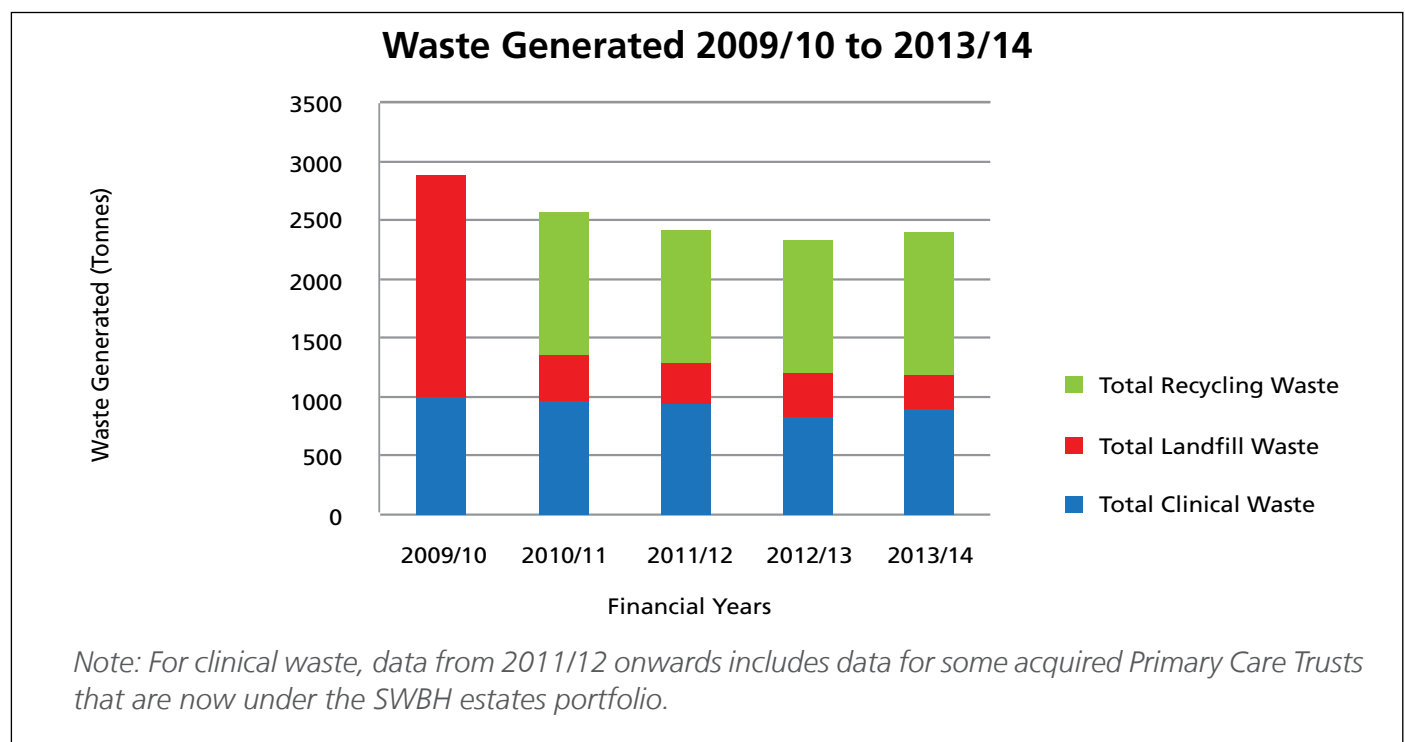
The Trust's water consumption has remained stable since the previous financial year (2012/13).



Note: From 2012/13, Leasowes Intermediate Care Centre data has been included in the Trust total.

Waste management (general and clinical waste)

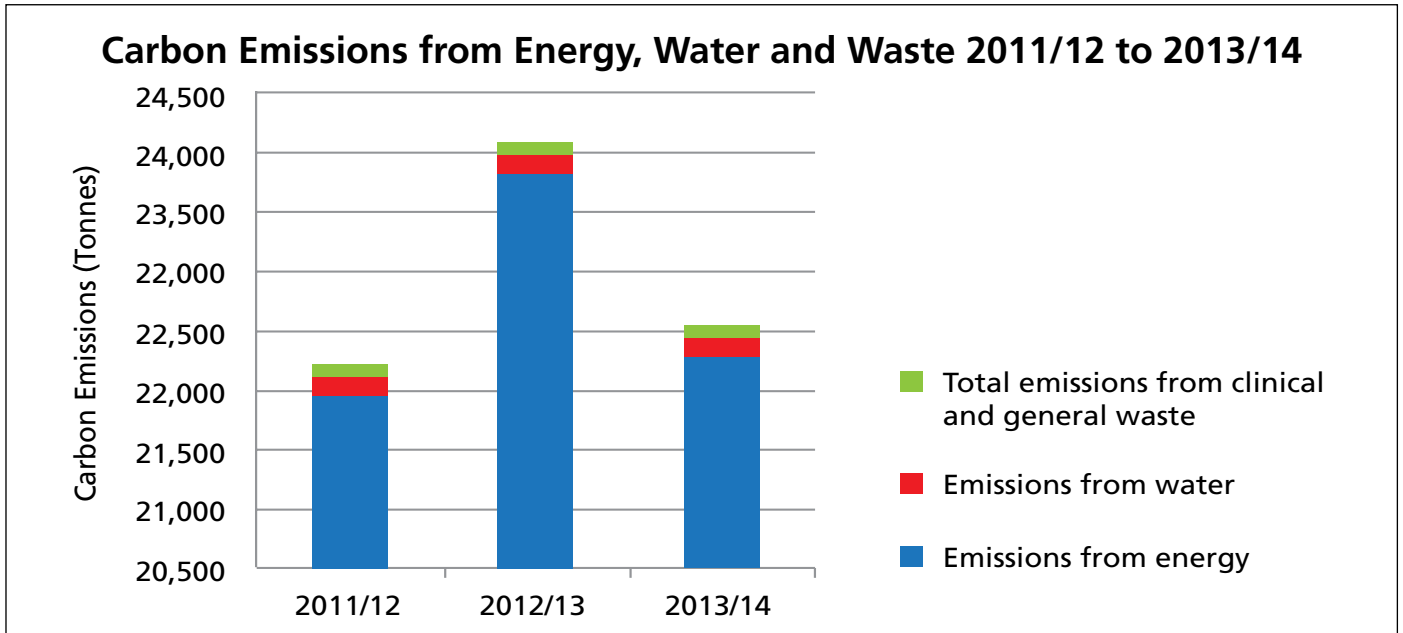
Our Trust recognises the importance of good waste management. The Trust's total volume of general and clinical waste has reduced steadily since 2009/10 as illustrated in the graph below. Significant progress has been made towards reducing the amount of general waste sent to landfill and recycling more of this waste. In 2010/11, the Trust introduced a waste recycling scheme at City Hospital alongside starting work with our waste contractor to increase recycling rates. The Trust is hoping to continue moving forward with recycling and reducing the amount of general waste sent to landfill.



Note: For clinical waste, data from 2011/12 onwards includes data for some acquired Primary Care Trusts that are now under the SWBH estates portfolio.

Carbon emissions (energy, water and waste)

The Trust has reduced its overall carbon emissions from energy, water and waste since the previous financial year (2012/13). Energy reduction has made a significant impact, with carbon emissions reducing in this area from 23,817.80 tonnes in 2012/13 to 22,302.15 tonnes in 2013/14 (see the graph and table below). The Trust's carbon emissions from energy increased during 2012/13. This increase was heavily influenced by the cold winter where more energy was required for heating. The Trust recognises that energy consumption is closely linked with weather patterns and other factors that may be outside of our control.



Carbon Reduction Commitment (CRC)

The Carbon Reduction Commitment (CRC) Energy Efficiency Scheme is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations. It is essentially a tax on carbon emitted as a result of energy consumption.

During 2012/13, the Trust's gross expenditure on the CRC was £211,404 (based on a price of £12 per tonne of carbon). For energy consumed between 2013/14, the Trust is due to pay around £250,000. This cost has increased despite the Trust's reduction in energy consumption and is due to an increase in the cost of carbon for 2013/14 to £15.60 per tonne (for forecasted emissions).

Priorities and achievements

The Trust has seen a number of significant steps forward in terms of environmental sustainability, including:

- Installing LED lighting and controls in areas across the Trust, with further works being carried out in 2014/15
- The Trust reports on its sustainability performance bi-annually through the NHS Good Corporate Citizen (GCC) self-assessment model. This self-assessment tool allows Trusts to measure their own performance against key sustainability themes and to map or benchmark their performance against others. We have set a target to improve on our GCC score by 10% or more by 2017 (on the 2013/14 baseline)
- Replacing gas boilers with more energy efficient models to reduce gas consumption
- An estates rationalisation programme has been completed, reducing energy consumption and therefore carbon emissions
- Waste recycling scheme at City Hospital continues to run well. This is reducing the amount of waste the Trust sends to landfill and increasing waste sent for recycling
- Photovoltaic solar panels have been installed on the roof of the Birmingham Eye Centre at City Hospital in May 2013 and on the roof of Rowley Regis Hospital in March 2014. These 50KW systems will save around 43,000 kWh of electricity each year (around £8,000 and 23 tonnes of carbon each year).

Building on the achievements made over the last few years our Trust also needs to:

- Implement our Sustainable Travel Plan for all of its sites (focusing on staff travel), with the aim of facilitating healthy and sustainable modes of travel (e.g. walking, cycling, public transport)
- Invest in energy saving technologies (e.g. further LED lighting and controls)
- Engage staff in the benefits of energy saving, water conservation, waste reduction and sustainable travel
- Continue to reduce the amount of waste the Trust sends to landfill and recycle more.

As part of the Trust's Public Health and Community Development Committee, we have developed plans with the aim of stabilising our energy consumption, improving on our good corporate citizen score, and reducing the amount of waste we send to landfill.

Widening participation

Following from last year's report where we outlined some of the innovative schemes we were adopting to support the widening participation agenda by getting local people into employment within our Trust, we are proud to report that one of those projects "The Learning Works" won a prestigious Health Service Journal (HSJ) award in November 2013, just six months after its official opening.

After review by esteemed judging panels, made up of senior and influential figures from the health sector, The Learning Works was announced winner of the Workforce category, sponsored by NHS Professionals. Anne O'Brien, Director of Clinical Governance and Operations at NHS Professionals, said: "The Workforce category is about looking for innovation in workforce development and recognising ways to bring people into the NHS. For us, Sandwell and West Birmingham Hospitals NHS Trust was an excellent example of this. Many Trusts can learn from the strategies used at the Trust and there is an opportunity for this to be rolled out further."

Lawrence Kelly, The Learning Works Centre coordinator, said: "Achieving this award is a really positive confirmation that we are making a difference in our community through workforce innovation. "The team has really worked hard over the last 12 months to launch and embed The Learning Works as a model in which our Trust can take pride. " The award was in recognition of the team offering new ways into employment and progression through multi-agency partnerships and recognising the role of the hospital trust as a large employer in the community.

The Learning Works is based in Unett Street, Smethwick. It is a community based building designed to help local people access employment in the health sector via a range of work experience, apprenticeship, volunteering and adult learning opportunities. This model has now been adopted across all Black Country NHS Trusts.

The Trust continues to explore innovative ways of supporting young people into employment and has recently awarded a contract to the homeless charity St. Basils to manage an accommodation block to help support young homeless people into employment via apprenticeships within the Trust. Jean Templeton, CEO of St. Basils made the following statement.

"St. Basils is committed to working in partnership with the Trust to ensure this innovative and ground breaking project is a success, and makes a real difference to the lives of homeless young people. One of St. Basils' principles is Working and Learning with others and it is the spirit and letter of this principle that will inform our partnership work.

The scheme is in line with the strategic priorities of both organisations, responds to the needs of homeless young people who are NEET in an effective and practical way, through offering good quality accommodation, training and work, enabling disadvantaged young people to earn and learn".

We are continuing our work towards becoming a Foundation Trust. Over the course of the last year, the Trust has been reviewing its key processes as part of our application timetable, including quality, governance and board development.

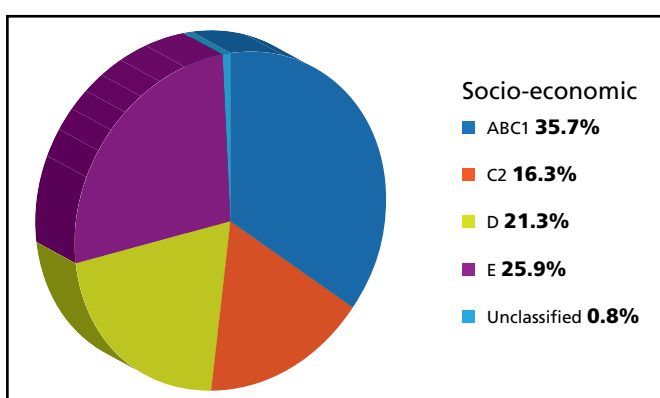
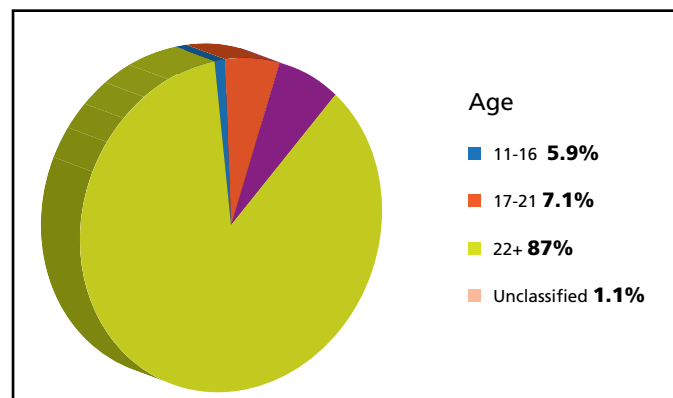
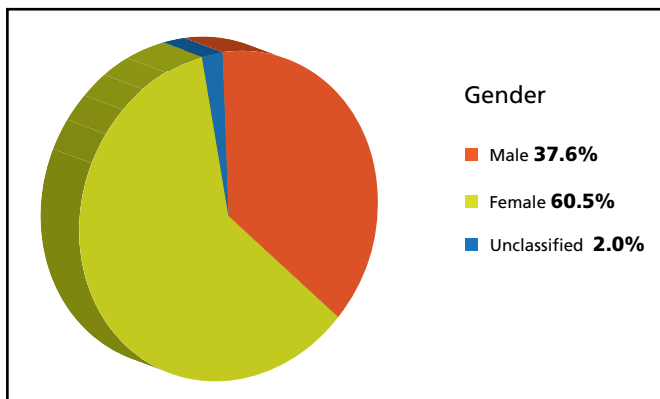
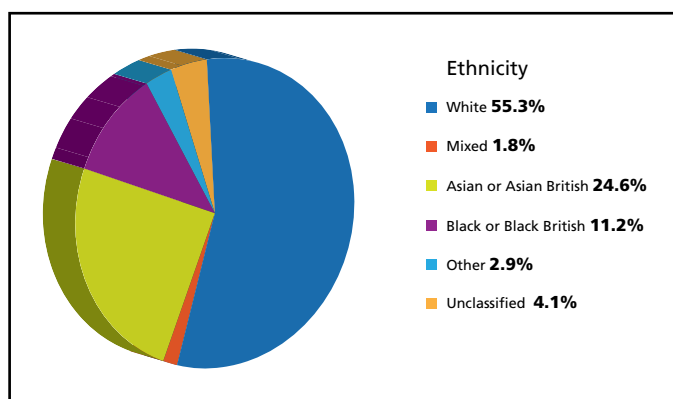
Our long-term Integrated Business Plan has been refreshed, in line with our plans for the Midland Metropolitan Hospital (Midland Met). This will be submitted to the Trust Development Authority (TDA) in June 2014 along with our 10 year, long term financial plans.

A key addition to the formal assessment process is the introduction of a comprehensive inspection by the Chief Inspector of Hospitals, the result of which will inform whether the Trust's application can be referred from the TDA to Monitor, which is responsible for assessing applicant Trusts. It is expected that the Chief Inspector of Hospitals visit will take place during the Autumn/Winter of 2014.

Membership at June 2013 is broken down by constituency below:

Constituency	Governor seats	Members 2013	Population (Census 2011)
Ladywood	3	994	126693
Edgbaston & Sparkbrook	1	406	104016
Perry Barr	3	1217	107090
Erdington	1	443	97778
Wednesbury & West Bromwich	3	1145	113222
Oldbury & Smethwick	3	1399	105807
Tipton & Rowley Regis	3	770	89034
Wider West Midlands	2	1832	4858207
Not Specified	0	65	
Total	19	8271	5601847

Membership demographics break down as follows:



Membership

Membership continues to steadily grow and at March 2014 numbers had increased to 8819. Foundation Trust members continue to benefit from receiving three newsletters a year providing updates on the Trust services and future plans. The structure of the newsletter ensures that information received by our members focuses on topics that are of most importance to the population we serve.

- New Year, New Start – Education and employment opportunities
- The Health of our Population
- Quality and Safety
- Hospital Facilities
- Stroke Services
- Eat Well
- Get Involved in Leading the Trust
- Infection Control
- Charity Fundraising Day – Family Fun Day
- Building a Healthier Future – Our mid-term plans
- Food Allergies Seminar
- Fundraising and volunteering
- NHS annual careers day
- Patient Experience
- Sustainability
- Keeping fit
- AGM
- Dermatology
- Festive Fete
- Twitter Chats – Alcohol and stop smoking
- Signposting services for Focus Groups including Diabetes, Stroke, Cardiac, Cancer and Rheumatology.

Foundation Trust Governors

Central to the organisation as a Foundation Trust, will be the Council of Governors. Public and staff members will be elected onto this body during the later stages of the Trust's application for Foundation Trust status - currently envisaged for late 2015.

The key responsibilities of a Foundation Trust Governor are:

- Representing the views of the people living in your local area
- Holding the Board of Directors to account
- Appointing or removing the Chair and Non Executive Directors
- Setting the salary for the Chair and Non Executive Directors
- Approving or not approving the appointment of Chief Executive
- Appointing or removing the Trust's external auditors.

Ahead of the establishment of the Council of Governors, the Trust will, from 2015, be introducing a body of staff and local people, who will operate akin to a Council of Governors; this group will be consulted on major plans and changes and undertake work on key projects.

Chaplaincy

The Trust has a multi-faith Chaplaincy Department made up of authorised religious ministers from the Christian, Hindu, Muslim and Sikh faith groups, and is assisted by authorised volunteers. The team are spiritual care providers, giving spiritual support for people with all faiths and none, including patients, relatives, visitors, staff, volunteers and trainees.

The team may have a background in one of the major religions but they are trained and skilled to support people's spiritual needs beyond the parameters of any single religion. A 24 hour call-out system is in place for the chaplaincy and we aim to respond within an hour.

During the year our ministers and volunteers have provided listening and spiritual counselling, events for religious festivals (Easter, Christmas, Eid, Vaisakhi, Diwali and Ravi Dass' birthday), baby blessings, bedside prayers and ceremonies, ward visits, weekly services for staff and patients, staff support groups, information and advice.

We conducted special services in memory of members of staff and family funerals. In conjunction with staff from Critical Care we held a memorial service and a specialist memorial service for those who suffered the loss of a baby.

We have sacred space and prayer facilities on the Sandwell and City Hospital sites including multi-faith chapels at each site, and Muslim prayer rooms with Wudu facilities. Our chapels offer quiet, reflective spaces for anyone to use.

9. Our workforce in 2013/14

Staff are at the heart of our organisation. Healthcare is provided by individuals working one to one with a patient, and we need to support our teams to provide the best that they can. The organisation should make their roles easier not harder and should respond to their needs.

In the annual NHS staff survey, it is clear that we have some real strengths. In particular:

- Bullying and harassment at the Trust has fallen sharply, though it remains too high
- We have seen a 10% jump in the proportion of staff who believe safety is our top priority and an increase in staff that would recommend our Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.
- The Trust's overall staff engagement score continues to improve and is average when compared to Trusts of a similar type
- The engagement of black and minority ethnic staff is higher than among the survey respondents as a whole (this is very unusual in the wider NHS).

During autumn 2013, we began a monthly staff survey of our employees. Whilst the national survey happens once a year and gathers a few hundred replies, this survey is receiving hundreds of views each month. A consistent picture emerges from it on some issues:

- Staff on the whole are enthusiastic and want to be more involved in driving better quality care for patients and are engaging well in service improvement projects e.g. better cross site working and paperless GP letters
- We need to support our service and clinical leaders to focus more on staff health and well-being to ensure that all staff come to work
- We need to improve on communicating the case for change and the benefits and to manage change better
- Where team leaders communicate the survey results and support their teams to act upon the findings we are seeing a significant improvement in engagement scores as a result.

Although there are Trust wide conclusions, the diversity of response by team is very striking. That is why in January 2013 we brought in additional support to help with a large scale, long term leadership development programme. This will run through into 2015-16. It is overseen by a committee of the Board. We are proud of our tradition of high quality educational provision. Examples shown below testify to the continued strength of medical and nursing education at the Trust. We are a trusted partner for a number of universities, and are well supported by Health Education West Midlands. During 2013-14 we indicated prima facie support for the creation of a new Medical School at Aston University.

Key achievements in 2013-14

Everyone employed by our Trust, excluding those on long-term absence, had an appraisal during the year

This builds on historically high rates of appraisal in the Trust, but is an important step-change in how we work. Because a number of the individuals had not been appraised previously or had not been appraised for a long time, they were in essence outside the system. During 2014-15, we want to develop our appraisal system further, linking it more closely both to peer and patient feedback, and to organisation and team performance.

We have further embedded good systems for compulsory mandatory training and reduced the proportion of classroom teaching required of our staff

It is vital that everyone working in the Trust has certain key competencies tested routinely. In addition, the law requires that certain training courses are maintained at specified intervals. We continue to work to find new ways

to deliver training, particularly on-line, and to ensure that employees who have training from elsewhere in the service can 'passport' those credentials into our Trust. The table below sets out our training assessment by area:

Staff Group:	Nursing				AHPs				Technical			Admin		Estates & Facilities								Management			
	Matron; Nurse Manager; Nurse Midwife	Health Visitor; School Nurse	HCA; Nursery Nurse Clinical	Nursery Nurse Non-Clinical	Physiotherapist; Podiatrist; Chiropodist; Radiographer	O.T.	Audiologist; Speech & Lang. Therapist; Counsellor; Psychologist; Dietician; Orthotist;	Pharmacist; Pharmacy technician	Phlebotomist	Laboratory	Biomedical Scientists	Office Based Admin Staff	Patient facing/front line admin staff	Porter	Domestic	Catering	Ward Services	Transport	Patient Transport	Security	Craftsmen	Consultant; Non-consultant Career Grade Doctor; Doctor in Training	Executive Director	Manager Clinical	Manager Non-Clinical
Conflict Resolution	√	√	√	√	√	√	√	√	√	-	-	-	√	√	√	√	√	-	√	√	-	√	-	√	-
Consent	√*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	√	-	-	-
Equality & Diversity	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Fire Safety	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Food safety	-*	-	-	√	-	√	-	-	-	-	-	-	-	-	-	√	√	-	-	-	-	-	-	-	-
Infection Control	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Harassment & Bullying	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Health & Safety	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Information Governance	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Medical Devices	√	√	√	√	√	√	√	-	√	-	-	-	-	-	-	-	-	-	-	-	-	√	-	√	-
Medicines Management	√	√	-	-	√	-	-	√	-	-	-	-	-	-	-	-	-	-	-	-	-	√	-	√	-
Moving & Handling	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Resuscitation	√	√	√	√	√	√	√	√	√	-	-	-	-	√	-	-	-	-	√	√	-	√	-	√	-
Safeguarding Adults	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Safeguarding Adults	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Transfusion	√	√	√	-	-	-	-	-	√	-	-	-	-	√	-	-	-	-	-	-	-	√	-	√	-
Breakaway Training	√	√	√	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

We have continued to support the Adair programme of leadership, and allied that to our new Top Leader's Cadre programme

161 people have been trained in these methods over recent months. Our aim is to introduce a consistent approach to leadership across our organisation. That helps us to recruit and retain, and of course it helps with delivering organisation wide or inter-departmental projects.

We have expanded and sustained our work on employment, including apprenticeships. As we describe in section 8 of this annual report, we continue to provide additional support to local people to join our workforce. In particular, we have assisted applicants with their maths and English skills. We do that as an additional service, but also work closely with local schools to support children in thinking about NHS careers. Our work on professional and technical disciplines for scientific students who might have considered roles in radiography, audiology, physiology and engineering is especially notable.

The Trust is a key partner in the Sandwell University Technical College. This opens on the High Street in West Bromwich in autumn 2015. Both for local children, and for our recruitment from outside the area, this school focuses on 14-18 year olds with a concentration on health and social care is an important landmark development.

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We have re-focused our work on equality and diversity, but we believe there is much more that we can do

The Trust will meet the new Race Equality duty in 2015 at its inception, whilst we continue to meet the Public Sector Equality duty. We collate and make use of data on protected characteristics for our workforce in partnership with trade union and staff side colleagues. The same collation takes place around patient care to establish that those attending our services reflect those living locally. We hope that the use of more technology in outpatient settings will give us richer, more comprehensive data in the future. We are committed to using that data to ensure that commissioners fulfil their obligations to purchase services that reflect local need.

We are due to consider in 2014-15 a revised equality plan. That will build on the work and objectives outlined below. The expected emphasis is on how we actively promote diversity in our workforce and especially in our leadership whilst maintaining our obligations to treat all involved equitably.



Mr Ayman Ewies, Consultant Gynaecologist

Our current equality objectives

The purpose of setting equality objectives is to strengthen both the performance and transparency of our general duty and to ensure that we are making sustainable progress in advancing equality and human rights for all protected groups and beyond, for our patients, carers and staff.

Our equality objectives have been drawn from the evidence and data currently collated on protected groups including our workforce. The following equality objectives for 2012 -2016 were approved by the Board:

Objective 1: Governance – ensure effective governance structure and processes are in place to support the delivery of equality, diversity and Inclusion.

Objective 2: Equality Data analysis – Improve the monitoring processes for equality data by protected characteristics for both service users and staff.

Objective 3: Leadership – ensure all senior leaders and managers have an annual objective as part of their Personal Development Reviews [PDRs] to embed equality, diversity and inclusion within their areas.

Objective 4: Service Delivery – ensure that our services are designed and delivered in ways which meet the needs of our service users, ensuring quality of outcomes and experiences.

Objective 5: Training and Development – ensure staff are culturally competent and confident in the provision of care, promoting and maintaining dignity, respect and inclusion at all times.

Our approach to equality objectives

The Trust has made real progress against the equality agenda both as a provider of services and an employer such as improved access for all to our buildings and services; website access and route plans to our hospitals and departments via 'DisableGo' website (the link is on the Trust website). Whilst developing our objectives we were able to share some of our key achievements with local interest groups. It was also recognised that issues relating to protected characteristics are often deep-rooted and difficult; it will take time and continuous commitment to fully address such issues of inequality.

The Trust is currently rolling out the Equality Delivery System [EDS] trustwide, the outcome of our equality analysis will enable us to better gauge our performance, provide learning and allow us to develop the priorities for our equality objectives.

To avoid repetition and possible exhaustion of local service users, a Black Country Cluster (BCC) wide approach has been adopted to enlist local interest groups. SWBH holds the responsibility for developing and maintaining a database of these groups. The database currently has over 200 contacts which include SWBH-only members.

We have held grading workshops with our SWBH Assessors. The events included individual service users as well as community representatives such as Gender Matters, Birmingham Institute for the Deaf (BID), Sandwell Irish Centre, Rights & Equality Sandwell, Agewell and Jehovah's Witnesses. The groups worked through a variety of evidence presented, this included service specific information and cross referenced to other evidence such as policies, CQC outcomes, Patient Experience Surveys, Staff Survey.

Feedback was positive and included suggestions that could further improve patients' experiences and outcomes.

Looking ahead to 2014/15 and beyond

As we set out in our annual plan for 2014/15, we want to tackle sickness, temporary staffing and turnover rates. At Trust level these are unacceptably high. Given that each indicator is also varied across the Trust, with some very good performance in place, we know means that in some areas performance is worse than the aggregate headline. There are areas, such as emergency medicine, where local issues are a function of national difficulties that are being addressed by others.

Our key workforce objectives are set out below:

- Achieve 100% PDR and mandatory training compliance by March 2015
- Cut sickness absence rates from their current 4.5% by focusing on 50 hotspots
- Improve employee well-being by implementing our public health plan
- Invest in our leaders, through our partnership with Hay Group and others
- Introduce 360° appraisal into all leadership roles
- Improve our 'time to hire' from vacancy to recruitment
- Provide extra support to high turnover departments and those with long-term vacancies
- Introduce an in-house medical bank
- Invest in our occupational health services counselling teams to tackle workplace stress
- Ensure that our training expenditure supports career and skill development.

The Trust has been explicit for many years that it expected to reduce, over this decade, the size of our workforce. By 2020 we would see the amount we spend on workforce reduced by £80m, notwithstanding wage rises over coming years. This will translate into:

- New roles in some specialties with different professionals taking on tasks traditionally done only by some disciplines. This is true across organisations as well, in partnership with our local authority colleagues
- Re-examining duplication of work, and the scope for technology substitution, in how we deliver care. We collect some information repeatedly from patients, and we duplicate work across our sites because we do not use technology smartly
- Ensuring that seniority in clinical departments does not automatically mean providing less face to face clinical care. We want our most skilled colleagues to be looking after patients and management roles should be configured to support that goal
- Working together with partners to ensure that the Trust spends more of each £1 on patient care, but is supported by very high quality "back office" functions, which may serve not only our Trust but other organisations
- Focusing hard on developing the skills of those we employ, not only to take on roles, but also to cope with and manage change in the NHS. In 2014-15 we doubled our training budget and will continue to try and protect that funding to support our long term mission.

10. Our strategic priorities for 2020 restated

Over the next five years, there is a great deal about what we do at the Trust that will not and should not change. Inevitably, plans for the future tend to focus on what needs to improve. But as we make those improvements we need to ensure that we do not damage or destabilise the much greater part of what we do that works well. We can demonstrate that the quality of care we offer in many parts of our organisation is exemplary. We want to maintain that.

In spring 2014, all NHS organisations were required to prepare and submit a variety of five year plans. Our Trust was well placed to do that because during autumn 2013 we developed and agreed a series of ten year planning documents. During 2013/14, our Board publicly approved:

- Our long term financial model (LTFM) 2013-2023
- Our long term workforce model
- Our updated estates strategy
- The Outline Business Case for the Midland Metropolitan Hospital development
- Our informatics strategy.

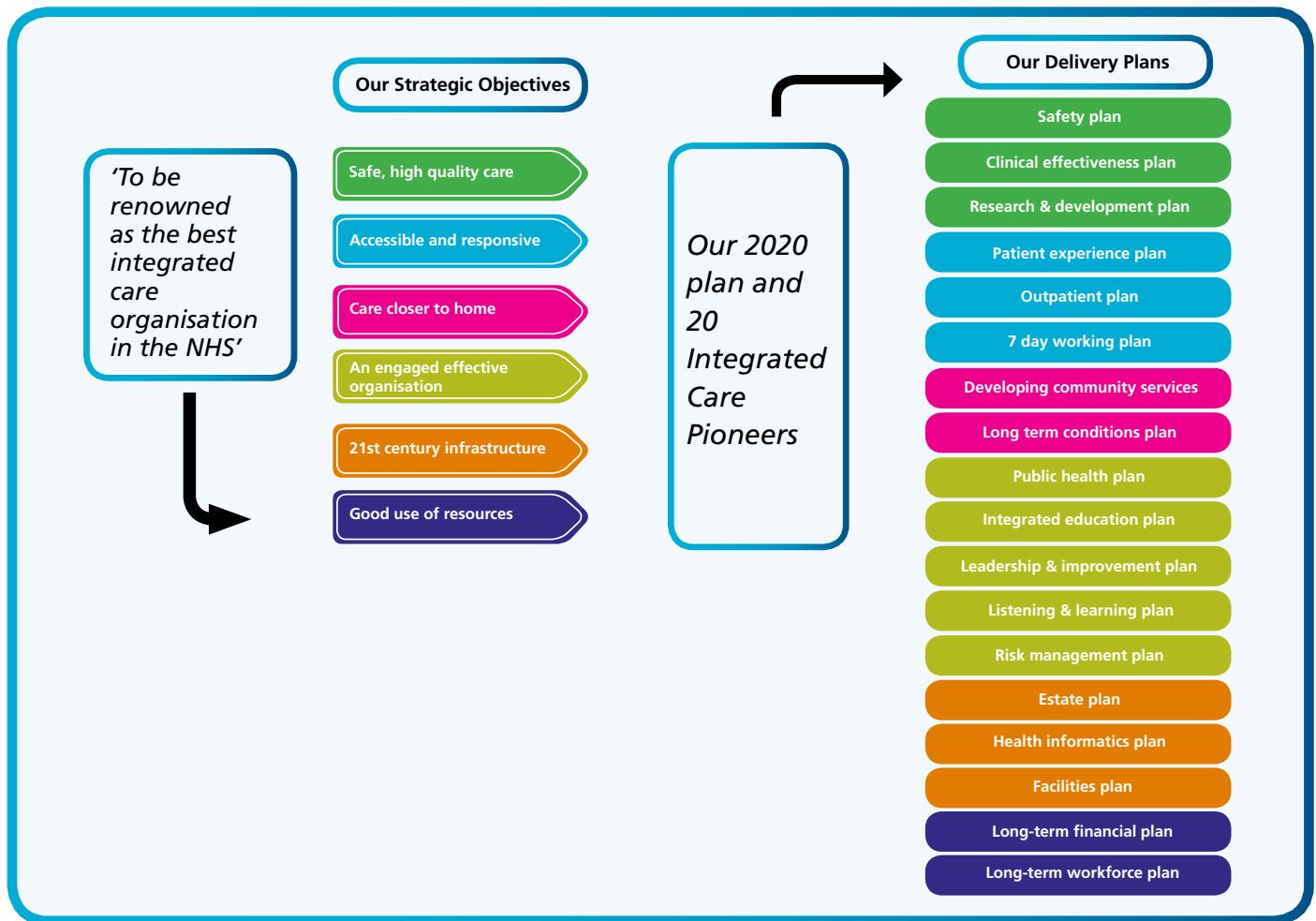
In improving services, we believe that we need to make investments in three key areas:

1. Our workforce – though we will employ fewer people in five years, we want to ensure that we can train and develop everybody in our Trust. That development is not only about technical skills, but also the teamworking and relationship skills on which care depends
2. Our technology – in 2016/17 we will change our main computer systems. Meanwhile, as this annual report illustrates, we are finding new ways to use technology to support care both by monitoring patients' vital signs in different ways, and by supporting clinicians to work remotely
3. Our estate – not only be opening the Midland Met in 2018-2019, but by completing the refurbishment of Rowley Regis Hospital, the current Sheldon block at City Hospital, and the main hospital building in West Bromwich on our Sandwell site.

The future strategic direction of the Trust remains grounded in the local population. Our first priority is to deliver more care to local people. We want local residents who might currently choose to travel further, to get their care from us instead. But as care models change, we recognise that we too need to change and so we expect in future years to substantially expand our community offer, and to work ever more closely with mental health and general practice partners. We value existing partnership arrangements with Walsall Healthcare and Dudley Group of Hospitals, which we continue to expand. Our tertiary partnerships with Heart of England Foundation Trust and University Hospitals Birmingham remain important to the quality of care we provide locally. In the future, we will seek the endorsement of both local partners and Monitor for our Foundation Trust application. We would do that because approval would indicate widespread support for our strategic direction and long term sustainability.

Right Care, Right Here is the basis for much of the partnership work that we do. In 2007, public consultation confirmed support for a strategy in which services moved ever closer to local people by being transferred into general practice and into community bases and town centres where it was sensible to do so. At the same time, acute care will be rationalised behind one A&E department in Smethwick. We will work with the local Overview and Scrutiny Committee and other parties to ensure that that agreed direction retains local support.

Our 2020 vision is “to be renowned as the best integrated care organisation in the NHS”. That is an ambitious goal, and the success of our changes to deliver will ultimately be judged by local patients. Only patients can tell us if they feel that our care is coordinated and that we are working to meet the outcomes that are important to them. With that in mind, during 2014/2015 we will identify at least 20 services that we believe will be critical to the future of care locally. Services that, if we are to move from two A&E departments and hospitals into one, must be enhanced and improved. These Integrated Care Pioneers will be at the forefront of our work to make sure that the changes we make with Midland Met are ones that retain local trust.

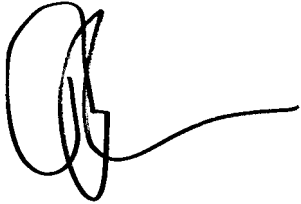


The future of care locally does need to be different. The needs of the population in 2020, and even more so in 2030, are subtly different to needs ten or twenty years ago. And we need to prepare now for those changes. In particular, we need to prepare to meet the challenges of ageing, with many more people living to 85 and beyond. We need to prepare to support a large adolescent population, whose underlying health will be so important to local prosperity in the future. And we need to recognise that supporting people with long term conditions, often with several long term conditions, means that we need to offer support framed around the individual not around each disease. We are confident that we can meet that challenge. But we need to start work now if we are to be ready to do so. Meeting that challenge at a time of austerity and 'flat cash' in the NHS means that we have to innovate to meet our goals. "There is no do nothing option for us". Yet our history of success and the current stable position of our organisation gives us a platform from which to approach with partners and with local people the work that we now need to do to better integrate care not just in some parts of the Trust, or sometimes, but consistently and uniformly.

If you have ideas about how we need to change or concerns about those changes, even at this very early stage, please do contact us via Vanya Rogers, Press and PR Manager on 0121 507 4093, or email: vanya.rogers@nhs.net.

11. Statement of the Accounting Officer's responsibilities

The Secretary of State has directed that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Department of Health. To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accountable Officer.



Signed: Chief Executive Date: **05.06.2014**

Toby Lewis

Annual Report
Remuneration Report

For the purposes of publication, the Accounting Officer/Chief Executive's signature on the Annual Report will also satisfy the requirement to sign the Remuneration Report, which is an integral part of the Annual Report.

The Auditor's report on the full annual report and accounts was unqualified. This represents a clean opinion that the financial statements give a true and fair view of our financial position and expenditure and income. In the auditor's report, the auditor's statement as to whether the strategic report and directors' report was consistent with the accounts was unqualified. This means that the reports were consistent with the requirements for inclusion.

12. Further information

For more information, visit the Trust's website at www.swbh.nhs.uk.

If there is any information you are looking for but are unable to find, please contact the Communications Team by telephone on 0121 507 4093 or email swbh.comms@nhs.net, or by post to:

Communications Department
Trust Headquarters
Sandwell General Hospital
Lyndon
West Bromwich
West Midlands
B71 4HJ

You can also use the Freedom of Information (FOI) Act (2000) to request information on a variety of subjects including infection rates, services, performance or staffing. For details on how to make a Freedom of Information request please see our website – click on the 'About Us' tab and scroll down to 'Freedom of Information'.

How to find us

You can find details of how to find each of our three hospital sites on our website, on the home page under the 'Find Us' tab. To contact us by telephone please dial 0121 554 3801.

Our sites are:

Birmingham City Hospital

Dudley Road
Birmingham
West Midlands
B18 7QH

This site is also home to the Birmingham Treatment Centre, Birmingham and Midland Eye Centre, the Birmingham Skin Centre and the midwife-led Serenity and Halcyon birth centres.

Sandwell General Hospital

Lyndon
West Bromwich
West Midlands
B71 4HJ

Leasowes Intermediate Care Centre

Oldbury Road
Smethwick
West Midlands
B66 1JE

Rowley Regis Community Hospital

Moor Lane
Rowley Regis
West Midlands
B65 8DA B66 1JE

Halcyon Birth Centre

Oldbury Road
Smethwick
West Midlands

Parking

The Trust implemented during spring 2014 arrangements to reimburse car park charges to patients where a significant avoidable delay to their visit was caused by the Trust.

Car parks are situated near the main entrance of each hospital. Vehicles are parked at owners' risk. Spaces for disabled badge holders are at various points around our sites.

The car parks operate a pay on foot facility except for two pay and display car parks at City Hospital. One is directly in front of the Main Entrance for blue badge holders only, and the other is by Hearing Services.

Visitor Charges

Standard tariff

Up to 15 minutes	FREE
Up to 1 hour	£2.60
Up to 2 hours	£3.60
Up to 3 hours	£4.10
Up to 5 hours	£4.60
Up to 24 hours	£5.10

Discounted parking charge options

For regular visitors and patients there are the following discounted parking charge options:

Season tickets

Three days unlimited parking :	£9.00
One week unlimited parking :	£18.00
Three months unlimited parking:	£42.00

A £5 refundable deposit is required.

One-time tickets

One-time tickets are valid for one visit of any length in the barriered (pay on foot) visitor car parks. To purchase four for £10, go to:

City Hospital – Birmingham Treatment Centre reception (Monday – Friday, 8am – 6pm) or the Cash Office on the Main Corridor (Monday – Friday, 8.30am-1pm and 1.30pm to 4.30 pm)

Sandwell Hospital – Main reception desk (Monday – Friday, 8am – 7pm).

Instead of going to the pay station at the end of your visit, proceed directly to the exit barrier and insert your one-shot ticket into the ticket slot at the exit barrier.

Scratch cards

Scratch cards are valid for one visit of any length in the pay and display car parks at City Hospital at £10 for a pack of six. They are available from:

City Hospital – Birmingham Treatment Centre reception (Monday – Friday, 8am – 6pm) or the cash office on the Main Corridor (Monday – Friday, 8.30am-1pm and 1.30pm to 4.30 pm)

Sandwell Hospital – Main reception desk (Monday – Friday, 8am – 7pm).

Blue Badge holders

The tariff applies to Blue Badge Scheme users. Parking for Blue Badge holders is located as close to main hospital buildings as possible.

Patients on benefits

Anyone on a low income who is entitled benefits or receives income support can claim for reimbursement of bus fare and receive a token to allow free exit from hospital car parks.

Bring proof of your benefits to one of the following places:

- Birmingham Treatment Centre reception
- Birmingham and Midland Eye Centre general office
- City Hospital Cash Office (ground floor, main corridor, near the Medical Assessment Unit)
- Sandwell General Hospital main reception
- Rowley Regis Hospital main reception.



Tracey Carter, Staff Nurse

Appendices

Appendix 1: Access and Safety performance

These are a list of areas we have set ourselves to improve upon, these are reported at the beginning of the year and monitored throughout the year. They have no financial implication attached to them however hold great importance to achieve.

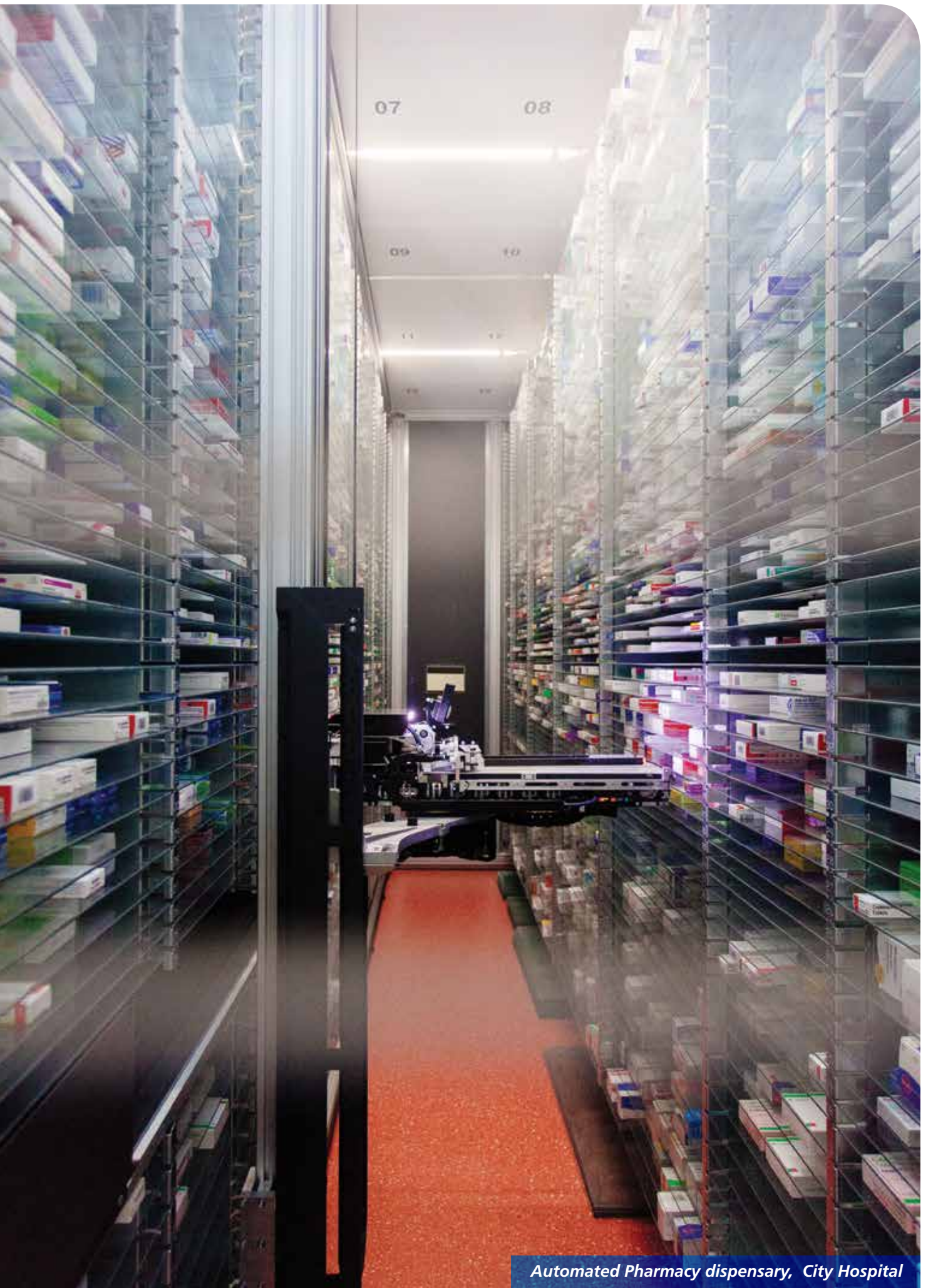
	Measure	2013/14
Access Metrics		
Cancer - 2 week GP Referral to First Outpatient	%	95.0
Cancer - 2 week GP Referral to First Outpatient (Breast Symptoms)	%	96.7
Cancer - 31 day Diagnosis to Treatment for All Cancers	%	99.2
Cancer 62 day Urgent GP Referral to Treatment for All Cancers	%	87.0
Emergency Care 4-hour waits	%	94.5
Referral to Treatment Time - Admitted <18 weeks	%	91.5
Referral to Treatment Time - Non Admitted <18 weeks	%	96.8
Referral to Treatment Time - Incomplete Pathway<18 weeks	%	93.4
Acute Diagnostic Waits >6weeks	%	0.81
Cancelled Operations	%	1.1
Cancelled Operations (breach of 28 day guarantee)	%	0.020
Delayed Transfers of Care	%	3.1
Outcome Metrics		
MRSA Bacteraemia	No.	1
C Diff	No.	39
Mortality Reviews	%	80.0
Hospital Standardised Mortality Rate	HSMR	92.1
Summary Hospital-level Mortality Index	SHMI	100.1
Caesarean Section Rate	%	24.9
Patient Safety Thermometer - Harm Free Care	%	94.4
Never Events	No.	5
VTE Risk Assessment (Adult IP)	%	98.7
WHO Safer Surgery Checklist	%	99.9
Quality Governance Metrics		
Mixed Sex Accommodation Breaches	No.	124
Patient Satisfaction (FFT) - Response Rate (IP Wards and Em. Care)	%	20.3
Patient Satisfaction (FFT) - Score (IP Wards and Em. Care)	No.	60
Staff Sickness Absence	%	4.33
Staff Appraisal	%	96.7
Medical Staff Appraisal and Revalidation	%	97.0
Mandatory Training Compliance	%	86.6

Appendix 1: Access and Safety performance (continued)

	Measure	2013/14
Quality Governance Metrics		
Stroke Care - Patients who spend more than 90% stay on Stroke Unit	%	91.3
Stroke Care - Patients admitted to an Acute Stroke Unit within 4 hours	%	76.4
Stroke Care - Patients receiving a CT Scan within 1 hour of presentation	%	71.9
Stroke Care - Admission to Thrombolysis Time (% within 60 minutes)	%	51.2
Stroke Care - Swallowing Assessments within 24 hours of admission	%	98.6
TIA (High Risk) Treatment within 24 hours of presentation	%	70.9
TIA (Low Risk) Treatment within 7 days of presentation	%	84.5
MRSA Screening Elective	%	92
MRSA Screening Non Elective	%	94
Inpatient Falls Reduction – Acute	No.	607
Inpatient Falls Reduction – Community	No.	119
Hip Fractures - Operation within 24 hours	%	70.3
Patient Experience		
Complaints Received - Formal and Link	No.	948
Patient Average Length of Stay	Days	3.7
Coronary Heart Disease - Primary Angioplasty (<150 minutes)	%	92.5
Coronary Heart Disease - Rapid Access Chest Pain (<2 weeks)	%	95.7
GU Medicine - Patients Offered Appointment <48 hours	%	100

Appendix 2: Register of Interests

Name	Interests Declared
Chairman	
Richard Samuda	<ul style="list-style-type: none"> • Director – Horton’s Estates Ltd. • Director – ‘Kissing It Better’ • Non Executive Director – Warwick Racecourse
Non Executive Directors	
Clare Robinson	<ul style="list-style-type: none"> • None
Gianjeet Hunjan	<ul style="list-style-type: none"> • College Finance and Administration Team Manager – University of Birmingham • Lay Member – Advisory Committee on Clinical Excellence Awards – West Midlands • Lay Member – NHS Midlands and East Workforce Deanery • Governor – Oldbury Academy • Governor – Ferndale Primary School
Sarindar Singh Sahota OBE	<ul style="list-style-type: none"> • Trustee – Acorns Hospice • Member – Court of University of Birmingham • Trustee – Nishkam Education Trust • Director – Asian Business Forum • Member – Smethwick Delivery Board • Chair – Birmingham City Council Citizen-Led Quality Board for Assessment and Support Planning
Harjinder Kang	<ul style="list-style-type: none"> • Managing Consultant – PA Consulting Group
Olwen Dutton	<ul style="list-style-type: none"> • Partner – Bevan Brittan LLP • Fellow – Royal Society of Arts • Member – Lunar Society • Member – Birmingham Forward • Member – Council of the Birmingham Law Society
Paramjit Gill	<ul style="list-style-type: none"> • Trustee South Asian Health Foundation • Trustee – Healthy Hearts • Clinical Academic at University of Birmingham collaborating with colleagues based at the Trust on a number of research studies • GP – Rotten Park Road Medical Practice
Executive Directors	
Toby Lewis (Chief Executive)	<ul style="list-style-type: none"> • Board member – Sandwell University Technical College
Rachel Barlow (Chief Operating Officer)	<ul style="list-style-type: none"> • None
Colin Ovington (Chief Nurse)	<ul style="list-style-type: none"> • None
Roger Stedman (Medical Director)	<ul style="list-style-type: none"> • Partner – Excel Anaesthesia (private anaesthesia services)
Tony Waite (Director of Finance & Performance Mgt)	<ul style="list-style-type: none"> • None
Associate Members	
Kam Dhami (Executive)	<ul style="list-style-type: none"> • None
Michael Hoare (Non Executive)	<ul style="list-style-type: none"> • Director, Fujitsu UK
Trust Secretary	
Simon Grainger-Lloyd	<ul style="list-style-type: none"> • Director – Parkfields Management



Automated Pharmacy dispensary, City Hospital

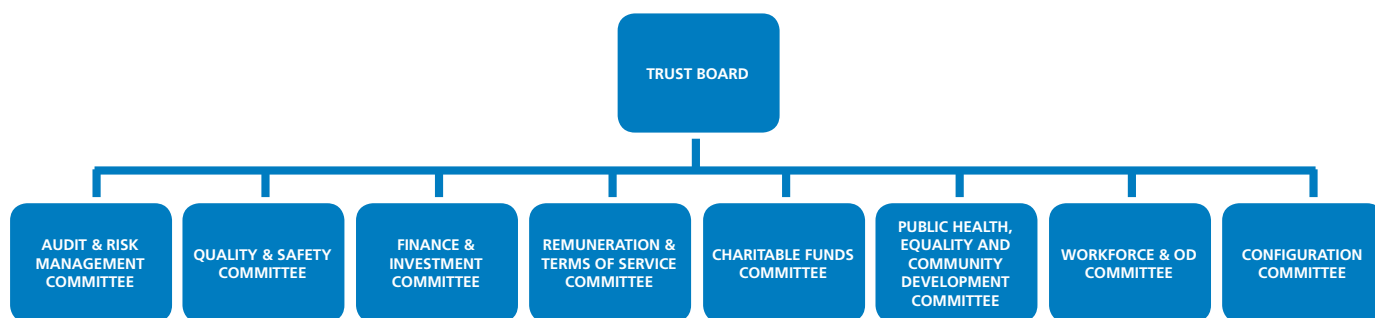
Appendix 3: Annual Governance Statement 2013/14

1. SCOPE OF RESPONSIBILITY

- 1.1 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. I have specific duties to ensure safety and to act in partnership with others.
- 1.2 I discharge these responsibilities as part of a wider system, and with due regard to the role of the Trust Development Authority, its local and national officers. In particular, this year we have played a leading role in the 'Right Care, Right Here' partnership with local authority and CCG colleagues which takes a long-term view of the health and social care system. I have attended the Overview and Scrutiny Committee as required and the Birmingham & Black Country Urgent Care Board which is designed to ensure safe and stable emergency care provision.

2. THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

- 2.1 The organisation is led strategically by the Trust Board, which this year has been supported by eight committees, which are shown graphically below. At Appendix A the roles and attendees to those committees are described. The Trust Board and its committees are administered by the Trust Secretary who maintains the Directors' Register of Interests and a register of attendance at meetings.



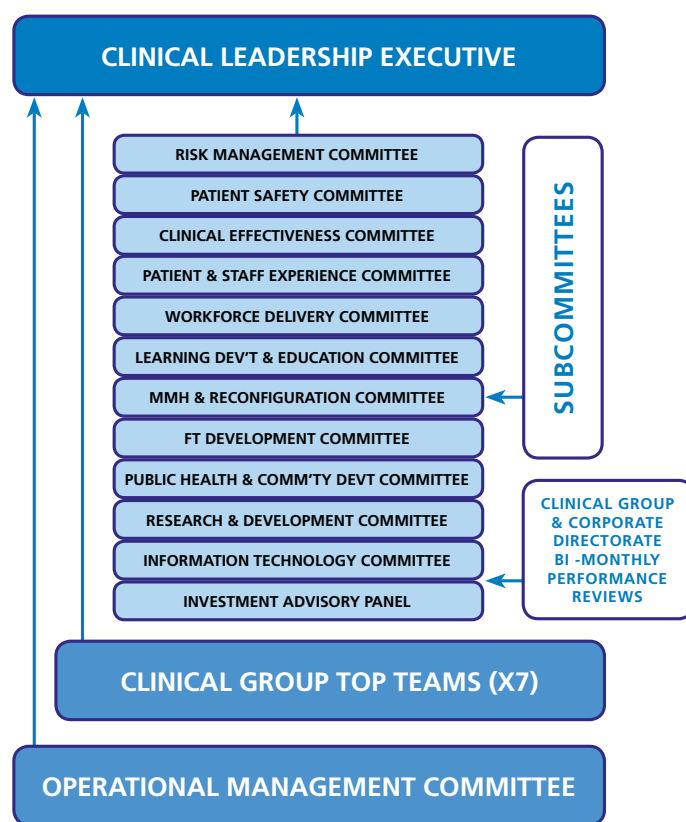
- 2.2 In June 2013 we completed a review of the committee structure and purpose of the organisation. This review reflected my own arrival in post in April 2013, and the future needs and objectives of the Trust, as an aspirant Foundation Trust organisation. That review was conducted with considerable consultation and with a view to best practice advice. Our intention is that five committees focus on assuring the full Board that we are operating the organisation in line with our agreed long term plans. These committees are:

- Quality and Safety
- Finance and investment
- Workforce and organisational development
- Configuration
- Public Health, Community Development and Equality.

The Audit and Risk Management Committee acts on behalf both of the Board and its committees to ensure the accuracy and integrity of the operating system of the Trust. Specific duties are associated with the remaining committees.

Two specific changes made through this review are worth highlighting: we have integrated operating performance into our Quality and Safety Committee at Board level to ensure that there is no possibility that the delivery of national priorities and standards is in conflict with our obligations to safe care and a safe working environment for staff; and we have chosen to focus part of our Board's infrastructure on equality, both the narrow assessment and publishing duty, which we discharged, but also on the wider intention to promote diversity in our workforce and leadership.

- 2.3 The committee structure is supported by standard reports and performance information. The format and nature of these reports reflects the needs of the committees and Board. We have commissioned Deloitte to provide additional advice on best practice in this field. During the first quarter of the next financial year, we will complete work to not only integrate all data on delivery into a single report, but to standardise the report from ward to Board. This report format will be available Trust-wide on public screens for both staff and visitors to examine.
- 2.4 The Trust is committed to transparency and public accountability. In 2013/14 we reversed our Board sequence so that public board preceded our private meeting. Accordingly all matters are considered in public unless specifically reserved for private consideration for reasons of commercial confidence or data protection. Integral to the preparation for the Trust's application for Foundation Trust status, have been a number of Board assessments, development activities and opportunities during the year.
- 2.5 During the year the Board has undertaken considerable work to consider the governance and effectiveness of the strategic leadership. Much of this work has been facilitated by independent sources, including the Board & Committee observations, board member coaching, a mock Board to Board and a series of 360 degree feedback events. The Board has also received and contributed to self-assessments against the Board Governance Assurance Framework and Quality Governance Assurance Framework during the year. There are other sources which contribute to the judgements of control effectiveness as outlined below.
- 2.6 Operationally, the Trust delivers care through seven Clinical Groups, each then sub-divided into directorates. The corporate group comprises seven directorates. The vast majority of clinical services report to the Board through the Chief Operating Officer. The Group Directors, along with the Executive Directors, comprise the Clinical Leadership Executive. This monthly body, chaired by the Chief Executive, directs the operational plan for the organisation. It is supported in this task by a series of cross-cutting committees as shown in the graphic below.



- 2.7 The Trust has and continues to seek to develop local, frontline and clinical leadership. We have engaged expert advisors in that process (Hay Group), who are working with us on an on-going basis to develop the leadership capability of the Trust. That determination to embed systems and a strong safety culture into the organisation is fundamental to our control model and how we ensure that risk is well managed.

3. THE RISK & CONTROL FRAMEWORK

- 3.1 The Trust has a Board approved Risk Management Strategy which identifies that the Chief Executive has overall responsibility for risk management within the Trust. The Chief Executive is supported with his responsibilities by the Director of Governance. All managers and clinicians accept the management of risks as one of their fundamental duties. Additionally the Strategy recognises that every member of staff must be committed to identifying and reducing risks. In order to achieve this the Trust promotes an environment of accountability to encourage staff at all levels to report incidents and risks via incident reporting and governance for a which allow for open discussion to prevent their re-occurrence.
- 3.2 In Clinical Groups, Group Directors supported by Group Directors of Operations and Group Directors of Nursing are responsible for managing risk. In all non-clinical Groups and departments, the appropriate Executive Director is responsible for managing risk via incident reporting and governance / management structures. The Trust has a designated Head of Risk Management within the corporate Group that includes Governance.
- 3.3 High value risks, unmitigated high risks, and increasingly low likelihood, high impact risks have been considered by the full Board since Quarter 4 2013/14. The risk register process was refreshed during the year to reflect the Trust's new management and committee structure along with standardisation of methodology and format.
- 3.4 Risk registers are maintained at the relevant management levels: ward / department; directorate; Clinical Group or corporate directorate / project. Risk controls and actions are maintained at each risk register level, with risks featuring on the next managerial level up to ensure higher management levels maintain an oversight of the risks within their service areas and/or higher management input is required. Each Clinical Group, Corporate Directorate or Project report their high (red) risks to the Risk Management Committee, which provides the initial Trust-wide risk register validation stage to ensure consistency in approach, adequacy of controls and that the standardised risk scoring matrix is being utilised. The Risk Management Committee reports validated high (red) risks for inclusion on the Trust Risk Register to the Clinical Leadership Executive, which reviews risk and controls prior to reporting to Trust Board.
- 3.5 During Quarter 1 2014-15 the risk registers of local teams will be published on the Trust's intranet site in order to promote transparency, reporting and a focus on what might be missed between parts of the system.

Board Assurance Framework

- 3.6 The Trust has a Board Assurance Framework which includes all key components required, including objectives, risks, controls, positive assurance, gaps in control and/or assurance and remedial action. In a recent review by Internal Audit, it was determined that Significant Assurance was provided by the Board Assurance Framework, with further areas for development identified to assist the Trust with continued improvement to the effectiveness of the processes in 2014/15.
- 3.7 The Board Assurance Framework was considered by the Board three times during the year. The planned refreshed approach to the Board Assurance Framework will take into account the recommendations from the Internal Audit, together with an intention to refocus the BAF more clearly on the key risks to the delivery of the Trust's strategy and strengthen the monitoring arrangement for the BAF by ensuring that it is considered on a twice yearly basis by the Audit and Risk Management Committee.
- 3.8 The Board Assurance Framework informs the declarations made in this Governance Statement.
- 3.9 Gaps in controls and assurance of the management of the risks associated with the delivery of a number of the Trust's objectives were identified, however the Trust has taken remedial action to address them which is reported in the update of the Board Assurance Framework.

Quality Account

- 3.10 The Trust has in place robust processes to develop its annual Quality Account. A task and finish group, led by the Medical Director was introduced in February 2014 which encompassed all the main contributors of the Quality Account. This body developed a schedule which has allowed for weekly progress monitoring of the contributions and creation of links with the production of the Annual Report. The process and progress with developing the Quality Account is overseen by the Audit & Risk Management Committee. The Quality Account is also subject to scrutiny by the Trust's external auditors, including a detailed verification of information provided to support the performance reported against two key performance indicators. This test was undertaken in March 2014 and validation process raised no concerns in terms of the quality of the data provided.

Information security

- 3.11 Senior responsibility for information security, risks and incidents rests with the Chief Executive, as supported by the Director of Governance. The Director of Governance (Senior Information Responsible Owner) is supported by the Information Governance Manager and Head of Risk Management. The Information Governance Manager manages information security risk and incidents on a day to day basis and seeks support from the Head of Risk Management and the SIRO.

Information security issues are raised through the usual Trustwide incident reporting routes.

An Information Governance Group is established to review the Trust's compliance against the requirement of the Information Governance toolkit, Freedom of Information Act legislation and the action plan to address the recommendations identified following the review by the Information Commissioner's Office

Counterfraud and whistleblowing

- 3.12 The Trust is supported through its Internal Audit function by a Counter Fraud service that reports routinely to the Audit & Risk Management Committee. The service, whose annual workplan is approved by the Audit & Risk Management Committee, is proactive in its role countering fraudulent activity within the Trust. The Trust's whistleblowing policy is currently undergoing a significant refresh to ensure that the processes by which all individuals working in and for the Trust may raise concerns are strengthened. The policy is due for publication in May 2014 and during the year, the Trust's senior managers, including the Trust Board have been provided with an opportunity to give input to the policy.

4. REVIEW OF EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

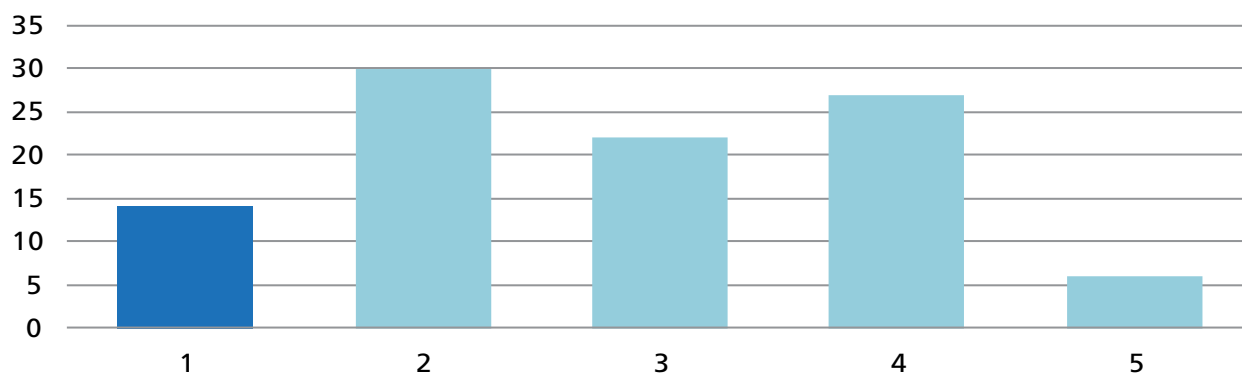
- 4.1 The Internal Auditor's Year End Report and opinion on the effectiveness of the system of internal control is commented on below. The internal auditor's overall opinion is that Significant Assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. As part of the auditor's opinion, it was emphasised that there was a need to further strengthen the its overall risk management arrangements going forward into 2014/15, including a more frequent review of the arrangements by the Trust Audit & Risk Committee going forward.

The auditor advised that his opinion also took into account the range of individual opinions arising from risk-based audit assignments that had been reported throughout the year. An internal audit plan for 2013/14 was developed to provide independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas. To achieve this the internal audit plan was divided into two broad categories; work on the financial systems that underpin your financial processing and reporting and then broader risk focused work driven essentially by principal risk areas that had been identified in the Board Assurance Framework.

The internal auditor concluded that in his view, taking account of the respective levels of assurance provided for each audit review, an assessment of the relevant weighting of each individual assignment and the extent to which agreed actions have been implemented, that the Trust has a generally sound system of internal control. It was highlighted however that notwithstanding this, the Trust would need to ensure it delivers overall improvements in its data quality management and arrangements going forward.

- 4.2 Building on the accreditation in 2012/13, in early 2014, the Trust gained accreditation against CNST maternity standards at Level 3. The Trust retains accreditation against NHSLA general standards at Level 2.
- 4.3 During the year, as part of the monthly Quality Report, the Board received a summary of the Care Quality Commission's Quality & Risk Profile (QRP). Overall the QRP showed the Trust as being at a low risk of non-compliance with the CQC's 16 essential standards of quality and safety. The data sources include the Stroke Improvement National Audit Programme, PROMs (groin hernia surgery and knee replacement), the CQC A&E Survey and Dr Foster Intelligence. From Autumn 2013 the Quality & Safety Committee also received the outcome of the CQC Intelligent Monitoring assessment, rating the Trust as initially at 4 out of possible 6 and in March 2014, 5 out of 6, indicating a low risk of non-compliance against the Essential Standards.
- 4.4 During the year there was one significant data security lapse that has warranted reporting to the Information Commissioner's Office. This incident concerned a confidentiality breach of patient-sensitive information where a third party viewed this on a computer in a waiting room. Actions have been put in place to prevent a reoccurrence of this incident, however the ICO are still conducting their investigation and remain to provide final feedback. During the period, the Trust initiated an assessment by Information Commissioner's Office, which although did not highlight any major non-compliance against Information Governance standards, did result in a Limited level of assurance. This is of concern and greater emphasis will be placed during 2014/15 on scrutiny of these issues at Executive level.
- 4.5 The Trust is evaluated through the TDA accountability framework. The latest assessment, shown below, indicates that we have the highest possible ratings within that framework. This reflects continued and improved performance in a number of domains, including emergency care, infection control, and elective access. [An external report on the systems we use for elective access is awaited, and if received prior to publication will be reflected in revisions to this document.]

Number of Trusts by Escalation Score (Levels 1 - 5)



Trust Development Authority Winter Report (August 2013 - January 2014)

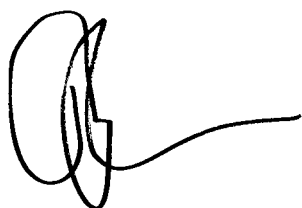
Escalation Scores Level	Trusts
1 No Identified Concerns	14 (inc. Sandwell)
2 Emerging Concerns	30
3 Concern Requiring Investigation	22
4 Material Issue	27
5 Formal Action Required	6

4.6 There are three areas of control concern which require further work during 2014-15:

- In 2012/13 significant long term lapses in the system to manage 18 week data integrity were identified. I reported on those issues in the 2012/13 report. Good progress in resolving those issues was made in the early part of 2013/14. I indicated in reporting on 2012/13 that these may be a symptom of some wider data quality issues in the Trust. During 2013/14 we identified a number of further issues on data quality and accordingly established a Board level taskforce to tackle the subject, with advice from our incoming auditors and with involvement from commissioners. This has made good progress both in creating standard operating protocols for data and in establishing a data quality kite-mark for information. I am satisfied both that our reported data (where the source data is from the Trust) is materially accurate and that we have a good basis for future data quality control.
- We reported five Never Events during 2013/14, of which four took place during the year itself. A wide-ranging audit of controls associated with Never Events has taken place which provides a basis for forward performance tracking at a very local level. This is due to be reviewed again by the Board before the end of June 2014. Remedial work within Ophthalmology (which had 3 never events) has given rise to an important process of Always Events, which provides a basis for confidence in future performance. In addition we have initiated the use of the Manchester Patient Safety tool to assess our safety culture at team level. This will be developed across the coming two years and will be used alongside, though not as part of our performance oversight of clinical teams. I am satisfied that we have a greater measure of control than at the outset of the year, but we will need to maintain our current trajectory of improvement in the governance of our theatre processes, in particular, whilst developing greater discipline and precision in how procedures undertaken in outpatient settings are monitored and supervised.
- The Trust has continued its tradition of strong financial performance. We have secured both our control total and controlled pay expenditure in line with budgets. Our non-pay performance shows considerable variation to plan and considerable in year variation. We have initiated work to introduce revised controls and revised reporting arrangements to ensure that, as budgetary pressures tighten, we are able to understand readily the data and the day to day reality. Unlike the other two issues of concern to which I am drawing attention this has, to date, not given rise to performance difficulty, but it is an area on which we intend to focus on the coming months.

5 CONCLUDING REMARKS

- 5.1 With the exception of the internal control issues that I have outlined in this statement, my review confirms that Sandwell & West Birmingham Hospitals NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.



Signed

Toby Lewis, Chief Executive (On behalf of the Board)

Date 5 June 2014

Appendix A – Purpose and attendance record of Trust Board and its Committees

TRUST BOARD

Chair: Trust Chairman

Frequency: Twelve times a year (note given the Board & Committee schedule revisions wef January 14, no meeting was held in January 2014)

Membership: Seven Non Executive Directors; Seven Executive Directors. Also in attendance are two advisory Executive Directors (non voting), a Non Executive Designate and the Trust Secretary

MEMBERS	DATE											
	25/4/13	30/5/13	6/6/13	27/6/13	25/7/13	29/8/13	26/9/13	31/10/13	22/11/13	19/12/13	6/2/14	6/3/14
Richard Samuda (Ch)	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clare Robinson	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓
Gianjeet Hunjan	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Sarindar Sahota	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Lilford#1	✓	A	A	✓	✓	A	A	A	✓	A		
Olwen Dutton	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	A	✓
Harjinder Kang	✓	✓	A	✓	✓	A	✓	✓	✓	A	A	✓
Mike Hoare#7											✓	✓
Toby Lewis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Robert White#5	✓	✓	✓	✓	✓	A	✓	✓	✓	✓		
Tony Waite#6											✓	✓
Rachel Overfield#2	✓	✓	✓	✓	✓	✓						
Colin Ovington#4										✓	✓	✓
Rachel Barlow	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Roger Stedman	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Mike Sharon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kam Dhami	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Linda Pascall#3							✓	✓	✓	✓		

NOTES:

- #1 Richard Lilford resigned wef January 2014
- #2 Rachel Overfield resigned wef September 2013
- #3 Linda Pascall took up post as Acting Chief Nurse September – December 2013
- #4 Colin Ovington appointed as Chief Nurse wef December 2013
- #5 Robert White resigned wef January 2014
- #6 Tony Waite appointed as Director of Finance & Performance Management wef January 2014
- #7 Mike Hoare appointed as Non Executive Director wef January 2014

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

AUDIT AND RISK MANAGEMENT COMMITTEE

Chair: Non-Executive Director

Purpose: The purpose of the Committee is to provide the Board with assurance concerning the establishment and maintenance of an effective system of governance, risk management and internal control across the Trust's activities that support the achievement of the organisation's objectives.

Frequency: Five times a year as a matter of course, including a specific meeting to review and approve the annual accounts. In the current year, due to the change in the Committee schedule the Committee only met four times. From 2014/15, the schedule provides for five meetings.

Membership: Five Non-Executive directors (excluding the Chair). The Directors of Finance and Governance has a standing invitation to attend and other Executives may attend when requested.

Attendance:

	DATE			
	9/5/13	6/6/13	22/10/13	30/1/14
MEMBERS				
Gianjeet Hunjan (Ch)	✓	✓	✓	✓
Clare Robinson	✓	✓	A	✓
Sarindar Sahota	✓	✓	✓	✓
Harjinder Kang	✓	A	✓	✓
Olwen Dutton	A	✓	✓	✓

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

QUALITY & SAFETY COMMITTEE

Chair: Non-Executive Director

Purpose: The purpose of the Committee is to provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and the delivery of Trust's long term quality goals as set out in the Quality & Safety strategy.

Frequency: Monthly.

Membership: Five Non-Executive Directors and six of the Executive Directors with specialist advisers in attendance when required.

	DATE										
MEMBERS	19/4/13	24/5/13	21/6/13	19/7/13	23/8/13	20/9/13	25/10/13	22/11/13	31/1/14	28/2/14	28/3/14
Olwen Dutton (Ch)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A
Richard Samuda	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓
Gianjeet Hunjan			✓	✓	A	✓	✓	✓	✓	✓	✓
Sarindar Sahota	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Lilford#1	A	A	A	✓	✓	A	A	A			
Rachel Overfield#2	✓	A	✓	A	✓						
Linda Pascall#3						✓	A	✓			
Colin Ovington#4									✓	✓	✓
Roger Stedman	✓	✓	✓	A	A	✓	A	✓	✓	✓	✓
Rachel Barlow	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A
Kam Dhami	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	A
Robert White#5	✓	A	A	A	A	✓	A	✓			
Tony Waite#6									✓	A	A

NOTES:

- #1 Richard Lilford resigned wef January 2014
- #2 Rachel Overfield resigned wef September 2013
- #3 Linda Pascall took up post as Acting Chief Nurse September – December 2013
- #4 Colin Ovington appointed as Chief Nurse wef December 2013
- #5 Robert White resigned wef January 2014
- #6 Tony Waite appointed as Director of Finance & Performance Management wef January 2014

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

FINANCE AND INVESTMENT COMMITTEE

Chair: Non-Executive Director

Purpose: The purpose of the Committee is to provide the Board with assurance concerning the delivery of Trust's financial plans, adherence to the Trust's investment policy and robustness of major investment decisions. The long term focus for the Committee will be the delivery of the Medium Term Financial Strategy including the Long Term Financial Model (addressing both revenue and capital), with a view to recommending its adoption to the Board when assurance gained.

Frequency: Alternate months from September 2013; monthly prior to this.

Membership: Three Non-Executive Directors, CEO, Director of Finance and Chief Operating Officer.

MEMBERS	DATE								
	19/4/13	24/5/13	21/6/13	19/7/13	23/8/13	20/9/13	22/11/13	31/1/13	28/3/14
Clare Robinson (Ch)	✓	✓	✓	✓	A	✓	✓	✓	✓
Richard Samuda	✓	A	A	A	✓	✓	✓	✓	✓
Harjinder Kang	✓	✓	✓	✓	✓	✓	✓	✓	✓
Robert White#1	✓	✓	✓	✓	A	✓	✓		
Tony Waite#2								✓	✓
Rachel Barlow	✓	✓	✓	✓	A	✓	✓	✓	✓

NOTES:

#1 Robert White resigned wef January 2014

#2 Tony Waite appointed as Director of Finance & Performance Management wef January 2014

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

REMUNERATION AND TERMS OF SERVICE COMMITTEE

Chair: Trust Chair

Purpose: The purpose of the Committee is to provide the Board with advice concerning the terms and conditions of employment, including the remuneration packages for the Chief executive and the Executive Directors. The Committee will also seek assurance on the robustness of the plans for the delivery of Trust's reward and recognition strategy for the Chief Executive & Executive Directors.

Frequency: The committee meets as required.

Membership: All Non-Executive Directors.

Attendance:

	DATE	
	27/6/13	29/11/13
MEMBERS		
Richard Samuda	✓	✓
Clare Robinson	✓	✓
Sarindar Sahota	✓	✓
Gianjeet Hunjan	✓	✓
Richard Lilford	✓	A
Olwen Dutton	✓	✓
Harjinder Kang	✓	✓

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

CHARITABLE FUNDS COMMITTEE

Chair: Non-Executive Director

Purpose: To provide the Board with assurance concerning adherence to the wishes of donors by monitoring the use of funds and the benefits gained. The Committee will also seek assurance on the robustness and progress with the delivery of the Trust's fundraising strategy.

Frequency: Four times per year. In the current year, due to the change in the Committee schedule the Committee only met three times. From 2014/15, the schedule provides for four meetings.

Membership: All voting Directors are Trustees, however they are represented by six voting Board members. The Director of Strategy & OD and the Head of Fundraising also attend.

MEMBERS	DATE		
	9/5/13	12/12/13	6/3/14
Sarindar Sahota (Ch)	✓	✓	✓
Richard Samuda	A	✓	✓
Clare Robinson	✓	✓	✓
Toby Lewis	✓	✓	✓
Robert White#1	✓	✓	
Tony Waite#2			✓
Rachel Overfield#3	A		
Colin Ovington#4		A	A
Mike Sharon		A	A

NOTES:

- #1 Robert White resigned wef January 2014
- #2 Tony Waite appointed as Director of Finance & Performance Management wef January 2014
- #3 Rachel Overfield resigned wef September 2013
- #4 Colin Ovington appointed as Chief Nurse wef December 2013

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE

Chair: Non-Executive Director

Purpose: To provide the Board with assurance concerning the delivery of the work programme and plans for implementing the Trust's Workforce & OD strategies (including strategic workforce planning, human resources management, learning and development and leadership development, to include the delivery of Trust's long terms workforce model.

Frequency: Four times per year. In the current year, due to the change in the Committee schedule the Committee met five times. From 2014/15, the schedule provides for four meetings.

Membership: Two Non Executive Directors, including the Trust Chair. Chief Executive, Chief Nurse, Chief Operating Officer and Director of Organisational Development.

MEMBERS	DATE				
	20/5/13	29/7/13	30/9/13	16/12/13	28/3/14
Harjinder Kang (Ch)	✓	✓	✓	✓	✓
Richard Samuda	A	✓	A	✓	A
Toby Lewis	✓	✓	✓	A	✓
Rachel Overfield#1	✓	A			
Colin Ovington#2				A	✓
Rachel Barlow	A	✓	✓	✓	✓
Mike Sharon	✓	✓	✓	✓	✓

NOTES:

- #1 Rachel Overfield resigned wef September 2013
 #2 Colin Ovington appointed as Chief Nurse wef December 2013

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

CONFIGURATION COMMITTEE

Chair: Trust Chair

Purpose: The purpose of the Committee is to provide the Board with assurance concerning the strategic direction to support the project to establish the Midland Metropolitan Hospital (MMH) and that the programme of interim reconfigurations is consistent with the long term direction towards the new hospital. The Committee will focus specifically on the delivery of the MMH business case.

Frequency: Alternate months.

Membership: Three Non-Executive Directors, the Director of Strategy & Organisational Development, Chief Executive, Chief Operating Officer, Director of Finance & Performance Management and Medical Director.

	DATE		
	15/10/13	12/12/13	28/2/14
MEMBERS			
Richard Samuda (Ch)	✓	✓	✓
Richard Lilford#3	✓	A	
Clare Robinson	A	✓	✓
Toby Lewis	✓	✓	✓
Robert White#1	✓	✓	
Tony Waite#2			✓
Mike Sharon	✓	✓	A
Roger Stedman	A	✓	✓

NOTES:

- #1 Robert White resigned wef January 2014
- #2 Tony Waite appointed as Director of Finance & Performance Management wef January 2014
- #3 Richard Lilford resigned wef January 2014

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

PUBLIC HEALTH, EQUALITY AND COMMUNITY DEVELOPMENT COMMITTEE

Chair: Trust Chair

Purpose: The purpose of the Committee is to provide the Board with assurance concerning the plans to improve the range and scope of whole life public health interventions from all areas of the Trust, including community & acute services and the delivery of the Trust's public health strategy.

Frequency: Quarterly from February 2014.

Membership: Three Non-Executive Directors, the Medical Director, Chief Executive, Chief Nurse and Executive Lead for Workforce.

	DATE
MEMBERS	27/2/14
Richard Samuda (Ch)	✓
Sarindar Sahota	✓
Gianjeet Hunjan	A
Toby Lewis	✓
Colin Ovington	✓
Mike Sharon	✓
Roger Stedman	A

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

Our promises to you...

1. I will... make you feel welcome
2. I will... make time to listen to you
3. I will... be polite, courteous and respectful
4. I will... keep you informed and explain what is happening
5. I will... admit to mistakes and do all I can to put them right
6. I will... value your point of view
7. I will... be caring and kind
8. I will... keep you involved
9. I will... go the extra mile



Where
EVERYONE
Matters

