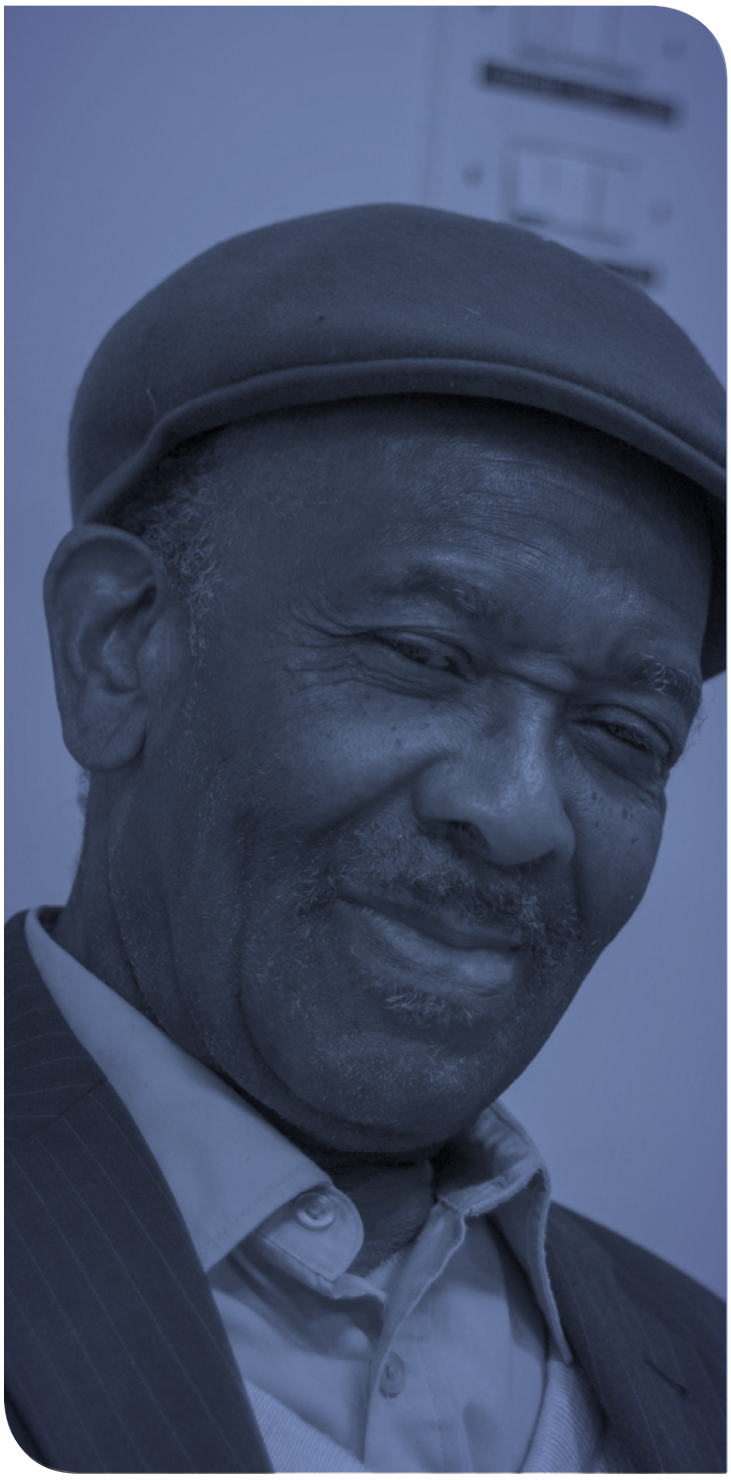
Sandwell and West Birmingham Hospitals NHS
NHS Trust



ANNUAL REPORT AND ACCOUNTS 2014/15

STICKING TO OUR LONG TERM PLAN

Where EVERYONE Matters

Supporting vulnerable patients in the community

In July last year, the Trust's Charitable Trustees commissioned a 'Find and Treat' service from London to deliver a week-long pilot TB screening programme aimed at local hostel and homeless shelter service users in the Sandwell, Dudley and West Birmingham community. The West Midlands region has the second highest rate of TB outside of London. TB is a local public health priority – with emphasis on awareness raising, early detection, treatment and control. Dr Imtiaz Ahmed, Clinical Lead for Respiratory at SWBH NHS Trust explained: "The purpose of the programme was to detect TB in this high-risk group and onward referral for treatment, not as a health protection measure in response to an outbreak. TB is an infection caused by Mycobacterium tuberculosis, a bacterium (germ) which can affect any organ in the body, but most commonly affects the lungs. TB can only become infectious when present in the lungs (pulmonary TB), but the disease can be completely cured by a course of antibiotics. Diagnosis of pulmonary TB includes a chest X-ray. The diagnosis is then confirmed by taking a sputum (phlegm) sample, which is checked for the presence of TB bacteria.

"The three minute check-up was well received with vulnerable citizens turning up to receive an x-ray on their doorstep, who would often find it challenging to access healthcare and other community services. The integrated approach to care included a partnership between SWBH NHS Trust, COCOA, Sandwell, Dudley and Birmingham TB Nursing Services, Public Health and volunteers. Our Trust TB Clinical Nurse Specialists also provided screening for latent TB infection and blood borne viruses (HIV, Hepatitis B and C) and initiated referrals where necessary. Over 600 people were seen in the five days the pilot was run." Tony Waite, Director of Finance and Performance Management said: "The initiative is simply terrific. We have reached out into the community and improved the wellbeing of the most vulnerable. A great example of just what can be achieved by pulling together and using a little money creatively."

Jacqui Nation, Tuberculosis Clinical Nurse Specialist, Tony Waite, Director of Finance and Performance Management, Tracy Morrod, Tuberculosis Clinical Nurse Specialist, Joan Piper, Tuberculosis Clinical Nurse Specialist, and Mary Tooley, Consultant Nurse Public Health SMBC.

Contents

Front cover images l to r: Dr Sarbjit Clare, Consultant Acute Physician and John Russell, Patient

1. Sticking to our long term plan
Introduction to the strategic report

In 2014/15 our organisation continued to deliver caring services to local people at home and in hospital. The annual report explains where we improved what we do, and where we fell short either of important standards or our own ambitions. It is important that we remain ambitious to deliver outstanding care, research and education, because that drive is what local people deserve: The best of what we already do sometimes in our Trust, delivered consistently across the organisation.

This year our report includes in one document the Trust's finances, our quality account, and the annual report of our charity. We are producing the report in June, not September, to help improve timely public scrutiny and accountability, as we move towards a foundation trust governance model. In that vein, our member's leadership group started life this last year and in 2015/16 we will improve opportunities for staff to take on governor style responsibilities. The report format as a whole places far greater emphasis than ever before on our workforce, their stories, awards and achievements. That reflects the view of the Board that it is our NHS colleagues across the Trust who are the heartbeat of the organisation.

Our quality account shows continued improvements in mortality, in infection control, and in cutting falls and pressure damage. At a time of huge competing priorities on the NHS, it is encouraging that we delivered those gains. Year on year improvement is becoming a consistent habit in many parts of the Trust. However, our Care Quality Commission report, (produced in March 2015 after an inspection in October 2014), shows that we have room for improvement. Over half our services were rated as good, and all were cited as caring, yet that cannot obscure the ratings given on both hospital sites for safety measures, nor does it reduce the unacceptability of some practices inspectors observed, in hand-washing, medicines and note security. The improvement plan we published has widespread support inside the Trust, and will be the focus of relentless leadership attention.

Within our annual report, as is clear from our monthly public Board papers, teams across the Trust are working hard and together to meet the NHS Mandate and deliver constitutional standards. Planned care, cancer, cardiac and diagnostic waiting times meet those standards and compare favourably with other providers in the West Midlands. In 2015/16 we aim to sustain that success and cut first appointment waiting times below six weeks in every discipline. At the same time the introduction of new appointment systems will aim to offer choice and reduce the waste of missed appointments, often arising because we give late notice to patients.

Emergency care at the Trust, as in the wider NHS, was under sustained pressure in 2014/15. After the relative success of our 2013/14 improvements, we have to improve further in the year ahead. Very long waits, and ambulance waits, remain rare. Whilst the volume of patients waiting less than four hours has risen, we have not always kept pace with demand, and patients avoidably in hospital beds when better cared for in the community has risen sharply, especially in Birmingham.

Our finances remain sustainable. We were able to invest in services like critical care outreach and health visiting, buy new equipment like our state of the art cardiac MRI facilities, and replace some of our IT infrastructure. Quality and finance came together as we successfully cut agency staffing spend by a third, and changed the way we look after patients who need extra help in our wards. In January we invested in more qualified nurses at night, giving skills and expertise as we look to provide greater consistency of care across the week.

The last year has seen us make major changes now with a view to our long term plans. We began the complex task of reshaping our workforce, successfully redeploying over 150 colleagues and investing more than ever before in training and development. The Board formally approved our electronic patient record business case, which commits the Trust to a revolution in technology, to be implemented between 2015 and 2017. And in July 2014, a decade after outline strategic case approval, the government committed itself to invest in the Midland Metropolitan Hospital, which we aim to open in 2018. It is significant that the announcement was made at Rowley Regis, where services have expanded in the last two years, because our new acute hospital also signals a major shift to locations for long term care that are more convenient for people in our local communities.

In 2015/16 we are committed to a very detailed annual plan, making major strides against all of our six strategic objectives. We also publish our 2020 Vision. This reflects our confidence that the ideas behind Right Care, Right Here, and the ideals that underpin our local health system, regardless of policy shifts or announcements, will endure. Our task is consistent implementation, across our organisation, compassionately providing great care. There is much to celebrate in the last year, but room for improvement in the months ahead.

Richard Samuda, Chairman

Toby Lewis, Chief Executive

The Health and Wellbeing Centre, Trust Headquarters at Sandwell Hospital - we relocated in April 2014

Key Facts And Figures

5,602 babies born through our services at City Hospital/Serenity Suite, and the Halcyon Birth Unit in Oldbury.

Halcyon Birth Centre

Every medical educational supervisor achieved new national accreditation standards

PALS

837 formal complaints were made – our PALS team helped over 2000 people informally.

We succeeded in getting investment into Research and Development from the Clinical Research Network as we aim to treble the number of patients recruited to research trials by 2017.

Every single service was assessed as caring by external inspectors from the CQC.

BMEC

182, 016 people used our A&E or eye casualty service, 92% of whom were seen in less than 4 hours.

C-difficile infection rates have been cut by over a third in the last two years.

We made a financial surplus and invested over £20m in new services and equipment.

We doubled investment in staff training.

539 new staff joined our organisation, over 40% of our staff have served ten years or more with the Trust.

We provide care from 150 locations, and serve a local population of 530,000 people, in partnership with over 100 GP teams.

We provide written, face to face and telephone interpreting services for local residents.

Bradbury House Day Hospice

No waste is sent to landfill from our Trust – a key environmental improvement

Recycling bins

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). The Trust includes the Birmingham and Midland Eye Centre (a supra-regional eye hospital), 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.

2. Our performance last year

Patients' voices, views and needs

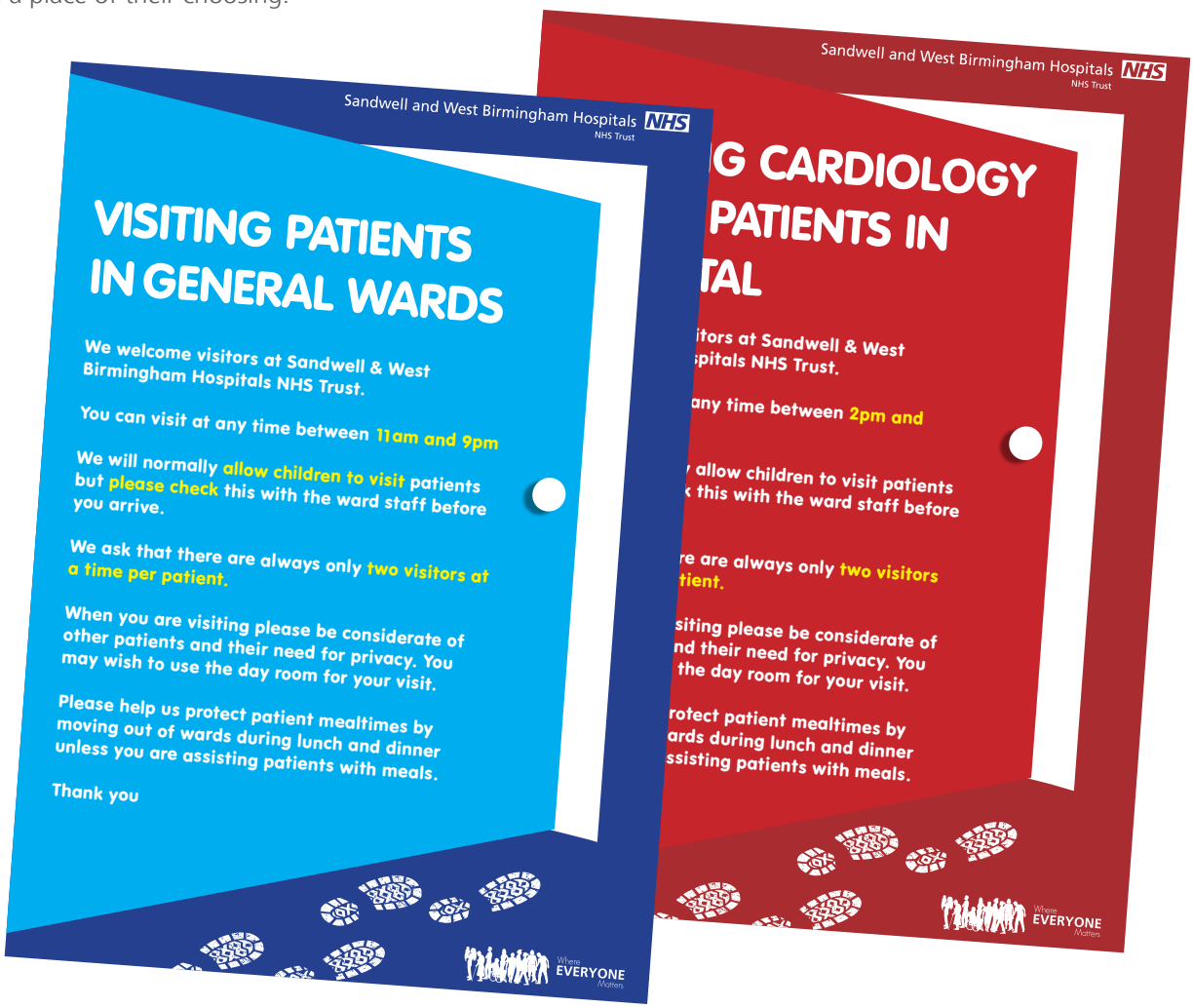
Listening and acting – room for improvement

We have contact with patients more than 1.5 million times a year. Just over 800 formal complaints were made about our services, and many more patients have given us feedback or submitted compliments to or about staff. Over 30,000 patients have given us feedback on our outpatient services, and about 1500 comments on inpatient services are collated every month. In addition we participate in nationally mandated surveys which are reported in the quality account chapter of this report. We are constantly looking for new ways to get feedback from patients. The Trust's Board hears a patient story every time it meets. Our website contains a direct link to NHS Choices, and we actively monitor and reply to comments from patients asking for help or information. In 2015/16 we want to be consistently faster at responding to formal complaints and to improve our response to complaints made about the care of patients who have died. The Board's complaints champion is determined to ensure that our systems are both efficient and humane.

Open visiting – involving carers and relatives

During 2014/15 we made a big change based on your feedback. For all of our inpatient wards we changed from limited hours of visiting, typically a couple of hours each day, to an Open Visiting system. This is still at the discretion of our ward managers, but between 11.00 am and 21.00 pm seven days a week two visitors per bed are now welcomed to stay with us. We ask that our protected mealtimes are respected, as it is important to our patient's care that they obtain both rest and nourishment. We will continue to monitor this policy and act on feedback about it.

Involving friends and family in the care of patients is very important to us. During 2015/16 we will develop further our ADAPT programme, which aims to set an expected date of discharge within the first 48 hours of a patient's stay. That decision depends on working closely with a patient's social network at home. Elsewhere in this report we describe progress with our Ten Out Of Ten patient safety checklist. Our annual plan for 2015/16 includes a commitment to do more to help patients to die in a place of their choosing.



Meeting individual's needs – a focus in 2015 on learning disabilities

Everyone matters at the Trust, and every individual is different. We work hard to meet the needs of individuals. We serve a super-diverse community, and whilst we invest heavily in interpreters and other advocacy systems, we know that we have more to do to reflect that diversity. We are working hard to make sure our information is translated and that we can provide additional help for patients with impaired eye sight or restricted hearing. Lost glasses and hearing aids are a common feature of complaints, and we need to do more to take care. The Board has specifically sought in the year ahead to focus on the needs of local residents with learning difficulties. We will work with Changing Our Lives to make sure that we meet needs consistently across our sites. In November 2014 we held our first Learning Disabilities month to raise awareness of needs and issues for local residents, and we know that we are not yet outstanding in making reasonable adjustments or adapting services for patients or their carers. Patients can ask us to add a flag onto their record highlighting any specific needs that they want us to take account of in providing care.

Our regulator – the Care Quality Commission

Inspection in October 2014

During 2014/15 the CQC continued to assess our services based on standard national data. That intelligent monitoring gave the Trust to the best possible risk banding.

In October 2014 a pre-announced inspection of most Trust services took place over a three day period. In March 2015 this inspection gave rise to a report into our services. A further inspection of children's community services will take place in June 2015, because the inspection was undertaken incorrectly. More details of the inspection outcome are in the quality account section of this report.

The Care Quality Commission found that the Trust required improvement. This reflected the need to improve safety systems, leadership arrangements, and our responsiveness in some services. Our effectiveness was rated as good, and every single Trust service was considered to be caring and achieved a good rating in that domain.

Our adult community services overall received a good rating, with both acute hospitals assessed as needing improvement. A number of services were highlighted for their outstanding practice, including our iCares team who provide enhanced support to avoid admission.

Room for improvement

The Trust published an Improvement Plan. It is on the front page of our website at www.swbh.nhs.uk. It outlines how we will tackle the specific recommendations made by inspectors. It addresses each of the compliance and improvement actions outlined in the inspection report.

Going the extra mile: Sarah Atkins and Matthew Brown were married at Sandwell Hospital so it could be witnessed by Sarah's terminally ill father Barry Atkins

It's usually a patient waiting area, but in April staff met in the Fracture clinic at Sandwell for one of more than 50 QIHD meetings in the Trust

In April 2015, we launched an important change in how the Trust governs itself. Replacing audit and governance meetings held monthly within a specialty, with a dedicated half day every month where the entire Trust cancels planned care work. We undertake a Quality Improvement Half Day (QIHD). This allows teams not only to focus on ideas for improvement in care in their area, but to share learning across the organisation. The Trust is a big place, with lots of sites and teams, and so we are looking to find ways to put standards in place across the Trust. Almost one in four employees took part in the first of these half days. They are a very important chance to spread good practice in the year ahead.

At the same time, we launched a campaign called 'OK to ask'. The CQC are clear that we have strong policies in place for key safety measures like hand-washing. Our own auditing programme suggested and continues to suggest good compliance with those policies. However, no policy or audit can be on guard 24 hours a day. So our campaign tries to mobilise among all employees a spirit of constructive challenge. We keep an eye out and raise a question if someone does not use the gel dispenser or basins to wash their hands. A similar challenge is intended to improve medicines security, and tackle the confidentiality of our note storage. Patients and visitors can get involved in OK to ask – all our staff, who wear name badges, will be happy to answer questions about your care.

Key achievements from the year

2014/15 saw us achieve clarity on our long-term plans for the Midland Metropolitan Hospital, a significant milestone in how we deliver care for the people of Sandwell and West Birmingham. We also began a long term process of workforce transformation, with the successful redeployment of over 150 staff in our midst. At the same time, we recognise that there is more to do to make the organisation a fulfilling place to work, and a place in which local teams can see their part in our long term future. Finally, our year ended with publication of the Care Quality Commission report. This highlighted the overwhelmingly caring nature of the Trust, whilst also confirming that we had significant areas of weakness, where basically we do well usually, were not consistently delivered. More than half our services were rated as Good, including all of our adult community teams. But the Trust as a whole has Room for Improvement.

Our plans for 2015/16 reflect on that improvement, but also on consistent change over the recent past, it is worth highlighting some significant achievements over the last twelve months. Our plans led to real action and genuine improvement, such as:

April: Full implementation of our GP-based diabetes service, DiCE across Sandwell and West Birmingham: This provides specialist nursing and consultant physician support to practices, with a risk stratified focus on the population within that practice. Trust expert clinicians act as coaches to GPs and others in the latest developments in the field. The project won national recognition

May: After an initial pilot in March 2015, deployment of Vitalpac reached more than half our target wards, and completed rollout over the summer. This system ensures observations are electronically recorded and alerts staff to patients at risk of deterioration. It is a key part of our safety culture.

June: We launched our revised Whistleblowing Policy, with information in everyone's payslips. The new approach, backed by staff-side and endorsed by the Trust Board, provides a range of routes through which to raise concerns, including an independent external helpline.

July: Confirmation by the Chancellor of Exchequer that Treasury and the Department of Health are supporting the Midland Metropolitan Hospital development, now scheduled to open in 2018. £100m of taxpayer's money will be spent alongside the Private Finance 2 basis for this long awaited project, which brings acute care excellence onto a single site capable of offering 24/7 care to a high and consistent standard.

AUGUST

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August: Start of the pilot phase of Ten Out Of Ten, a key safety project aimed at standardising care basics across our wards.

SEPTEMBER

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September: Our nurse leaders launched revised guidance and support tools to ensure that we have the right support in place for complex inpatient care, especially patients with dementia who need additional support. The Focused Care toolkit has helped us to reduce the use of agency staff and improve the quality of our service for some of the most vulnerable people.

October: We won the prestigious Nursing Times Award for Integrated Care. Our iCares team of nurses and therapists beat off national competition to scoop this inaugural award. The prize reflects wider praise for the service, both from the King's Fund and the Care Quality Commission.

NOVEMBER

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November: Conclusion of consultation on our workforce changes – which signalled a major investment in overnight qualified nursing, as well as midwifery care. Almost a quarter of the proposals put forward for consultation were withdrawn or adapted based on feedback from staff and managers. The redeployment process began immediately and continues.

December: Opening of our latest Intermediate Care unit - D47 in Sheldon Block. This reflects our continued efforts to best meet the needs of residents across our districts for ongoing care and rehabilitation. This facility is delivered in partnership with Midland Heart. In February, a further pilot project with Sevacare opened on behalf of Sandwell Metropolitan Borough Council.

January: The end of January saw us celebrate one full year without a Never Event. BMEC had worked especially diligently to tackle a persistent issue with errors, but the whole Trust is engaged in ensuring that mistakes around consent, patient identification, and equipment do not re-occur.

February: Launch of our new Cardiac MRI service based at City Hospital. When combined with our outstanding Cardiac CT provision at Sandwell, this provides an excellent basis for local expert care. Cardio-vascular diseases remain extremely prevalent in our local community. The Trust has strong service, educational and research presence in this field.

March: Launch of our Live/Work scheme. This project provides apprentice opportunities to young people from across Birmingham and Sandwell, many at risk of being without education or employment. The project is delivered for us by St Basils, and offers opportunities to over 25 apprentices. The Trust as a whole now has over 100 apprentices, and won two major awards for this work at the Health Education West Midlands 2014 ceremony.

Reporting on our commitments in the Annual Plan 2014/15

Strategic Objective	2014/15 Priority	Delivered?
Safe, High Quality Care	• Implement year one of our Public Health plan, making every contact count	✓
	• Reduce preventable deaths, in particular by focusing on the Sepsis Six Care Bundle	✓
	• Reduce readmissions by 1%, through integrating care and better managing risk	✗
	• Meet the emergency care waiting time standard as we did in April 2014	✗
	• Deliver our Year of Outpatient programme, to reach 98% patient satisfaction	✗
	• Improve our Friends and Family results, towards being the best in the region	✗
	• Reduce the number of complaints, especially repeat complaints	✗
Accessible and Responsive	• Cut cancelled operations, and eliminate repeat cancellations	✓
	• Deliver national cancer wait times, even where other Trusts deliver part of the care specification	✓
	• Comply with both the letter and the spirit of the Safe Staffing promise made after the Francis Inquiry	✓
	• Achieve the emergency care standard, and meeting our own ambitions around mental health care in an acute setting	✗
	• No mixed sex breaches of our privacy and dignity standard, now reported from eBMS	✗
	• By October 2014, specialty delivery of 18 week wait standards, and introducing these standards into therapy services	✗
Care Closer to Home	• Develop further our model of intermediate care at Leasowes, Rowley Regis and in Sheldon at City Hospital	✓
	• Implement our pacesetting project to change the shape of district nursing delivery, making our services part of the primary health care team	✓
	• Ensure that our plans for winter 2014 are supported by consistent models of our of hospital care in nursing homes and the other settings of risk	✓
	• Complete the transfer of 27 clinics into Rowley Regis, as agreed by the Clinical Leadership Executive	✓
	• Resolve the long term configuration of midwifery services for 2015/16 with our CCG partners, local families and the local authorities	✗
	• Reform another long term conditions specialty into general practice, year two of what we have achieved with diabetes	✗
Good use of resources	• Ensure that our training expenditure supports career and skill development	✓
	• Providing extra support to high-turnover departments and those with long-term vacancies	✓
	• Standardise our consumables & 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	✓
	• Investing in occupational health services counselling teams	✓
	• Introducing an in-house medical bank	✓

Strategic Objective	2014/15 Priority	Delivered?
Good use of resources	• Cut our reliance on agency, overtime and bank staffing, on which last year we spent over £25m	✓
	• Eliminate the costs of poor quality care, where patients need more expensive treatment because of errors or omissions that we have contributed to	✓
	• Reduce overheads in our system, so that more of every pound is spent on patient care	✓
	• Improving our 'time to hire' from vacancy to recruitment	✗
21st Century Infastructure	• Resolve issues with the Birmingham Treatment Centre to ensure better staff and patient experience	✓
	• Proceed with Midland Metropolitan Hospital	✓
	• Invest in estate that we are keeping for the long-term including Sandwell General Hospital, Rowley Regis and Sheldon at City Hospital	✓
An Engaged & Effective Organisation	• Improve employee wellbeing by implementing our Public Health plan	✓
	• Invest in our leaders, through partnership with Hay Group and others	✓
	• Introduce 360-degree appraisal into all leadership roles	✓
	• Achieve 100% PDR and mandatory training compliance	✓
	• Cut sickness rates from their current 4.5% by focusing on our fifty hotspots	✗

Priorities we didn't meet: our focus for 2015/16

In our future plans in chapter 9 of the Annual Report we describe the targets and goals prioritised by the Board for the year ahead. These maintain a focus on the items not successfully delivered above, whilst anticipating vigilance and sustained success where we did achieve our goal.

For example, we continue to look to:

- **Reducing readmissions:** Our readmission rates increased across both sites in 2014/15, and this remains a key priority for 2015/16 with a specific focus on reducing readmission rates at Sandwell by 2%.

- **Achieving the emergency care standard:** The Trust did not meet the 4-hour ED wait target during 2014/15 (apart from in April 2014), although our Eye Casualty succeeded consistently. Overall multi-site performance was 92.52%.

- **Improving our 'time to hire' from vacancy to recruitment:** Time to hire has increased to 22 weeks at the end of 2014/15 as compared with 19 weeks at the end of 2013/14.

- **Cut sickness rates from their current 4.5% by focusing on our fifty hotspots:** This remains a key Trust priority in 2015/16, with the aim to cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness.

3. Our award winning staff

Since 2007, the Sandwell and West Birmingham Hospitals NHS Trust Staff Awards have honoured hundreds of healthcare professionals who have brought about real improvements to the care of patients. Winning an award is a great achievement. It acts as a catalyst for award winners to go on to bigger and better things, both in terms of their own careers and in terms of further improvements to patient care.

Nominations are open to clinical staff, non-clinical staff, and community staff and to patients and carers who have spent time at our Trust. The staff awards attract hundreds of entries. Three finalists from each category are shortlisted and the winner is announced at the glittering awards ceremony where sponsors have the opportunity to network with staff, executive members, senior leaders, local businesses and our community.

SWBH Awards 2015

Celebrating Where Everyone Matters

Staff Awards 2015

The theme of the 2015 awards represents cultural diversity, something that is represented highly in our Trust and the community that we work within. With six new awards added this year, the Sandwell and West Birmingham Hospitals staff awards 2015 are set to be the biggest and best to date. The 2015 awards were launched on Monday 27th April. The nominations will close on Friday 3rd July.

Congratulations to our 2014 Staff Award Winners

Lifetime Achievement Award – Steve Clarke, Deputy Director of Facilities.

Outstanding Leadership Award – Des Conlon, Deputy Lead Practitioner, Theatres, City Hospital.

New Leader Award - Justine Irish, Matron,D43/Eliza Tinsley Medically Fit for Discharge/Ready to Go Wards.

Staff and patient engagement Award - Joint winners – Cancer Services Team and Natalie Reeves, Discharge Co-ordinator Priory 5.

Patient safety Award – Diane Rhoden, Adult Safeguarding Lead Nurse.

Clinical effectiveness Award - Julie Edwards, Sister, Clinical Nurse Specialist in Headache.

Patient Experience Award - Mandy Burns, District Nurse/Clinical Lead, Sandwell District Nursing Team.

Innovation Award - Joint winners – Justin Drew and Denise Charnock, Speech and Language Therapists, Children's Therapy Service.

Transformation Award – Diabetes Team

Excellence in Customer Care - Oncology Unit, City Hospital.

Three vote winners!

Employee of the Year – Maria De La Fosse

Maria is as an individual who goes above and beyond her role on a daily basis. She is an integral and highly valued member of the serenity birth centre team; Maria constantly goes out of her way to ensure that every member of staff and every woman that comes into Serenity feels welcome during an important time in their lives. She ensures that the Serenity Unit is kept as clean as it can be and it is ready to welcome any women who are in labour. Maria has been described by her colleague as 'the kindest and most caring member of staff that she has ever met.'

Maria De La Fosse

Clinical Team of the Year – The Acute Medical Unit

The Acute Medical Unit at City is the busiest department within the hospital. The ward have overcome a series of changes over the past year and have done so with acceptance and a willing attitude. The merging of wards faced changes in practice and ways of thinking.The way in which all of the staff have embraced this change has been made clear through the excellent feedback that has been received from patients and visitors. Even when faced with provocation and obstruction, the team ensure that they are delivering the highest standard of care with great morale and enthusiasm.

Acute Medical Unit

Non Clinical Team of the Year - The Medical Records Clinic Prep team

The Medical Records Clinic Prep team is made up of two teams. They supply patient medical records for surgery, medicine, diabetes, cardiology, oncology and pain management and minor procedure appointments in the outpatients department at City Hospital. The team work behind the scenes to guarantee that the outpatientclinics are provided with the correct patient records. Nothing is too much for this team. They always go the extra mile to ensure that they deliver excellent service at all times.

Medical Records Team

If you would like to nominate for the 2015 Staff Awards, please visit our website or contact Charlotte Rochelle in the communications team, on 0121 507 5303 for more information.

4. Our clinical services and dedicated staff

Our Trust is organised into seven clinical groups and one corporate group. The clinical groups provide leading treatment and care for the communities that we serve across Sandwell, the West of Birmingham and further afield. The corporate group supports the clinical groups in delivering patient care and includes organisation development, facilities, estates, corporate nursing, finance, communications, corporate nursing, governance and the medical director's office.

In this section of the report you can read about the work of the groups and their key achievements during the year. The teams of people working throughout Sandwell & West Birmingham Hospitals NHS Trust have provided caring and effective care to patients and their families round the clock, every day of the year. The work that individuals do is hugely varied. We have included a diary entry of a Sandwell & West Birmingham Hospitals NHS Trust colleague to give you a flavour of a typical day in the life of a few members of our dedicated workforce.

You will also be able to read about some of the exceptional work done by our staff. Their stories are published each week in the Sandwell Chronicle under the 'NHS Hero' banner. The NHS is full of remarkable motivated heroes who give a lot to our communities and often go unnoticed. Our NHS Hero scheme recognises these staff, from a wide variety of backgrounds, doing a wide variety of jobs, in one of the Black Country's largest NHS organisations. If you would like to read more of their stories, you can visit www.swbh.nhs.uk/about-us/nhs-heroes.

We have also included stories from our patients, who want to share their thoughts and opinions of the services they have received. If you are inspired by them and want to share your own story, please contact Vanya Rogers, Head of External Communications on 0121 507 4093 or by email: vanya.rogers@nhs.net.

Community & Therapies

Introduction
The Community and Therapies group was established in 2013 and brings together 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, provide a broad range of services across secondary care and in the community.

Group Director
Fiona Shorney
Workforce
600 people
Budget
£27,000,000

Key achievements

- **iCares win prestigious national award** - Our Integrated Care Service iCares has won a prestigious Nursing Times Award. iCares won in a new category, added to the awards this year, for Integrated Approaches to Care. This award celebrates over two years of hard work, dedication and passion on behalf of everyone who works in the service; nurses, therapists, support workers and the admin team. Service manager Ruth Williams said: "It's always a team effort, as we try and go the extra mile every day to make sure the people of Sandwell get the best NHS care we can provide out in community. This award is a thank you to everyone who works in iCares as well as everyone in SWBH and the non NHS services who have worked with us over the years to get to this point."

Staff tucked into a birthday cake to mark the 20th anniversary of the opening of Rowley Regis Community Hospital

- **A new way to deliver community rehabilitation** - A new Winter scheme called 'Own Bed Instead' is starting to challenge the way we offer community rehabilitation. Funded by Sandwell and West Birmingham Clinical Commissioning Group, as the name suggests the idea is that care is delivered in the patient's own home rather than admitting them to a unit. It started small in November with 10 virtual beds. The scheme is a real triumph of integrated working where the Beds Hub allocate the patients and ensure the social care package of care is set up. The iCares therapists will then provide intensive therapy with the social care re-ablement workers. A social worker and iBeds case manager continue to support the patient to ensure their four week length of stay in the scheme is managed.

- **New clinic helps patients manage their breathlessness** - Patients who suffer with fatigue, anxiety and breathlessness are being helped by a new six week pilot clinic (F.A.B.). The clinic is a collaborative venture between the Specialist Palliative Care Team, Respiratory and iCares team and is based at Bradbury Day Hospice. The team recognised that some patients were suffering more because of their anxiety about their symptoms, which in turn leads to increased attendance at A&E and admission to hospital. The clinic is for those people who need to have help to manage their symptoms and use relaxation techniques and other self-management skills to lessen their symptoms and empower them to feel in control of their breathing.

Leasowes launches new commemorative garden - Nine months after an articulated lorry left the road, crashed through railings and struck Leasowes Intermediate Care Centre on Oldbury Road, staff, former patients and friends saw the unveiling of a new commemorative garden at the site in October last year. Dedicated to the memory of former patient and community campaigner for older people, Anthony Salter OBE, the garden was officially opened by his wife Sheila Salter and Trust Chairman, Richard Samuda. It was decided to open the gardens in honour of Tony (as he was known to the people of Sandwell), as he had raised the prominence of older people's rights over many years locally, was an original founder of Agewell and was a friend of Leasowes, having spent two spells in the Centre's care during the previous five years.

Sheila Salter was accompanied by her three daughters and a son-in-law. Jayne Salter-Scott spoke on behalf of the family, paying tribute to her father but also to the work of the staff at Leasowes who had been able to rehabilitate Tony on two separate occasions until he was well enough to return home. Although repair work was undertaken quickly at the time of the lorry crash, in which incredibly, no one was seriously hurt, the incident coincided with significant investment into Leasowes. This was possible following a successful bid for £903,700 from a Department of Health scheme to 'Improve the Environment of Care for People with Dementia.' Speaking at the launch, Richard Samuda said, "Despite some testing times earlier this year when we had to evacuate Leasowes, staff have come through with such determination and enthusiasm. It's very gratifying to see the centre not only restored to the full, but with the added bonus of the tranquil and picturesque garden which provides the ideal outside setting for all patients coming through its doors. We were pleased to dedicate the space to the memory of Tony Salter and show our appreciation for both his support and that of his family for the work we do at Leasowes."

Richard Samuda with Sheila Salter at the opening

A Patient's Story

Community staff from Sandwell General Hospital have been providing care in the Sandwell and West Birmingham region for decades and are constantly praised by patients for the care they give and one local woman will always hold a place in her heart for the nurses who have looked after her.

Francis Mason

Francis Mason, 70, has been suffering from Multiple Sclerosis (MS) for over 20 years as well as developing a cancerous growth near her perineum resulting in an anal fistula which required Radiotherapy and Chemotherapy.

"I had my first operation for my growth in 1994, which was the same year I lost my husband, which was performed by Mr Ellis and Dr Spooner" Francis said.

In 2014, unfortunately the cancer had grown again so Francis had to have a second operation in Sandwell before moving to the Queen Elizabeth Hospital for treatment.

Even through all of the health problems in her life, Francis keeps an upbeat outlook on life which she believes comes from the nurses and healthcare staff she has been treated and in the care of.
"After my operation, I flew to Bahrain as I had been given a ticket by my daughter who was an air hostess much to the surprise of my doctor. He couldn't comprehend how I could go through with such a big trip after having such a gruelling operation.

"I believe that due to the positive attitude the district and community nurses have when they come to dress my fistula or even to check on me, I feel like I am being treated in the best way which really makes my life a lot easier."

Francis has been wheelchair bound for many years due to MS, which was found through a scan she had for a problem she was having with her eyes.

"I went for a scan as the doctor said that I had a problem with my optic nerve, which turned out to be the early stages of MS and after that I lost the feeling in the left side of my body.

"I thought I had a stroke at first but I was still able to move my arms up and down.

"I still have no feeling or movement in my left leg which is why I am in my wheelchair but I have a great family who help me every day whenever I need it."

On average, Francis is seen by nurses every other day, sometimes more frequently than that, who change her dressings. She has been extremely satisfied with the care she has been given and makes them aware of her gratitude any time that they visit.

"I love every single one of them dearly" she said.

"I always tell them that I'm going to miss them when I don't require treatment anymore and will have to make up some injuries so that they have to keep visiting.

"What is great is that they all have a fantastic sense of humour and have a laugh and a joke with me which makes the atmosphere really relaxed."

Francis has lived in West Bromwich for the majority of her life, she moved to Tooting in London in 1969 for nine years, and believes that the nurses, therapists and doctors from Sandwell are the best in the world.
"I have never had to deal with anyone who I did not like and was not helpful.

"They have always treated me with the upmost respect and for that I would like to thank them, they in my eyes are the best in the world."

DIARY

Ruth Williams - Clinical Directorate Lead for Community and Therapies

8am starts are a regular occurrence for Ruth Williams, Clinical Directorate Lead for Community and Therapies. Sandwell Hospital is where she kicks off her day by checking in with the admin team, who tell her that last night a patient's son asked to speak to a manager and left his contact details for her.

After an hour of meetings and discussions with different teams and team leaders, which leads to different ideas and pathways being agreed upon for iCares, at 9:30am Ruth goes to a nursing home to visit a patient, their physio and the wheelchair service to assess how her positioning and tone is affecting her speech.

A quick write up of the patient's notes from the nursing home and a phone call to the patient's mother to fill her in on the plan, leads to Ruth calling the son from the night before to listen to his concerns. By 11:15am they reach an agreement, that he is happy with the service so far but would like to see the team more often.

Ruth then calls the patient's community team to set up a case conference and agrees to how they will work with the local leisure centre and will set him up on a 'walk from home' scheme to get him out and about again.

A sandwich from the canteen and a short car journey later, Ruth arrives at Rowley Regis Hospital for a 1:00pm meeting with the commissioning manager and GP lead of the Trust's admission avoidance clinic, PCAT, to discuss a communication plan and present the latest data that shows that patient referrals are lower than target.

Two hours later the PCAT team have to deal with an emergency after a patient has a fall in the car park, so Ruth takes over the phones and takes details of a man who may need a chest x-ray and IV therapy and a call from a GP about a lady who is stuck in bed with a possible urine infection. The details of the lady are passed onto the therapy team who can see her later in the day as long as the patient's daughter is there to open the door for them. After a last few bits of admin, checking emails and checks with the GP in PCAT to remind him to answer the bleeps while on the wards, Ruth heads home at 16:45pm before it all starts again the next morning.

NHS HERO

Helen Bessant, Occupational Therapist

For over 20 years, Helen Bessant has been working at Rowley Regis Hospital, helping patients in the community live comfortably and safely and for many, regain their independence after a spell in hospital.

The Clinical Team Lead for Rowley and Tipton and occupational therapist by profession, Helen (54) explained: "After receiving my degree in English and American Literature from Canterbury University, I was initially unsure of what field to pursue. I moved to Bath and worked in a Methodist home for the elderly, and that is where I discovered occupational therapy, and the difference it could make to someone's life. I decided that is what I wanted to do, so I applied to Wolverhampton to study for a diploma in Occupational Therapy. I was sponsored by Sandwell Hospital, and after graduation I came to work at Sandwell Hospital, and quite frankly have never looked back. Back then I studied with a friend – Jayne Sheldon – who is also still working for the Trust to this day.

"I started working with inpatients at Sandwell Hospital, then moved as one of the first members of staff to work at Rowley Regis Hospital (which celebrated its 20th anniversary last summer). I work in the community now, as part of a truly integrated service. We work alongside social services, district nurses and organisations such as Age Well, as we don't just consider the patient's needs according to what we can provide, but what is needed in entirety – considering the whole person.

"My heroes are my team who work above and beyond their normal duties, for instance responding immediately when a patient living alone with no family, rang late in the afternoon to say a heating contractor had left her with inadequate heating and she was cold – when no other service could be found to assist - two of our staff went out and sorted the situation. This demonstrates exactly what we are about - we are responsive, flexible and ready to meet an urgent need.

"Patient safety is our first concern, and as that particular patient was left in an unsafe condition, with no heating, we got on with our job and sorted it for her."

Consultant Radiographer Indrajeet Das, Cardiology consultant, Emily Ho, patient Nisha Pathak, Radiographer Sarah Smith, Chetan Varma specialty lead and Cardiology Consultant and Imaging Director of Operations, Jim Young at the opening of the new Cardiac MRI service

Imaging

Introduction

We provide a wide range of Imaging services to inpatients and outpatients, as well as providing a direct access service for GPs. This covers Diagnostic Radiology (x-rays, CT, MRI, Ultrasound, and DEXA scans), Interventional Radiology, Nuclear Medicine, and Breast Screening. We also have a Medical Illustration department which provides Medical Photography, printing, and graphics design services to the whole trust.

Over the last year we have completed approximately:

- 33,000 CT scans
- 23,000 MRI scans
- 55,000 Ultrasound scans

Group Director
Dr Jonathan Benham
Workforce
321 people
Budget
£17,978,000

Key Achievements:

- **New Cardiac MRI scanning service launched -** The new service, which was launched on the 16th February 2015, is the first time the Trust has been able to offer MRI scanning to local cardiac patients and will mean many more patients not having to travel to other areas for scans. Adding another scanning facility should also see waiting times for cardiac scans come down over time in the West Midlands.The plan is to gradually expand the number of patients who are able to use the service at SWBH (the aim is for 300 patients in the first year and 500 in the second and thereafter), which will also include sickle cell and thalassaemia patients.

- **Breast Screening -** In Spring 2015, the breast unit took to the road to provide a breast screening service as locally as possible for thousands of women. All women aged 50 to 70 are routinely invited for breast screening every three years. The programme aims to save lives from breast cancer by detecting the early signs when they are too small to see or to feel. Screening saves about one life from breast cancer for every 200 women who are screened. This adds up to around 1,300 lives saved from breast cancer each year in the UK.

- **'New Web PACS' system helps doctors care for patients better** - Sandwell Hospital wards Lyndon 3 and Newton 3 trialled a 'New Web PACS' system, which allows doctors to view radiology images on standard computers or an ipad to discuss them with the patient at their bedside. New Web PACS enables:
    - Display of greyscale and colour images from any radiology type;
    - Visual navigation of the available series of images through the use of thumbnails;
    - Side-by-side comparison of at least two sets of images for example CT slices (with synchronized scroll);
    - Windowing, pan and zoom for cross-sectional modalities;
    - Measurements of linear distance and angle;
    - Ciné capability for dynamic images.

- **Dr Bill Thomson was recognised by the British Nuclear Medicine Society** - Dr Bill Thomson - Head of Nuclear Medicine and Medical Physics, was recognised by the British Nuclear Medicine Society with the awarding of the prestigious Norman Veal Award for his outstanding contribution to science and the practice of nuclear medicine in the UK.

- **Nuclear Medicine Consultant named President of the British Nuclear Medicine Society** - Dr Notghi, Nuclear Medicine Consultant was named President of the British Nuclear Medicine Society and also won the Multimodality prize for his description of the added value of coronary calcium score to the MPS (Myocardial Perfusion Study). His study showed how combining two separate tests in one patient visit (one looking at the blood flow of the heart - MPS) and the other looking at the amount of calcium in the diseased arteries in the heart) can improve the test and management in patients with chest pain.

Left to right: Joyce Yates, Consultant Radiographer, Pat Bennett , Programme Manager - City, Sandwell & Walsall Breast Screening Service, Anne Powell, Consultant Radiographer Dr Doreen Cox, Consultant Radiologist - Director of City, Sandwell & Walsall Breast Screening Service, Jennie Waldron, Consultant Radiographer

A Patient's Story


Linda Evans

Linda Evans, from Redditch, had only been to City Hospital twice for her scanning appointments at Nuclear Medicine Department. Yet, she felt absolutely reassured when she stepped in the scanning room.

She said: "Last time, I came here with my friend as I was quite nervous. But the team was very friendly and nice. They told me what was happening and put me at ease, so this time I came here by myself as I know I am in good hands."

She was referred by her doctor to City Hospital to take the myocardial perfusion scan to ensure her heart is in good condition. The scan was done by the Double Headed Gamma Camera with 16 slice diagnostics CT. This state-of-the -art equipment was recently bought by the Trust, as part of the refurbishment project that was worth £1.4 million. The project bought two Double Headed Gamma Cameras to provide detailed diagnoses about the functioning of the heart, the lungs, the thyroid, and many other parts of the body. Since the images were produced in a matter of seconds, doctors are allowed to monitor the conditions closely and able to treat patients in a timely manner.

DIARY

Julie Shephard – Advanced Practitioner Radiographer

Every morning around 6.20am, Julie wakes to the sound of her alarm and starts the business of getting ready for work. She arrives in work at the Breast Screening Department, Birmingham Treatment Centre before 8am.

She then checks her emails and the tasks that she will have to do before patients go to the theatre today. She will also look at her rota to know if she will see patients who will come for repeated biopsies.

At 8.45, Julie starts seeing her patients. She either sees patients who come for the symptomatic clinic, where patients are referred to the clinic to have the breast screening if there were symptoms of cancer, or she will see ladies from the Breast Screening programme to go through with them their mammographic images.

She works until the clinic closes at 1pm and then takes her lunch break. Julie normally spends about 20 minutes at lunch before getting back to her work in the afternoon.

She normally spends her afternoon in the dark room to do film reading. Julie studies thousands of mammographic images of well ladies to detect early signs of breast cancer. She also reports on images of patients on annual mammographic surveillance following previous breast operations.

Julie often finishes her work at 5pm and gets home around 6.10pm. She spends an hour to do her domestic chores and cook dinner for her family before she does her study for her Masters course in Radiography at 7pm. Currently, Julie is completing her dissertation, which looks into the patient experience while having their breast screening.

After studying for two hours, Julie will take a break and watch TV before heading to bed around 10pm to get ready for work the next day.

Breast screening in Imaging

NHS HERO

Bill Thomson, Consultant Physicist

Dedication and commitment can be measured in many ways, but one local NHS hero has defined a new scale of measurement in caring for his patients.

Consultant Physicist, Bill Thomson (65) has worked in the NHS for 43 years, the last 30 as Head of Physics and Nuclear Medicine for Sandwell and West Birmingham Hospitals NHS Trust. He is also both the Radiation and the Laser Protection Adviser for the Trust.

Nuclear medicine uses radiopharmaceuticals to accurately detect early forms of cancer and also measures the function of the heart, brain, kidneys and lungs. In addition to his 'day' job, Bill runs a national service supplying radioactive krypton gas generators to other nuclear medicine departments across England. For five nights a week, a small team of technologists work in a lab in Birmingham to produce radiopharmaceuticals used to accurately detect blood clots in the lungs (pulmonary embolus). He recalls: "There have been occasions in the past when it looked like the service would have to stop. One was when the old cyclotron we were using closed down. However I arranged for the service to continue with solution from the only other cyclotron in the country doing this, at the Hammersmith Hospital in London. I still remember helping out occasionally by driving down to London at 2am to pick up the solution to get back and load our generators by 6am."

Bill is no stranger to awards as this year he received the Norman Veal medal from the British Nuclear Medicine Society, awarded for outstanding contributions to science and practice of nuclear medicine. He has contributed numerous articles to scientific publications and given over 150 presentations, and has had an idea for an improved measurement technique adopted nationally and sold in his name.

A driven man and a scientist at heart, he is passionate about improvements and new concepts for the clinical studies he is involved in. He explains: "I work with a fantastic team who simply want to do what is best for the patient, and are always coming up with ideas to improve things. We have a great record of involving all staff in research and development work and are often invited to present at conferences. It was great to see a technologist winning the best scientific paper at last year's nuclear medicine conference.

In his spare time Bill enjoys mountaineering, skiing and photography. He usually visits the Alps once or twice a year to climb, although a catastrophic climbing accident four years ago has tamed his adventurous streak, but has not diminished his love of climbing. He still enjoys indoor climbing two to three times a week and in quieter moments he also plays the classical guitar. Bill's own hero is the Irish polar explorer Sir Ernest Shackleton. He explained: "I am inspired by the way he led his men to explore Antarctica, particularly in 1914 on the Imperial Trans-Antarctic Expedition, where in the face of extreme conditions, he kept his head, completed a heroic sea crossing and came back to save his men. Wow, that's some leadership and courage."

Pathology

Introduction

The key aim of the Pathology group is to ensure that our clinical laboratories deliver relevant services for the diagnosis and treatment of the patients we serve. We have an emphasis on continually increasing efficiency and working to develop new innovative services that can improve patient care. Pathology uses different areas of science to help study human disease. Our department offers a full range of services to our hospitals and also the GPs in our area. We are an accredited Pathology Department under the Clinical Pathology Accreditation and are fully recognised for the training of biomedical scientists, clinical scientists and medical trainees. Pathology is divided up into a number of specialist laboratories and our services include: Biochemistry, Haematology, Cellular Pathology, Immunology and Microbiology.

Group Director
Dr Jonathan Berg
Workforce
320 people
Budget
£16,000,000

Key Achievements:

- **Cutting edge test helps rule out false positives for allergy sufferers** - The SWBH Immunology Laboratory is the first in the West Midlands to introduce a cutting edge allergy blood test called ISAC®. From a tiny blood sample this test, which uses biochip technology, can detect an allergy to 112 different proteins. Traditional allergy tests, which include skin tests and older allergy blood tests, look for allergy antibodies to whole food rather than specific proteins. This can lead to false positive results even where the patient is not allergic; this is because of similar proteins present in all plant food.

- **New food poisoning test at City Hospital** - The Microbiology Department has pioneered a new test for food poisoning which has reduced waiting times for results from two days to less than one. Only the third laboratory in the UK and the first in the Midlands to use his new technology, the 'EntericBio' investigation utilises the latest gene-probe molecular science. A number of common food poisoning organisms, including Salmonella, Shigella, Campylobacter and E.coli are tested by Polymerase Chain Reaction (PCR). This identifies a gene sequence specific to a target bacteria and, if it is present, amplifies it many thousands of times until a measurable reaction is obtained. By this means a preliminary positive or a negative result can be obtained the same day, as opposed to using traditional bacterial culture techniques which can take up to 48 hours. This means that many patients can move out of side rooms much more quickly than is currently the case, freeing-up isolation beds for other patients who need them.

Shabir Rajpar, Deputy Manager, Sadia Noorani, Consultant Immunologist & Head of Department and Helen Sandy, Immunology Manager

- **Blood culture training for doctors** - The Infection Prevention and Control Nursing Service has launched a new training DVD and training programme on taking blood cultures for doctors. As part of an on-going drive to promote best practice, SWBH advocate that all practitioners involved in taking blood cultures should undergo training in the principles of Aseptic Non Touch Technique (ANTT) and taking blood cultures. The aim of the training is to ensure patient safety by correct specimen collection and to reduce the risk of contamination of specimens. The Infection Control team have introduced a training programme for all doctors attending the annual and mini induction programme, to include follow up training for clinicians after the identification of blood culture contaminants. The training sessions involve watching a new and updated blood culture DVD and participation in a practical session.
- **Pathology wins contract to continue innovative partnership** - After a successful tendering process Pathology has retained the contract for the provision of routine and specialist pathology services for Birmingham and Solihull Mental Health NHS Foundation Trust [BSMHFT]. The contract guarantees a further three years with the possibility of a two year extension. Over the past five years we have been working in partnership with BSMHFT to develop a clinical science service specifically aligned for needs of mental health patients. We believe ours is the first pathology department in the UK that provides this clinically relevant service for mental health issues

Hannah Walkowiak, Biomedical Scientist , Mohamed Abbas Roshanali, Medical Laboratory Assistant, Vicki Hill, Medical Laboratory Assistant at Pathology, City Hospital

A Patient's Story

Claire Bhalla (38), from Sutton Coldfield, was diagnosed with Antiphospholipid Syndrome (APS) when she was in her 20s. The condition affects her immune system causing an increased risk of blood clots, which can result in having a stroke or heart attack.

Claire Bhalla

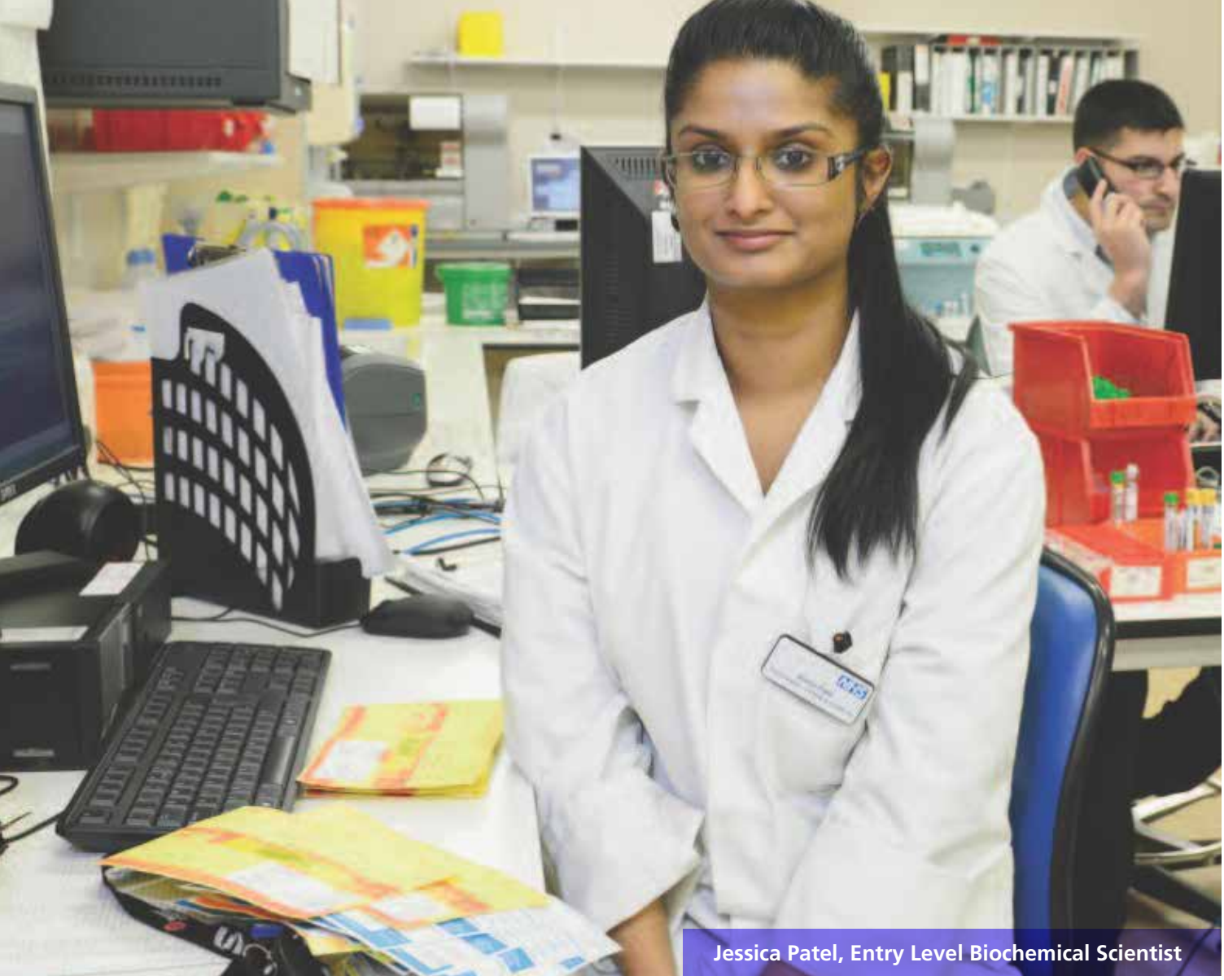
Claire has been a regular patient at the Anticoagulation Services at City Hospital since 1997. The service helps many patients like Claire, who have conditions caused by a blood clot or who are at risk of developing one, to monitor their health and let them know the treatment that they need.

Claire is now taking Warfarin (the main oral anticoagulant used in the UK) to keep her condition under control and reduce the risk of further blood clots. Warfarin medication requires careful and regular monitoring, Claire uses a self-testing analyser to measure her INR (International normalisation ratio), a test recommended by NICE (The National Institute for Health and Care Excellence) to monitor the rate that it takes her blood to clot. This test only requires a small drop of blood from the thumb or the finger and the result is obtained straight away without the need to send a sample to the laboratory.

Now, Claire can monitor her health at home and ring the services to know the dose of warfarin that she needs to take.

Speaking about the Anticoagulation Services at City Hospital, Claire said: "The staff are very helpful. I can give them a call anytime that I want. They always come across friendly and caring. I do not remember I have any trouble with them. They always answer my questions and make sure I am fully informed of my conditions."

Michelle Hogan, Medical Laboratory Assisstant, Dr George Trafford, Microbiology Specialist Registrar, Nathan Reading, Senior Biomedical Scientist project lead, Kailash Desai, Project Manager



Jessica Patel, Entry Level Biochemical Scientist

DIARY

Jessica Patel - Entry Level Biochemical Scientist

Jessica Patel is an Entry Level Biochemical Scientist in the Clinical Biochemistry Laboratory who works mostly night shifts. On these shifts, she works as part of a two person team, which is separated by five miles across the Black Country.

When her night goes as expected, she prepares 50-60 samples including booking in most of the work for Biochemistry and Haematology and placing them on the analyser. She also maintains the analysers as required but does not undertake the full daily maintenance as she is not trained to do so.

Eight times out of ten, Jessica can deal with the bleeps herself, but, if she can't she has to pass them onto her colleague in Haematology at City Hospital.

Sometimes things happen which are unexpected and this can lead to some interesting situations, which can be quite stressful for Jessica. For example, the piece of software linking the Biochemistry analysers to the main laboratory system can occasionally fail. When this happens one's pulse rate increases fast!

In this particular case, which has only happened once to Jessica, they had to enlist the help of the Consultant on-call – someone who is surprisingly friendly when woken at 3am. They then arranged to put a taxi service in place and instead of Jessica analysing samples, the results of which would not be seen at the hub, she then interacts with friendly Birmingham minicab drivers to get samples over to my colleague

Living a "nocturnal" lifestyle can have a major impact on both home and social life as it feels as though you are living in a different time zone to people most close to you. Although one may think it is something you can get used to, coping with shift working is not as straight forward.

Ricky Dragon, Medical Laboratory Assistant

Not many people would mix a laboratory assistant and a rapper but in Ricky Dragon you get both.

Ricky, 42, from Handsworth, is a Medical Laboratory Assistant at Sandwell and West Birmingham Hospitals NHS Trust. His role includes testing a wide range of medical samples from patients across Sandwell and Birmingham.

He said: "Every sample that is taken from an ill person is sent to our department so we can prepare it, put it on slides, and grow it in an area that mimics the conditions of the human body. From this we can identify what it is in order to provide the most appropriate treatment for our patient."

"I saw the opening as a Medical Laboratory Assistant and decided I could do it, and luckily I got the job five years ago.

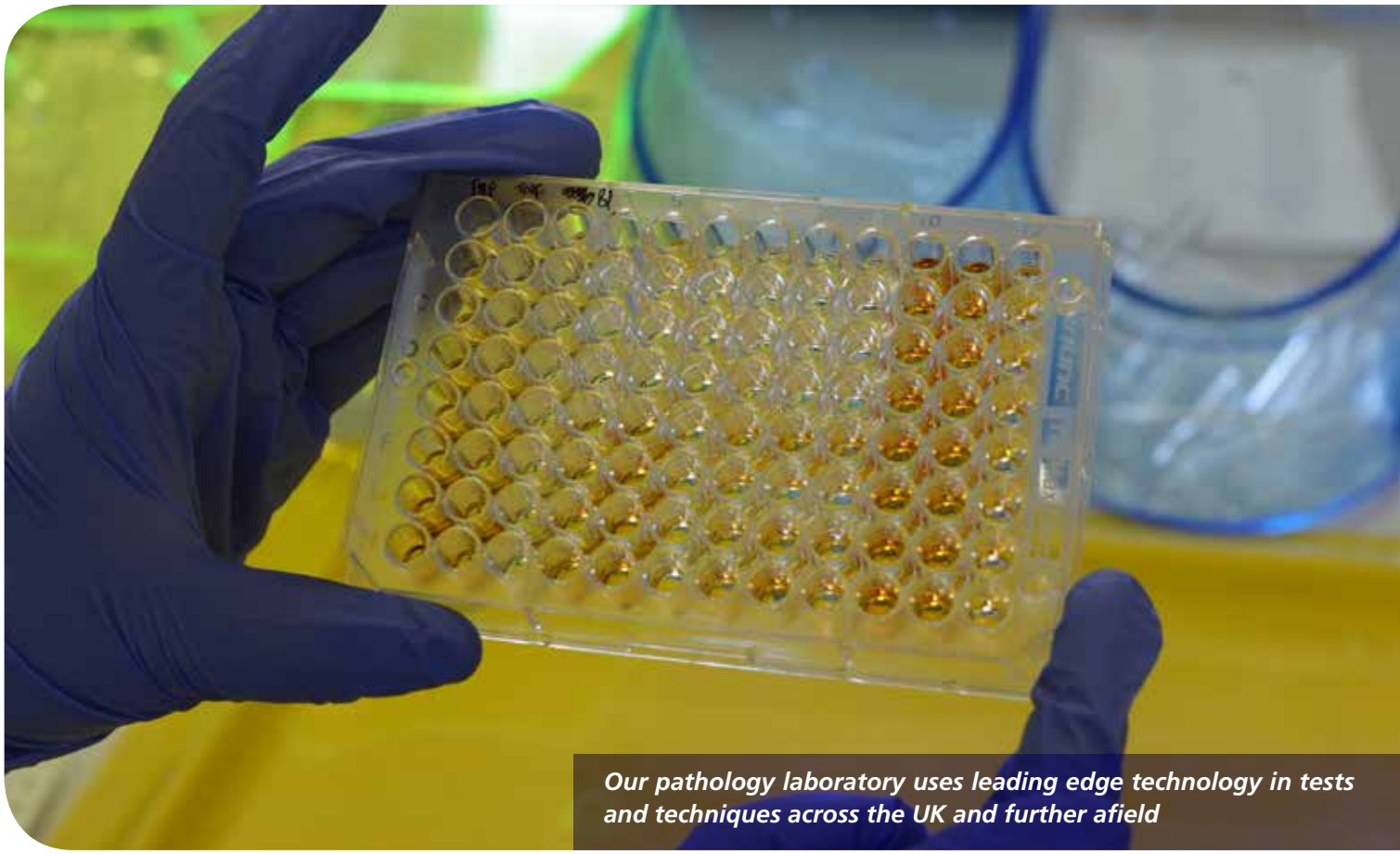
"I enjoy making a difference. I enjoy knowing that somebody got a treatment because I got a sample back on time, or I did my job well. It may be a child who needs help. Every sample deserves my attention and focus to do a good job. I try to do the best I can do.

"I had never worked in a lab before but I got the opportunity to come here and learn from some great teachers, who can put into a few words what some people would struggle to understand. I appreciate and value everybody's experience."

He said: "I couldn't be happier to work in the hospital. There are so many wonderful people that have so much experience they are willing to share."

Ricky recently won the Trust's Got Talent competition with his original rap 'The Anthology of Pathology' which gave him some useful prize money to go into the pot before the forthcoming birth of his first child.

He said: "Some people have called me a rapper, it means rhythm and poetry, so I find a rhythm that I like and express myself to it."



Our pathology laboratory uses leading edge technology in tests and techniques across the UK and further afield

Surgery A

Introduction

Surgery A group includes Trauma & Orthopaedics, General surgery, breast surgery, plastic surgery, vascular surgery, urology, anaesthetics and critical care. This is a large group providing surgery and critical care for our patients. General surgery and orthopaedics is mainly delivered from Sandwell, plastic and urology is delivered from both the City and Sandwell sites and critical care wards are at both the City and Sandwell sites. We treat patients who present to our Accident and Emergency department with acute surgical or orthopaedics emergencies, as well as performing a large number of elective operations.

Group Director
Mr Ajai Tyagi
Workforce
1,023 people
Budget
£68,700,000

In 2014/15 we saw the following numbers of patients:

- Follow up patients 48,035
- New outpatients 41,275

In 2014/15 we completed the following numbers of procedures:

- Emergency 6234
- Day Case 9820
- Elective 3800
- Total 19854

Key Achievements:

- **821 days pressure ulcer free – and counting -** Three wards in Surgery A are celebrating being free of pressure ulcers for more than 12 months. Lyndon 2, Priory 2 and D21 have had no patients suffer a pressure ulcer for between 350 and more than 800 days. On D21 they haven't had a pressure ulcer since June, 2012. The safety briefing, including nutrition and hydration, is now always done at the beginning of each handover. Patients are quickly and accurately assessed as soon as they come onto the ward so any appropriate equipment, like pressure-relieving matrasses, can be used straightaway.
- **Cancer patients say service is improving -** The results of the Cancer patient Experience Survey 2014 by Quality Health are in and 87% of patients surveyed about their treatment with us have rated their care as excellent or very good. Significant improvements from previous years were seen in the number of nursing staff on duty and shortened waiting time for treatment. The trust also scored highly on enabling access to support groups and financial assistance for patients and in communication with GPs about patients' progress on treatment. Written information was greatly improved, enabling patients to more easily understand their diagnosis and treatment options.

- **Trust's FINCH Team nationally recognised** - The Trust's FINCH team has caught the attention of other trust's nationwide after giving an excellent presentation about the service it delivers at SWBH. The team attended the annual pelvic floor scientific meeting in Bristol and gave two presentations, one on the 4 stage nursing approach used in the management faecal incontinence and the other on the 4 stage approach for constipation. The feedback was that other centres across the UK should be adopting a similar approach, rather than moving so quickly to surgical interventions. Since giving the presentations, Trusts from across the county have been in contact to learn about the pathways used at SWBH.

- **Pain Management Going The Extra Mile** - Staff literally went the extra mile to help patients forget their pain when they organised and accompanied them on a trip to Blackpool. Pain Management Services at SWBH extends to both acute and community services. Within these services Pain Management Programmes (PMP) are offered to chronic pain patients with a view to helping them self-manage their long term pain problems and improve their function. The programmes are run by physiotherapists and/or nurses with help from health care assistants and/or a technical instructor.

- **Award Winning Student Development** - D25 has won the Nursing Placement prize at Birmingham City University's Health and Social Care awards, demonstrating how much the Trust invests in the future of nursing. Also nominated for the Healthcare awards were the Clinical Nurse Practitioners and Theatres at City Hospital.

Leading the way in critical care

Sandwell & West Birmingham Hospitals NHS Trust provides high standards of critical care to patients who are seriously ill. The intensive care units can care for up to 14 level 3 patients across Sandwell and City Hospitals. Level 3 care is for patients requiring one-to-one support such as patients who are ventilated and the unit also has level 2 intensive care beds for high dependency care. Critical care does not just happen in our intensive care units. The critical care outreach team support patients who are critically ill but who are able to be cared for in other wards with the right monitoring, care and treatment.

Critical care was praised by the Care Quality Commission in their report that followed the inspection of the Trust in October 2014. Services at City Hospital and Sandwell Hospital received a "good" overall rating and were rated "good" in every one of the five assessment domains: safe, effective, caring, responsive and well-led.

The Care Quality Commission said that patients receive good care and treatment according to national guidelines; staff care for patients in a compassionate manner with dignity and respect; and patients and relatives are happy with the care provided.

The Trust is continuing to invest in improvements to critical care, even though we know the care that we provide in this area is already to a high standard. In 2015/16 we are increasing the numbers of nurses to provide critical care outreach to a consistently high standard throughout the day and night.

Raghu Devarajan , Urology Consultant and Charina Lacorte, Advanced Theatre Practitioner

A Patient's Story


Nadeen Hall

Nadeen Hall did not expect that her holiday could lead her to a totally different experience.

Nadeen, 19, flew to Turkey on Thursday 31st July, 2014, with her friends, expecting a long holiday in the sunshine, only that just lasted for a day. The next day after arriving in Turkey, she and her friends decided to go for a jog, and then had a small dance in the hotel's reception. With a bit of twist, she slipped and smashed her ankle which resulted in breaking her bones in her leg. The injury was so serious that she had to be admitted to a hospital in Turkey.

Nadeen, a carer from Rowley Regis, said: "My experience at the Turkish hospital was disappointing. "I needed an operation for my injury, but the hospital refused to do so and gave me three casts on my leg and charged me £400 for the treatment." She added: "I regret not buying travel insurance and now I have learned my lesson. Fortunately, a friend of mine kindly helped me to go back to England the next day." She was on the aeroplane back to Manchester, where her partner had waited and took her straight to Sandwell General Hospital, West Bromwich. Nadeen was taken to the A&E unit, where she was receiving intensive care from the doctors and nurses here. After having the X-ray checked, it was decided that Nadeen needed to have surgery immediately because of her broken bones.

As soon as she went into the theatre, the doctors found out that there were three blisters in her leg and they needed to have a further check before they could start the surgery.

Nadeen said: "I found that it was not easy to lie down and rest because I am used to taking care of others, not the other way round. The staff at Newton 3 had given me such welcoming and pleasant care. The staff are fantastic and nice. I was very grateful when the nurses sat next to me, made me a cup of coffee and gave me company in the evenings."

Staff even went the extra mile. Claire, the ward sister, also pushed Nadeen on a wheelchair to go for a walk when she was feeling down.

Nadeen said: "The way you get treated here is fantastic. They actually talk to you, sit next to you, and do not push you away. The pain I have is horrendous but the staff here are very good at their job and they make me feel much more comfortable.

"I can tell most of the people who work at Sandwell General Hospital, work here because they actually want to be here, whereas where I have worked before, people only want to work for money."

Nadeen added: "When my leg gets better, I want to work here. This is my dream."

Georgie Fuller - Senior Healthcare Assistant, Critical Care

Georgie starts her day at 5.45am to allow herself enough time to get ready and prepare her lunch. At 6.30 am she leaves the house to get her bus and arrives at the hospital by 7.10am.

After the handover she is normally allocated to work specifically with a nurse and two level 2 patients. She checks that the patient meals have been ordered the night before and then continues to order for the rest of the day. After the nurse carries out the safety checks she helps and assists any jobs that need to be done. She helps the nurse observe the patient, write down any observations of level two patients under supervision and reports anything to the nurse that is unusual. She would normally take blood from an arterial line and then process the blood though the blood gas machine.

Georgie removes any cannula that was no longer needed, take blood sugar readings and remove urine catheters. For patients who are able to communicate, breakfasts are provided and Georgie assists the nurse or patient with their daily washes, frequent repositioning and rehab. It is important that bed spaces are checked and ready to use so she makes sure that all monitors have the correct lines and drawers topped up with toiletries, linen, IV lines, syringes, wound care stock and ventilators. All ventilators are checked and Georgie also carries out a self-service test so that it can be used immediately.

A very important part of her job is to make sure the bed spaces and equipment are cleaned to a platinum standard in line with the trust policies and procedures. All these jobs can take her up to and beyond lunchtime but she would always help serve the patients meals and assist the patients if necessary. There are many medics on the unit and she will help and assist the doctors with any procedures that they have to carry out within her role.

As well as the wonderful things that are done in ITU she also has to help and assist families during a time when a relative or loved one can be going through a very traumatic experience. Not all patients make it so she is there for the family with tea and kind words and also prepares the patient for their final resting place.

She needs to be able to set up enteral feed sets, arterial and central line giving sets, CVVH and HF machines (these are a form of kidney dialysis), carry out ECGs, locate the defib trollies, perform point of care MRSA and many more procedures which can all be required in an emergency. She also needs to know her way around the hospital as ITU staff and medics can request life-saving equipment brought to them immediately i.e. portable ventilators, cooling packs or even intubation boxes.

She finishes her shift at 8.30pm, she then comes home at around 9.30pm just to have a quick supper. At 11pm she will go to bed to get ready for the next day.

Tsitsi Banza, Staff Nurse, D25

Tsitsi, 40, from West Bromwich, has been nursing since 1998, and has worked for Sandwell and West Birmingham Hospitals NHS Trust since 2001, when she moved over from Zimbabwe. She said: "I always wanted to be a nurse, even when I was a child. My mum was a nurse, and seeing her in action really inspired me to follow her into nursing."

Tsitsi balances her home life with husband Paul and her three children aged six, 13 and 20, with working nights on D25 at City Hospital - a short stay surgical ward. Patients rarely stay on this ward longer than 72 hours, yet Tsitsi, while doing her ward observations, finds time to interact and get to know patients.

On NHS Change day in March 2014, the Trust made an organisational pledge to adopt Dr Kate Granger's 'Hello my name is...' campaign across the Trust with every contact we make starting with us saying hello and giving our first name. Tsitsi was already ahead of the game as she explained: "I have always introduced myself to patients and enjoy conversations with them, as it helps them to feel more comfortable and by learning a little about them I can understand their needs better.
"I enjoy helping patients and seeing a change in them. When they come in some are very ill and it is fantastic to help make them feel better, to have helped make a change." Tsitsi enjoys the support of her colleagues, as they are full of admiration for her. Her Senior Sister, Kim Kaur said: "She is never fazed by anything, and is well organised and a role model to the rest of us. The patients always speak really highly of her and she handles work and family pressures excellently.

"She was recently recognised on the ward for her fantastic attendance record, having not had a day off sick in five years. She was awarded a certificate and badge by our Chief Nurse Colin Ovington to acknowledge this achievement."

Away from work, Tsitsi spends a lot of her time with her family, but also enjoys catching up with her mum, who still lives in Zimbabwe. From two generations of nurses, there may well be a third if one of Tsitsi's children decides to follow in mum (and gran's) footsteps. On that we'll have to wait and see…

Birmingham & Midland Eye Centre (BMEC)

Surgery B

Introduction
We provide diagnosis, conservative intervention and elective day case surgery for adults and children accross ENT, Oral and Maxillofacial and Eye Services. Surgical intervention requiring general anaesthesia is carried out in the Birmingham Treatment Centre, whilst surgery under local anaesthetic or local anaesthetic and intravenous sedation is carried out in the department.

In 2014/15 we saw the following numbers of patients:
- Audiology - 37,360
- ENT - 20,866
- Ophthalmology - 164,619
- Oral Surgery - 6,039
- Ophthalmology's A&E - 27,157

Group Director
Velota Sung
Workforce
386 people
Budget
£46,000,000

Key Achievements:

Audiology team first among equals with national accreditation
Last spring, the Audiology Department at the Trust became only the seventh NHS trust in the country to gain a coveted national accreditation. The department was granted the Improving Quality In Physiological Service (IQIPS) Standard by the United Kingdom Accreditation Service (UKAS) - the sole national accreditation body to assess organisations that provide certification, testing, inspection and calibration services. The IQIPS programme aims to improve service quality, care and safety for patients undergoing physiological diagnostics and treatment.

In order to meet the IQIPS standard, the Audiology team was involved in self-assessment and external peer assessment against a set of 26 standards to assess accurately the level of performance in relation to established standards and to implement ways to continuously improve. The standards cover patient experience; safety; facilities, resource and workforce and clinical criteria.

Dr Suki Dhillon, Consultant Clinical Scientist (Audiology) and Service Manager, said: "The whole department worked extremely hard to fulfil the IQIPS criteria, and we are delighted to gain the UKAS accreditation recognising this. "We are only the third trust in the region to gain the accreditation and the first local NHS organisation to achieve it for paediatrics. We can now use the UKAS stamp, with its Royal Crown signifying government recognition, on our letterheads, leaflets, emails and web pages, bringing national recognition to the service and reassuring patients that they are receiving high quality services that are most appropriate for their needs."

Filming eye surgery leads to safer care

The team at the Birmingham and Midland Eye Centre has led the way in introducing a programme of work to improve the safety of eye surgery. A major achievement for Surgery B was that during the year there were no 'never events' - a healthcare incident that should not happen. In the past, the Trust experienced four in a 12 month period. But, due to the combined efforts of teams of staff across the Trust, there were none over the past year. Latest figures show how uncommon that is in large hospital trusts.

Hilary Lemboye, Operations Director with Surgery B, has worked with the team's leaders to introduce video technology to film surgical procedures. With the patient's consent, these films are used to enable surgical teams to reflect on how safety procedures are carried out during surgical sessions. Teams review the films together and it helps them to understand what they do well and how they can continue to improve and perform consistent safety checks on all occasions.

Speaking about the video programme, Hilary said: "We have worked hard to improve our safety record, making sure that the teams providing care to patients are carrying out the right safety procedures at every stage of the surgical process. Despite some initial uncertainty about being filmed, the vast majority of staff working in theatres have now embraced video reflexivity and can see the benefits of watching the films and reflecting on how they work as a team."

A Patient's Story

Endoscopic Vitreolensectomy and a Baerveldt Tube Implant sound like very daunting procedures, but they are two things that Sarah Willis knows very well, as these are the two procedures that have helped her retain her sight over the past few years.

Sarah, 45, was born with Congenital Glaucoma caused by Rubella and has had to live with seriously impaired vision for her whole life. She was referred to Birmingham Midland Eye Centre in March 2011 and was placed in the care of Mr Sung.

BMEC is an internationally acclaimed treatment facility with a number of leading consultants employed within the centre.

"As a child I started at Birmingham Children's Hospital, but during my adult years I made my way over to the Eye Hospital on Dudley Road and have been with Mr Sung since 2011.

"I was preparing myself before my first operation at BMEC to go blind as I didn't see any scenario in which I would be lucky enough to keep my sight" Sarah said.

"Mr Sung told me he would slow down any potential blindness with this surgery but I was not expecting in 2015 to still have my vision."

Over the past few weeks Sarah's life has been made better after receiving her specialist contact lenses.

"Glasses do not work for a person with my condition as you do not have peripheral vision, it is very much only straight forward you can see, but with Scleral Contact Lenses, I feel a lot happier now. "They are thicker and are painted to cover that my eye is completely white due to my Glaucoma." Even with her ongoing eye problems, Sarah has kept working. She currently works part-time in the Stourbridge Job Centre as an Administrative Assistant.

"I work 21 hours a week, having just finished working full-time hours, inputting data at the Job Centre in the week. It makes me happy to think that I can keep working when I was ready to lose my sight before my treatments."

Even though the treatment and procedures have been at times traumatic, Sarah is still very grateful of the care she has received from BMEC.

"The treatment I have received has been of a very high standard and I am very happy with the work of the consultant."

DIARY

Mohammad Tallouzi – Advanced Surgical Practitioner/ Ophthalmology- PhD Student

Mohammad's day starts around 6am when he wakes up and gets ready for work. He normally leaves the house at 7am aiming to be in the office at 7:30am. He checks his emails and chases up results for patients' specimens/biopsies that have been sent and sign letters that he has dictated before sending them to the GP.

He normally works two long days at Birmingham and Midland Eye Centre. On Monday his clinic starts at 9am and finishes at 7pm, however on Wednesdays he starts earlier at 8am as he needs to see his patients to get them ready for theatre, and write their discharge notes and medication before he starts his theatre. His theatre list is always busy and will have around 12 patients with eyelid conditions who need minor operations. He finishes his session around 12:45 and have lunch and get some admin completed before the afternoon clinic starts.

He starts the afternoon clinic around 1.30pm aiming to finish at 5pm and then rush to start the evening clinic where patients will be waiting to be seen. In addition to the clinic and theatre session he runs, he will always have one intra-vitreal injection clinic every other week. This provides the opportunity to utilise his knowledge in many different areas.

About half of his job is clinical, however, he has just started his PhD research project at the University of Birmingham, investigating Uveitis macular oedema (swelling to the central part of the retina responsible for the central vision) and its management and prognosis. Uveitis macular oedema is one of the leading causes of blindness in uveitis (group of disorders and intraocular inflammation). He attends the university three days a week from 8am and finishes at 6pm.

Once he finishes his clinical commitment, he tends to leave the hospital aiming to get home by 7.30pm. When he gets home, his one year old son will be waiting to see him so that they can spend time together before he goes to sleep. Then he relaxes with his family and watch a little TV before heading to bed around 11pm, in preparation for the next day.

Mohammad Tallouzi, Advanced Surgical Practitioner

Arijit Mitra, Ophthalmic Consultant

Many of us have dreams of what we'd like to be, and some are lucky enough to achieve our ambitions. Fortunately for us, this is true for eye consultant Arijit Mitra, who as a child dreamed of helping vulnerable people regain their vision, and is today one of the new consultant ophthalmologists at the Birmingham and Midland Eye Centre (BMEC). Arijit, aged 39, worked as a trainee at BMEC from 2007 to 2011 before undertaking a fellowship in Manchester for a year. He then came back to work at BMEC in 2012 as a consultant.

During his training program at BMEC, he won a number of rewards for his outstanding work, including the Roper Hall Prize Medal and the Midland Ophthalmological Society Travel Award. Mr Mitra has a special interest in vitreo-retinal surgery and medical retina. When asking about what motivates him at work, he says: "I love the nature of my job. It is very challenging as the cases are usually very complex. "However, whenever I help patients regain their vision, I find the job absolutely rewarding. It makes me feel that I have made such a positive difference to someone's life. Being an eye doctor has always been my dream.

"One of the memorable moments in my career was when I successfully carried out surgery on a patient, who is the husband of the former Mayor of Sandwell. After seeing the care that we delivered to her husband and other patients, she chose BMEC as one of her two charities of the year, helping us to raise money to improve the care at BMEC." Mr Mitra has been helping BMEC to set up the Birmingham and Midland Eye Hospital Alumni Association, which aims to create a network to connect all previous BMEC consultants. The association organises annual scientific events for the alumni.

This is seen as an opportunity for all the leading consultants to share best practice with each other, helping their colleagues improve their profession. He has also co-authored a book on the history of Birmingham and Midland Eye Hospital. Mr Mitra explained: "BMEC is one of the largest eye hospitals in Europe. We have a great team working together to provide the best service possible to our patients.

"The team has always been very supportive and friendly to me, ever since I was a trainee. They provide such a nurturing environment where you can freely discuss your opinion and knowledge with your colleagues and become better every day."

Katy Lewis, Clerical Officer/Assistant Audiologist

Medicine and Emergency Care

Introduction

We provide acute emergency medical services for approximately 193,000 patients each year. We also contract a GP service and actively stream patients that present to Emergency Department but only require GP services.

Acute medical assessment units provide inpatient care for patients requiring a short length of stay i.e. less than 48 hours for adult medical patients.

Alongside these services we provide an ambulatory service for patients requiring services that previously would have resulted in an admission to hospital i.e. cellulitis requiring intravenous antibiotics.

Group Director
Dr Matthew Lewis
Workforce
1,628 people
Budget
£144,802,000

Key Achievements:

- **Virtual clinic -** A new Virtual Clinic has been set up in acute medicine to enable the safe and swift discharge of patients from the Acute Medical Units (AMUs). The Virtual Clinic has enabled us to close three weekly clinics down and now all consultations are done over the phone and via letters and thus the patient does not need to come into hospital for review.

- **Diabetes patients get expert knowledge delivered in their own language -** The first ever Asian Diabetes X-PERT programme has been delivered at City Hospital's Diabetes Centre. X-PERT is a structured education programme based upon the theory of patient empowerment, discovery learning and patient-centered diabetes care. Its main aim is to develop knowledge, skill base and confidence in participants to enable them to make informed decisions regarding lifestyle and diabetes management.

- **Award from the Ambulatory Emergency Care Network -** The Trust has been given an award in recognition of the good coordination and engagement we have in this health economy, associated with a project which is giving patients all the benefits of a hospital admission but doesn't require them to stay in overnight.

- **The Smethwick Community Pathfinder Diabetes Project won Quality in Care award for the best primary Care/ Community initiative in the National Diabetes Awards.** The project was launched to address some of the un-met needs of people with diabetes. GP practices identify patients for a one-off advice and management plan by a consultant and diabetes specialist nurse.

- **Reducing risks for frail older people -** With the increasing recognition of problems older people may have when attending A&E and Medical Units, the Trust has been trying out a system, involving the daily presence of two consultant geriatricians, to provide early input into the management of frail older people on AMU-A at Sandwell.

- **New mental health units aim to improve care and safety -** Emergency Care teams have started a project working with Birmingham and Solihull Mental Health NHS Foundation Trust and Black Country Partnership NHS Foundation Trust to improve the care of patients with acute mental health problems who attend our Emergency Departments. We have introduced the Dudley Room at City Hospital and evolved the role of the existing Oak Suite at Sandwell Hospital. Both of these facilities create a safer and therapeutic setting for patients who can be extremely vulnerable.

- **Building 'esteem' among high risk patients -** A confidence, wellbeing and emotional health support scheme, established by Sandwell and West Birmingham CCG and now run by the Tipton Care Organisation (TCO), is helping to enhance the care of a high-risk group of Sandwell patients. Support Time Recovery (STR) Link worker Kathryn Ryan is on hand each week to meet with patients and others in need of more help than just medical. The system works by the healthcare assistant and receptionist highlighting the service to patients. Since the project started in October 2013, 41 people, including staff and carers, have been referred for further emotional support after coming to the clinic.

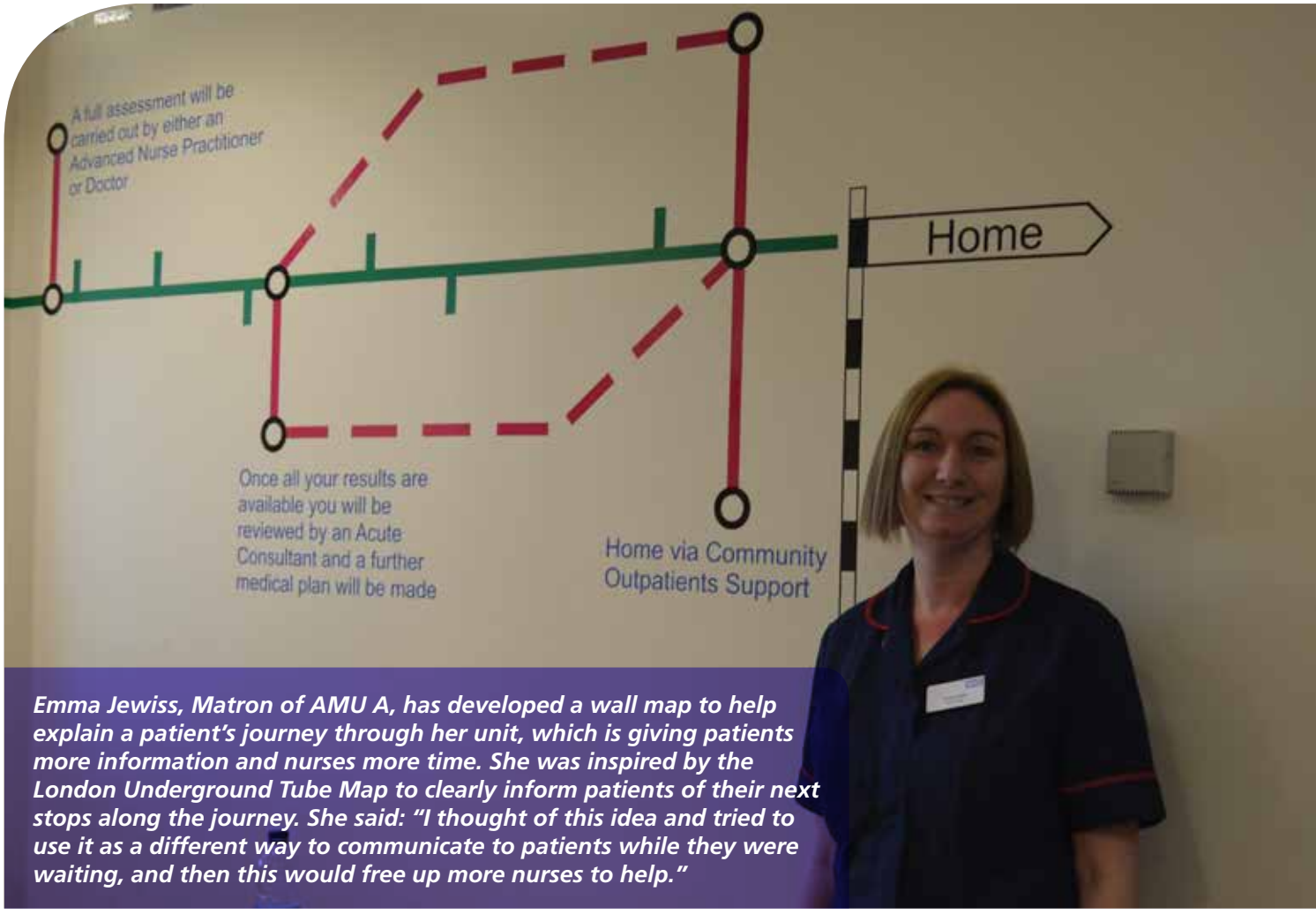
Cardiologist named in world's top ten

Last year, one of the Trust's cardiologists was named in the top ten in the world in his field. Professor Gregory Lip is ranked number six in Expertscape's list of world experts in hypertension, a condition more commonly known as high blood pressure. The accolade comes soon after Professor Lip's ranking as world's number one expert for his expertise in atrial fibrillation, which is a common heart rhythm condition which can lead to an increased risk of stroke and heart failure. Professor Lip was also listed in 'World's Most Influential Scientific Minds: 2014', which was a global ranking of today's top 17 scholars who have published the greatest number of research papers, ranked in the top 0.1%, in the 2014 Thomson Reuters Hottest Researchers list. Professor Lip's work in atrial fibrillation has led to important changes in the way the condition is managed and changes in guidelines nationally and internationally. He said: "I am humbled to be listed amongst the world rankings of experts, as well as amongst World's Most Influential Scientific Minds. Hypertension and Atrial Fibrillation are very common conditions, and is the focus of my clinical and research activities. It is nice to know that my work is highly regarded, appreciated and recognised externally.

Neurologist makes world history

A consultant neurologist from Sandwell and West Birmingham Hospitals (SWBH) NHS Trust has contributed to the world's largest drug trial of Parkinson's which aims to help improve the quality of patients' lives. Professor Carl Clarke, Professor of Clinical Neurology and Honorary Consultant Neurologist, has joined together with a team of specialists, 'UK PD Med Collaborative Group', to conduct the trial which looked to settle a 15-year-long debate; 'which is the best first treatment for Parkinson's?' 2,000 people with Parkinson's, 1,300 carers, 100 hospitals and the University of Birmingham worked in collaboration to complete the clinical trial examining different medications including, levodopa, dopamine agonists and monoamine oxidase inhibitors.

The trial was successful in concluding that despite the previous concerns over its long term usage; Levodopa remains the best first treatment for Parkinson's. This is backed by the patients' feedback on their quality of life. The study also found there were no long-term adverse effects from the therapy. Professor Clarke said: "PD MED trial will change clinical practice worldwide so that all patients are initiated on Levodopa therapy." Switching initial therapy to Levodopa will help to save the NHS money as it is the cheapest medication studied in the trial. Around 120,000 people in the UK are affected by Parkinson's disease. It is caused by the progressive loss of nerves in the brain. Symptoms include: motor symptoms (tremor, slowness of movement, instability), constipation, anxiety, depression, sleep disorders, and dementia.



Emma Jewiss, Matron of AMU A, has developed a wall map to help explain a patient's journey through her unit, which is giving patients more information and nurses more time. She was inspired by the London Underground Tube Map to clearly inform patients of their next stops along the journey. She said: "I thought of this idea and tried to use it as a different way to communicate to patients while they were waiting, and then this would free up more nurses to help."

A Patient's Story


Gary Lane

Gary Lane (48), from West Bromwich, had a serious stroke less than two weeks after he had his heart surgery. On the 21st of May 2014, the day that Gary and his family were planning to celebrate his seven-year-old daughter's birthday, he was found in the toilet by his partner's daughter in a state of unconsciousness. His partner, Joanne Harper, immediately called the ambulance as she realised he had had a stroke as he could neither speak nor move his right side. The paramedics appeared just a few minutes after the call and the team quickly rushed him to A&E at Sandwell General Hospital.

Gary was met by the on call stroke team as the hospital is pre-alerted by the paramedics when an acute stroke patient is expected. After the initial assessment by the stroke nurse and doctor, Gary had a scan and the team found that there was a clot obstructing the flow to the left part of his brain. Because of his recent open heart operation, Gary was not a candidate for the clot busting treatment. This was usually given to treat acute stroke patients that present early to the hospital. However, in his case, the risk of major bleeding was very high.

The stroke consultant, explained fully to Gary's family that the only thing that could potentially help him was a procedure at the Queen Elizabeth hospital, which at the time was not part of the usual treatment for stroke. This is called thrombectomy and it involves removing the clot using a wire that goes from the groin all the way to the brain. Gary's partner, Joanne, agreed to let Gary go through this procedure. The Stroke Alert Response Nurse (SANS) worked very hard with the A&E staff preparing Gary quickly for the transfer as this procedure should be done as soon as possible for the brain to benefit.

It was a very difficult procedure and the Neuroradiologists at the Queen Elizabeth hospital had six attempts before they managed to take out part of the clot. Gary then started moving his right arm. He was transferred to Sandwell a couple of days after that for further physiotherapy.

The cardiology team at Sandwell General Hospital also contributed to his care as his heart problem and recent operation was deemed to be responsible for the stroke.

At the hospital, the team provided him with a number of therapy sessions to help him recover. Speaking about the journey that he went through, Gary said:

"The stroke has changed me as a person. I have been eating healthier with more green food and feel more confident. I am extremely grateful towards my stroke consultant and her team. She is the best doctor that I have ever seen. She has saved my life and she still cares for me although I have been discharged. She calls me often to check how I am doing with my progress. I couldn't thank her enough."

After the recovery, Gary and his partner organised a fund-raising campaign called 'Step out for stroke'. They and their family and friends did a six kilometres walk within 60 minutes to raise funds. They managed to raise £1,800 to help the stroke team at Sandwell General Hospital buy equipment that will help the team to save more lives in the future.

Dr Amir Ahmad – Consultant in Geriatric Medicine – AMU

Amir normally starts his day at 6am. He helps his wife- who is a consultant at Queen Elizabeth hospital- to get their three children ready for school. Afterwards, he drives to work and arrives at Sandwell General Hospital at around 7:45am.

He then sees the night on call medical team on the AMU (Acute Medical Unit) to get an update of the overnight admissions. Anyone who is acutely unwell is prioritised to be seen first. After meeting with the team, Amir and another consultant will do a walk around the ward to see each patient. Amir starts by introducing himself and asking how the patient is doing. A junior doctor also goes around with him to learn and perform various tasks required like booking investigations and doing discharge summaries.

At around 10am, everyone has been seen, some are already gone with their treatment complete, and the night team have gone home to bed after their handover at 9am. Amir will go to the 'board round' with the junior doctors, senior nurse, and therapist from the Rapid Response Team and a social worker. All patients on the ward are discussed, plans are made and acted on: scans, mobility assessments, transfers to rehabilitation units and medications to take home and follow up tests and clinics as an outpatient.

At 10.30am, after the 'board round' finishes, Amir starts to assess all the frail older patients who are being admitted with a Frailsafe checklist tool. Sandwell Hospital is one of the pilot sites for the nation Frailsafe project of the British Geriatric Society. It is intended to reduce and eliminate avoidable harms in care of frail older patients being admitted to the hospital. Amir and his consultant colleague Dr Nigel Page are currently running the front door frailty service in association with the Rapid Response team.

The work is completed by 12pm, which is when Amir goes for his lunch. After having his lunch break for 30 minutes, Amir visits the Perry Locks care home to see frail patients in collaboration with the General Practitioner. This service is a part of wider integrated care delivery strategy of the Trust and working in collaboration with our primary care colleagues. At 4pm, he finishes his work and spends time checking his email. He then goes to pick up his children by 5pm.

In the evening, after having dinner and spending time with his family, he watches some television or reads about any interesting case presentation that he had seen earlier in the day. Around 10pm, he ends his busy day by going to sleep to make sure he fully recovers for the next day.

Dr Amir Ahmad, Consultant in Geriatric Medicine

Beth Sykes and Hazel Guy from the Rapid Response Physiotherapy Service

NHS HERO

Matron Annabel Morgan, A&E Department at City

With determination and dedication to her job, Annabel is the lead nurse at one of the busiest A&E units in the region.

Annabelle Morgan (38), from Erdington, is an acting matron for the Accident and Emergency (A&E) Department at City Hospital. Her responsibilities include assessing and identifying patients requiring urgent medical care, supporting nursing staff and managing the day to day issues of a fast-paced environment.

Annabel sees the job as a wonderful opportunity for her to stretch herself. She said: "I enjoy the challenging situations I face on daily basis requiring the ability to think and act on your feet. This job gives me great job satisfaction especially when I know I have made a positive difference to the day or the life of patients or relatives.

"Within the A&E department, no two days are ever the same. Patients and medical emergencies vary each day and at times are exceptionally challenging. Not only do I take care of patients and manage staff, I have to ensure that patient flow through the department and other areas within the Trust goes smoothly so that patients are safely taken care of.

"I feel fortunate that I have this opportunity to be working with the A&E team. They are an amazing group of people that work in very challenging and difficult circumstances on a day to day, shift by shift basis. The pressure in A&E at times can be really high and the staff on the whole smile through the tough days and support each other through the difficult times. I have worked in many other departments and have never worked with a team such as the one at City Hospital."

Talking about her decision to nurse, Annabel said: "I have always wanted to work in the medical profession, as when I was growing up I saw firsthand the amazing nursing care my dad received through treatment for some serious medical conditions. This drove me into nursing as I wanted to provide 'hands on' care for patients, and being able to spend time with them and try and make a difference."

Thinking about her next challenge, Annabel is considering whether she should follow the leadership path to advance her career.

Annabel's hero is her father, who had been through so much but chosen to never give up. She admires her father for his strong determination and his optimism under any situation. His spirit has inspired her to always strive forward and overcome challenges that may arise.

Outside work, Annabel loves spending time with her 19-month-old daughter, Sophie. She hopes to introduce her daughter to different cultures by visiting and exploring other countries.

Women's and Child Health

Introduction

The Women's and Children's group includes specialist doctors, midwives, sexually transmitted infections team, newborn baby specialist nurses with community based midwives, sexual health and contraceptive services, children's doctors and gynaecological clinics. This year we integrated the community and sexual health services with the sexually transmitted disease clinics. In 2015 the maternity service achieved recognition for its safety by being awarded an insurance CNST level 3 (The Clinical Negligence Scheme for Trusts) which is the highest that can be awarded. We aim to achieve those standards throughout the whole of our services by the end of 2016.

In 2014/15:

- 5595 ladies had babies.
- 24% required a caesarean section.
- 71% of ladies initiated breast feeding at birth.

Our community midwives provided care to 10,646 women from the Sandwell and West Birmingham areas.

Group Director
Gabrielle Downey
Workforce
1,023 people
Budget
£69,023,000

Key Achievements:

- **Baby Friendly success gives mothers' confidence** - Our Maternity service has just been accredited by UNICEF UK for the Baby Friendly Initiative. The accreditation is the result of 2 years work, led by the Infant Feeding Team, and gives confidence to mums-to-be that the advice they receive from our Maternity team will be consistent and of a high quality.

- **The paediatric department had its three yearly deanery training visit in October to assess the quality of training provided to the 27 trainees in the department.** - Dr Helen Goodyear, the lead of the visit and Head of the School of Paediatrics, commented on the high quality education and training, and good educational supervision, with supervisors being proactive in undertaking work based assessments and access to clinics which provide a good learning opportunity and constructive feedback.

- **A novel technique for hysteroscopic surgery training developed in the Trust** - Consultant gynaecologist, Ayman Ewies, organised a national workshop to teach advanced hysteroscopic surgical skills, a first for the Trust. Only about 10% of consultant gynaecologists are in the UK able to perform advanced hysteroscopic surgery.

- **SWBH Paediatric Team presented in Paris** - The Paediatric team, led by Dr Rasieka Jayatunga, consultant paediatrician, travelled to Paris to present its work on Improvement in Quality & Safety in Healthcare organised by the British Medical Journal. Dr Jayatunga's team presented two posters which focussed on 'Reducing Medication Errors' and 'Lessons Learnt from a Near Miss Never Event'.

- **Speech and language work with school is something to shout about** - Using the skills of the Trust's speech and language therapists for two days a week has led to significant improvements in the communication skills of the children they have been working with at a Tipton School.

Halcyon Midwife Led Birth Centre

Emma Meah and her baby Sherbaz Shaheen

A Mother's Story

Amy went into labour and when she arrived at Serenity, she was met and cared for by midwife Helen who she had previously met. After being shown into a room and checked over Amy was found to be in established labour and opted to use the birthing pool for pain relief and relaxation. Amy progressed smoothly and had a beautifully calm and controlled water birth of a little girl. Amy commented that she found the use of the pool 'calming and relaxing in her labour', which helped minimise her need for any further pain relief. She opted for a physiological third stage of labour and birthed the placenta in the pool whilst having skin to skin contact with her new daughter.

Following the birth, dad also had chance for skin to skin contact with his new daughter.

Both Amy and her husband were delighted that they felt that they had managed to establish a good relationship with the midwife. They both said they 'felt comfortable and in control' during the birth processes. This, along with the environment and facilities in the birth centre, was conducive to reducing the fear and pain that was originally anticipated. Both commented that the unhurried atmosphere meant they had precious time bonding with their baby during those first few magical moments.

Normally, most mums are able to return home within a few hours of birth but Amy's baby required extra observations. Amy and her husband spent this time on Serenity as a family, enabling them both to get to know their baby. After 12 hours, the baby was well and discharged home with her parents.

On leaving the unit, Amy wrote the following in our guest book: "AMAZING!! From the time we arrived to the time we left everyone who works in Serenity is so helpful and friendly…"

Day in the life of 'Serenity Midwife' - Helen Giles

After starting her day with a quick cup of tea at 07:10am, Helen Giles starts her shift in the Serenity Birthing Suite by saying hello to a couple who became a family of three overnight.

At 7.45am, Helen receives a phone call from Sue, expecting baby number three. Her waters had broken and she wanted to come in. Room two was prepped as they anticipate a quick birth and at just after 8.15am, the first baby of the day is born, a beautiful baby girl, which sends the dad to tears as it is their first girl.

Just as Helen is going through paperwork later in the morning, the emergency buzzer goes off. But, it was a false alarm, someone had pulled it accidently in the toilet in the waiting room, having thought it was the light switch.

By 10.20am, Serenity had its second birth of the day and it wasn't going to be long before it had its third. Tara is brought into the suite by her mother Nicola. On examination Tara is found to be in good labour. We discuss options for pain relief and begin to fill the pool; Tara is shown how to use Entonox. The oils are used to give her a massage to help her relax as Nicola is shown how to do this to help with her daughter's care. The baby's father Joe is on his way by 11am so that Tara has both of her birthing partners.

The staff received a nice surprise in the afternoon, as a Mum returns with her baby, some chocolates and a thank you card. She had travelled a long distance to give birth at Serenity after hearing about how good the facilities were. At 3pm, Tara felt her baby coming so the staff prepped a room for the birth and within 45 minutes, Joe was cutting the umbilical cord of the lovely baby boy.

The rest of the shift consists of paperwork and meetings for Helen before she can handover to the staff coming in for the night shift at 7.30pm. She gets to then go home, albeit a little bit achy from a hectic day but feeling very happy for the new families she helped to bring together.

Midwife Olivia Agar

What drives a young woman to become a midwife? To be a champion of breast feeding and to work tirelessly to support women in the choices they make for the most important event in their lives?

Mother-of-three Olivia Agar (36) explained: "I became a midwife in my mid-twenties, as I have always been fascinated by pregnancy and the science that creates life from a group of cells. To be part of such a special event is an enormous privilege and I couldn't imagine doing anything else.

"I have worked for Sandwell and West Birmingham Hospitals NHS Trust for six years, as it is an amazing forward thinking trust with committed staff and supportive management. I am so proud of our midwife-led units – Serenity at City Hospital and Halcyon in Smethwick. It is a real joy to share the delight of women seeing the facilities for the first time, as they are overwhelmed by how different they are from traditional NHS hospital environments."

Olivia is part of the Infant Feeding Team which is working towards informing women's choice to breastfeed their babies.

She said: "There are numerous benefits of breastfeeding for both mother and baby, including less chance of the baby developing diabetes, asthma, eczema, chest infections, ear infections, gastroenteritis and for the mom it reduces the chance of breast cancer, ovarian cancer and osteoporosis. Evidence shows that one of the biggest reasons women cease to breastfeed is feeling unsupported, so we are determined to demonstrate our commitment to women to provide the help they need, and make a real difference to new moms in this area."

A keen cook, Olivia loves to spend time in her kitchen creating delicious dishes for her family and friends, although she jokes that her cakes need work.

From left to right: Our inspiring midwives Norma Palmer, Esther Romaine, Hannah Beynon and Isabel Gallego-Ballester

Richard Ormonde attends training with our new resuscitation simulator

Introduction

The corporate group comprises seven large teams: Estates; nursing and facilities; organisational development, including communications; chief executive's team, including governance, risk and strategy; operations; the medical director's team which includes informatics; and finance and performance management.

Each makes a vital contribution to the delivery of services on a day to day basis, as well as ensuring that service delivery tomorrow is well prepared for the future. Key performance indicators for each part of the corporate group have been established to govern the functions provided to teams across the Trust. During 2015/16 the Board intends to review all corporate functions to make sure that those that deliver routine transactional processes are able to do that with increased efficiency in support for clinical staff.

Chief Executive
Toby Lewis
Workforce
2000 people
Budget
£68,000,000

Corporate

Ten Key Achievements:

- Risk registers were completely reviewed across the organisation and made available electronically to all employees internally. Later in 2014/15 ongoing staff feedback about our incident reporting systems led to further changes to improve effectiveness and encourage even higher rates of reporting.

- Led by our estates team, the Trust continues to hold down energy costs. Our sustainability report is included in chapter 8 of this annual report. It shows us eliminating landfill, investing to tackle both electricity usage and more sustainable forms of supply.

- The complaints process for the Trust has been completely changed. Local clinical investigators now drive our examination of concerns, supported by a central team. Our PALs service handles more than 2,000 informal queries each year.

- Our patient environment (PLACE) results remain very strong when compared to others in the West Midlands: 22 of our 24 scores are rated as green, with no red ratings. All three sites achieved over 99% for cleanliness. This though remains a focus for work, based on our own studies and those of the TDA and CQC. The 100 year+ age of some of the Trust's estate creates issues for us to overcome on a daily basis.

- Research and development forms a key responsibility for the Trust. A three year plan is now in place, backed by significant investment. To succeed in our headline aim of trebling trial recruitment by 2018, we will need to both build on current strengths, in collaboration with the University of Birmingham, and identify new areas for growth, in collaboration with primary care researchers.

- Corporate nursing and the medical director's team continue to focus on amenable mortality, by improving mortality review coverage. Sepsis remains the major opportunity which by better identification and rapid care we can treat better. The Trust's Lead Sepsis Nurse has launched a country-wide forum for peers to share ideas on what works.

- We continue to provide benefits and support services to staff. In year we launched salary sacrifice schemes for both cars and bicycles. Our nursery provision goes from strength to strength and Ofsted have commended our service noting that "staff show high expectations of themselves, and the children they are for".

- Occupational health services were awarded on of our Trust's prestigious beacon awards for excellence. The team won flu vaccination prizes in national awards for the second year in a row. In 2015-2016, as we tackle our sickness rates, we will be focusing on musculo-skeletal services, as well as broadening the reach of our mental health support services, in which we have invested over the last twelve months.

- The Trust has contingency plans in place for major incidents and we prepared for the possibility of Ebola in response to its rise in West Africa last year. Working to national guidance standards, the Trust implemented number of preparations to safely deal with suspected cases. The measures included updating our viral haemorrhagic fever policy, which was completed in late Spring 2014. We produced and tested an algorithm which worked well – as was proved each time a case came through with suspected symptoms. Our Infection Prevention and Control team worked to ensure all emergency staff were comfortable with how to safely put on and take off their PPE (Personal Protection Equipment.) We increased our stocks of PPE and installed boxes of equipment for high risk cases in both emergency departments so it was on hand at short notice. Additionally we introduced two days of FFP3 (offering the highest level of protection from the virus) mask training and introduced wellington boots to maternity as an additional precaution.

- The first step into a new world of shared information where we are able to access GP information on patients direct from our own Clinical Data Archive (CDA). Your Care Connected (YCC) is a ground-breaking health information exchange project in the West Midlands, which went live in March 2015. There are not many hospitals in the UK where clinicians can access their patient's GP record directly from their own EPR. The initial phase is called proof of concept [POC], during which high volume specialities such as the emergency department and ophthalmology are most likely to find the new function useful. The purpose of POC is to see that this can work in clinical practice and to gather an evaluation of information from clinicians and patients.

Somewhere to relax at Sandwell Hospital

Ten out of Ten

Last September we launched our new Ten out of Ten initiative, which is made up of 10 quality standards, drawn up as a check list, that sits inside the patient's bedside folder. It aimed to become the Trust's number one quality initiative helping to improve safety and reduce harm to our adult inpatients.

Colin Ovington, Chief Nurse, said: "All the items on the Ten out of Ten checklist are things that are already done and are recorded in patient notes and doctors' and nurses' documentation – the change is that the Ten out of Ten checklist brings them all together, demonstrating to our patients that we take their safety seriously. If we are not doing them, patients and relatives should feel comfortable and empowered to ask why not.

"If we can get this right every time with every patient, they will be much safer and the more importantly, they will also feel much safer." The Ten out of Ten campaign is ground-breaking in the region, designed to drive a culture change in ward environments where patients and multidisciplinary teams work as partners to explore the balance of power in terms of patient safety and experience.

The Ten out of Ten standards are:

STANDARD	PATIENT EXPECTATION
1 Positive patient identification	We will ask your name, address, date of birth and match these details to your wristband before admitting you
2. Mental capacity	We will ensure you (and with your permission, your carer) have all the information you need to make decisions about your care and treatment options
3. Baseline observation	On admission, a registered nurse will observe and record your temperature, blood pressure, pulse, height, weight and breathing and take any appropriate action
4. Medication/allergies	We will check and record your current medication and any allergies
5. Pain control	We will assess your levels of pain and offer you appropriate pain relief
6. MRSA screening	We will test you for MRSA, as well as other hospital bugs, and give you appropriate treatment
7. Waterlow/Falls risk assessment	We will assess your risk of developing a pressure ulcer (bed sore) or falling, and take all relevant action
8. VTE	We will assess your risk of developing a blood clot (venous thrombo-embolism or VTE) and prescribe any appropriate treatment
9. MUST	We will assess your fluid levels and identify and record any special dietary requirements
10. Health promotion	We will review your lifestyle choices (healthy eating, smoking, alcohol, drug/solvent abuse) and offer appropriate support and advice

Occupational Health Service receive beacon award for excellence

Dottie Tipton, Primary Care Liaison Manager

The NHS is the largest employer in Europe. It is a vast organisation that spans all of healthcare including GP surgeries and hospitals. Keeping communication links between the GPs and the hospital is crucial. Dottie Tipton is that link.

Dottie, from Staffordshire, is Primary Care Liaison Manager at Sandwell and West Birmingham Hospitals NHS Trust. She said: "I work with GP practices keeping them informed of things happening in the trust. Practices can contact me if they are having problems with things at the Trust. I help organise education events for GPs and work with the rest of the Strategy team on long term plans with teams in the Trust."

Dottie has had quite a few highlights in her career at the Trust. She commented: "I read a patient story out to 300 primary care staff in the patient's own words and I have helped the diabetes team change the way they work so now they deliver care in local GP practices alongside GPs and practice nurses."

When asked what drives her at work, Dottie said: "Working with talented people to make services the best they can be for everyone. I work within a small team in the Trust, mostly on strategic pieces of work. Outside of this team I work with hundreds of people in and outside the Trust. I have just been involved in moving diabetes services. Our current team project is developing the Trust's vision for the year 2020."

The perks of the job for Dottie are meeting people and getting the job done, something she gets to do a lot in her role. Away from work, Dottie enjoys a range of activities as well as spending time with her family. She said: "I like to read, travel, occasionally I do amateur dramatics and I, with a team of local volunteers, organise a biannual music festival in the village I live in."

Dottie also likes to spend time with her family and friends. Her children Oli, 21, and Abbie, 18, are both at or heading off to university. Oli is studying maths in Manchester and Abbie is waiting for her A level results and hopes to follow her brother to Manchester but to study history. To get away from it all Dottie likes to travel to Croyde in Devon.

As well as being an NHS Hero, Dottie has her own hero. She said: "My hero is a gentleman who is no longer with us called Mr Whitehouse. He lived in our village into his 80's and fostered along with his wife over 30 children, six of whom they adopted. When I met him in his late 70's he was volunteering at school listening to year 2 pupils read, both my children read to him. He was the kindest most thoughtful person I have ever met."

Ofsted rated Sandwell nursery as good in their recent inspection

DIARY

A day in the life of Mariola Smallman, Head of Risk Management,

Mariola's day starts with the alarm clock waking her and her husband up at 6.15am.Today it's her turn to make the coffee. (Mariola and her husband take it in turns to make the coffee, which means every day one of them can cheerfully tell the other it's their turn.) She leaves the house by 7.40am and gets to work about 8.20am.

Her work area is across patient safety, health and safety and information governance. A typical Monday starts with Mariola reviewing and following up emails and incidents on the daily logs – there's always a flurry of activity after the weekend. This morning she had a teleconference meeting with a colleague about a serious incident investigation. This week she will have several meetings and committees to attend plus committee reports to write. She often receives requests from colleagues who need incident or risk information urgently – whether it's because clinicians are meeting with patients or their families or because a short deadline was imposed on them, so she deals with these as a priority.

She's currently working on the implementation of an electronic risk register system and is liaising with colleagues to ensure she obtains current versions of their risk registers so she can review and ask the company to import them onto the system. After which she runs some tests on it before the roll-out to end users commences. She receives calls from colleagues who want to run particular reports on the incident reporting system so she helps them with those or creates a report for them to run themselves.

Mariola's afternoon is spent finalising a template information governance risk assessment for local managers to use, and reviewing a draft information governance related policy.

She usually leaves work between 4 – 5pm, to collect her son and start making dinner when she gets in. She always sits down to eat with her family at about 7pm. Sometimes she works on her laptop depending on deadlines and whether or not her husband is watching football or lately "how to build castles" or she'll read articles on her i-pad.

Alice Demuth, Infection Prevention and Control Nurse Advisor in her PPE as part of our ebola preprardness

5. Our care and quality of services

Staff Nurse Ian Hartland observing good hand hygiene practice

Improving Quality and Safety: Our Quality Account 2014/15

Introduction

This chapter forms our Quality Account for 2014/15.

Quality Accounts are annual reports to the public from NHS healthcare providers about the quality of the services they deliver. Their purpose is to encourage the organisations to assess the quality of the services they provide and to continuously improve the quality of care provided to patients and their families. This Quality Account is a report which covers:

- How we performed against our priorities for 2014/15
- How well we performed against targets set by our Clinical Commissioning Group (CCG)
- How well we performed against targets we have been set by the Department of Health
- How well we performed when compared to other Trusts
- Our priorities for 2015/16

Statement of Directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2012 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable and conforms to specified data quality standards and prescribed definitions, and is subject to scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Trust's directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

Peer Group

National Trust Development Authority guidance requires data to be reported against an agreed peer group, so that stakeholders can assess relative performance. For this Quality Account we have kept the same group of peers identified for last year. The peer group is a mix of Foundation Trusts, non-Foundation Trusts, Local and Inner City Trusts with a geographical spread and similar levels of activity to Sandwell and West Birmingham NHS Trust. It was also vital that there was access to data with which comparisons could be made.

The Trusts are:

- Bradford Teaching Hospitals NHS Foundation Trust (BTH)
- Kings College Hospital NHS Foundation Trust (KCH)
- Royal Liverpool and Broadgreen University NHS Trust (RLBUH)
- Royal Wolverhampton NHS Trust (RWH)
- University Hospital Bristol NHS Foundation Trust (UHB)
- Worcester Acute Hospitals NHS Trust (WA)
- Northumbria Healthcare NHS Foundation Trust (NH)

How we performed against our local priorities for 2014/15

In our quality account for 2013-14 we set out five priorities for the year ahead, now the year just completed. These were reflected in our annual plan agreed by our own Board, and with our regulator the Trust Development Authority.

In summary, we made really encouraging progress on mortality and on public health. Re-admissions saw considerable work, but as yet our overall outcomes have not changed by as such as we wish. This remains a priority for 2015-2016, as outlined in chapter 9 of this report. The same sense of more to do applies to outpatient change and to Ten Out Of Ten. Implementation has happened in part, albeit outpatient change has been slowed by some technology dependencies. We will keep going until we deliver the results we promised our patients.

Aims	Latest Assessment	Did we achieve our goals?
Focus Area 1: Readmissions		
Embedding the use of the LACE tool.	We have used the LACE tool with patients with complex needs and involved community staff working closely with colleagues on two wards. This offered better support to patients on discharge and use a multi-disciplinary approach to ensure the patient's complex needs were met.	✓
Improving the quality and timeliness of information provided to GPs on discharge.	A new discharge summary is shortly to be rolled out that will include identification of patients at high risk of readmission with plans to support them in the community.	✗
Implementation of evidenced based discharge bundles for patients with Respiratory disease and Heart Failure.	COPD, Brochiectasis, Community Acquired Pneumonia are all complete and published on our intranet.	✓
Improving specialist advice at the front door through initiatives such as a Cardiologist in AMU and the front door Geriatrician.	Cardiology have introduced 'Hot Clinics' and there is now a front door Geriatrician as part of the Fail Safe project.	✓
Improving integration of hospital, ambulance, primary care and community teams – with a system of alerts for patients at risk of readmission.	This is partially done. The Respiratory Team have set up an alert system internally and with community teams, but as yet we have not linked this to primary care or ambulance services.	✗
Conduct an audit into the 'last year of life' – looking into reasons for multiple readmissions.	The End of life audit is complete. In May 2015 we are holding a workshop to look at Advance Care Planning. End of Life care planning and choice remains a priority for 2015/16.	✓

Aims	Latest Assessment	Did we achieve our goals?
Focus Area 2 – Reducing preventable deaths (mortality)		
Improving our mortality review system with the aim of reviewing 100% of deaths within 42 days by the end of the year.	Since our last report we have set up a mortality database to better manage the allocation of our mortality review process. There has been an improvement on last year's figures, but not yet to our stretch standard.	✗
Investigating differences in mortality between the weekend and week days and improving seven day services.	We have seen a reduction in the difference between mortality rates in the week and at weekends.	✓
Improving the process of death certification and referral to the Coroner. An electronic system for referral and recording of death will be used.	Notes of deceased patients are now scanned. An electronic system for referral to the Coroner has been implemented across the Trust.	✓
Introduction of Vital Pac – the electronic recording and monitoring of patients' vital signs. All adult acute wards will have Vital Pac by September 2014.	Vital Pac was successfully rolled out to all acute adult wards by September 2014. This year we are going to extend this to paediatrics and A&E and with other modules to promote safe care.	✓
Continuing with the work to improve the recognition and response to patients' sepsis. Increasing the percentage of patients who screen positive for sepsis and receive the sepsis six care bundle.	The role out of Vital Pac has helped with the identification of patients with sepsis. We have seen a comparative increase in the number of patients receiving the sepsis six bundle and a reduction in the number of patients with severe sepsis.	✓
Improving the prevention of hospital acquired venous thromboembolism (HAVTE) – improving risk assessment, prophylaxis and conducting root cause analysis on all HAVTE cases. More than 98% of inpatients to be risk assessed.	We met the national standard of 95%. We fell short of our own goal of 98%. We continue to address this, with a particular focus on ensuring improvement in obstetrics and gynaecology.	✗
Focus area 3 – Year of Outpatients		
Letters to patients and their GPs following appointments will be sent within five days.	We are now ensuring that letters are copied to patients and their GPs. In March 2015 we increased the numbers of letters sent within five days from 19% to 29%. This remains far short of our standard. Weekly monitoring is now being in place to address backlogs in either dictating, typing or signing off correspondence.	✗
Hospital led cancellation of appointments will be a rarity.	This has not yet been achieved because we have not yet implemented partial booking. We now expect to do so from autumn 2015. This change, combined with implementing a changed capacity plan during 2015-2016 will help to both reduce waits and cut hospital initiated cancellations.	✗
Patients will be informed that we have received their referral.	Since February 2015 an acknowledgment letter is sent to all patients when the Trust receives their referral, reducing uncertainty about care.	✓

Aims	Latest Assessment	Did we achieve our goals?
Focus Area 4 – Public Health Implementation		
Formally launch the strategy 'Our Public Health Plan' by June 2014.	We launched our plan in June 2014 as planned.	✓
Promote Health Improvement training in the Trust including the Making Every Contact Count (MECC) programme, focusing on giving staff the skills in very brief interventions for stopping smoking, reducing alcohol consumption and making lifestyle preventions for patients and employees.	Our goals and actions are not yet fully achieved. We are improving how we capture and evaluate health promotion interventions.	✓
Promote Health Improvement training in the Trust including the Making Every Contact Count (MECC) programme, focusing on giving staff the skills in very brief interventions for stopping smoking, reducing alcohol consumption and making lifestyle preventions for patients and employees.	During 2015 we will engage our staff in health promotion training to ensure the workforce are confident in advising colleagues, patients and relatives about prevention and be able to signpost for further advice if required. We have improved the range of healthy food in the cafeteria and other food outlets, and reduced its cost, to encourage better diet in staff, patients and visitors.	✓
With our partners in Public Health Departments, implement an integrated information technology support system across the Trust's computers to assist staff training in health promotion and referral of patients for formal smoking, alcohol and lifestyle counselling.	We are improving how we capture and evaluate our health promotion interventions. Data collection on employee lifestyle choices is progressing.	✓
We will offer lifestyle support services to our patients, staff and the wider local community in partnership with other agencies and organisations.	We have obtained a significant grant from the Trust Charity to improve how we deal with people who need particular help to reduce their drinking, increasing use of alcohol screening and referral to our alcohol treatment partners.	✓
Formally adopt the principles of the Health Promoting Hospitals Network into our Trust's mission statement, policies and procedures by December 2014.	Achieved.	✓
Make contact with other organisations locally, nationally and internationally to further develop our reputation and capability in Public Health.	We have engaged with our local authority Public Health Departments, local and national organisations and charities to establish links.	✓
Focus Area 5 – 10/10 Patient Safety Standards		
Implement a programme aimed at ensuring that we do everything possible to prevent harm being experienced by any patient	The 10/10 safety standards were implemented last year to improve safety by initiating checks and taking action to prevent harm. Although we have launched our 10/10 programme we have set ourselves achievement targets that are higher than national standards such as 100% compliance for VTE assessment and MRSA screening. We have not yet achieved these targets.	X
We want patients to know about our 10/10 Patient Safety standards and will be placing a copy beside every bed in our hospitals.	We have a wide range of information including posters, banners, leaflets and checklists that describe the standards.	X

KPI (Key Performance Indicators) 2014/15

Access Metrics	2014/15	Target
Cancer – 2 week GP referral to first outpatient appointment	93.5%	=>93%
Cancer – 2 week GP referral to first outpatient (breast symptoms) appointment	94.7%	=>93%
Cancer – 31 day diagnosis to treatment for all cancers	98.6%	=>96%
Emergency Care – 4 hour waits	92.52%	=>95%
Referral to treatment time < 18 weeks non admitted	95.09%	=>95%
Referral to treatment time < 18 weeks admitted	90.41%	=>90%
Referral to treatment time – incomplete pathway < 18 weeks	93.15%	=>92%
Acute diagnostic waits > 6 weeks	1.03%	<1%
Cancelled operations	0.78%	=<0.8
Cancelled operations (breach of 28 day guarantee)	0.71%	0%
Delayed transfers of care	3.76%	=<3.5%
Outcome Metrics		
MRSA Bacteraemia	5 cases	0
Clostridium Difficile	29 cases	<37
Mortality reviews	84%	=>80%
Risk adjusted mortality index (RAMI)	88 RAMI	<100
Summary hospital level mortality index (SHMI)	95.7 SHMI	<100
Caesarean Section rate	23.9%	=<25%
Patient safety thermometer – harm free care	93.5%	=>95%
Never Events	0 cases	0
VTE risk assessment (adult inpatient)	97.8%	=>95%
WHO Safer Surgery Checklist	99.9%	=>98%
Quality Governance Metrics		
Mixed sex accommodation breaches	105 cases	0
Patient Satisfaction Friends and Family response rate (inpatient wards and Emergency Care)	43.2/21.9%	>28/>20%
Patient Satisfaction Friends and Family score (inpatient wards and Emergency Care)	72/52%	>68/ >40%
Staff sickness absence	4.69%	=<3.15%
Staff appraisal (as at 31 March 2015)	90.5%	=>95%
Medical staff appraisal and revalidation	92.8%	=>95%
Mandatory training compliance (as at 31 March 2015)	87.6%	=>95%

Clinical Quality and Outcomes	2014/15	Target
Stroke Care – patients who spend more than 90% stay on Stroke Unit	91.77%	=>83%
Stroke Care – Patients admitted to an Acute Stroke Unit within 4 hours	79.42%	=>90%
Stroke Care – patients receiving a CT scan within 1 hour of presentation	71.48%	=>50%
Stroke Care – Admission to Thrombolysis Time (% within 60 minutes)	80.28%	=>85%
TIA (High Risk) Treatment within 24 hours of presentation	98.10%	=>70%
TIA (Low Risk) Treatment within 7 days of presentation	97.11%	=75%
MRSA screening for elective patients	96.90%	=>80%
MRSA screening for non elective patients	82.52%	=>80%
Inpatient falls – Acute	811 cases	<660
Inpatient falls – Community	184 cases	<144
Hip fractures – Operation within 24 hours	69.5%	=>85%
Patient Experience		
Complaints received – Formal	837	
Patient average length of stay	3.7 days	=<4.3
Coronary Heart Disease - Primary Angioplasty (<150 mins)	90.95%	=>80%
Coronary Heart Disease – Rapid Access Chest Pain (<2weeks)	92.7%	=>98%
GU Medicine – patients offered appointment <48 hours	100%	N/A

Disabled car parking Sandwell Hospital

How well we performed against targets set by our Clinical Commissioning Group (CCG)

CQUINs (Commissioning for Quality and Innovation)

The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals. The regime operates on a fines basis.

The Trust works closely with the commissioners to develop the quality schemes. The contract value for 2014/15 was £8.328 million. The table below details the CQUINs for 2014/15 and the outcome at the end of the year. As there were two areas that were only partially achieved (Dementia – Find, Assess, Investigate and Refer and Community Dietetics) the actual income received was £7.956 million.

CQUIN Target	Compliance
Family and Friends Test	✓
Dementia - Find, Assess, Investigate and Refer	X
Learning from safeguarding concerns	✓
Reducing mortality due to Sepsis - Implementation of Sepsis Six	✓
Eliminate the pain review process that leads to variation in patient's experience of pain relief.	✓
Medication and falls	✓
Serious Untoward Incidents / Never Events	✓
Community Dietetics	X
Maternity	✓

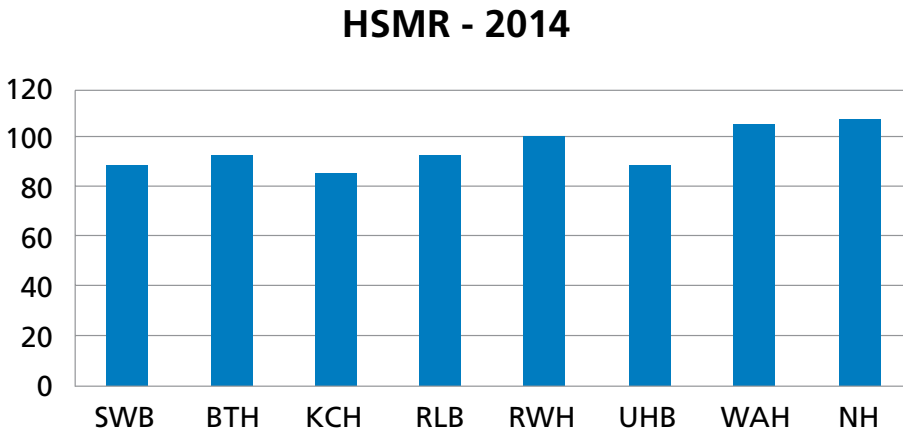
City Hospital on the Dudley Road

How well we performed against our targets set nationally

Mortality

Our current performance

Mortality data is now extracted from CHKS system which reports the Risk Adjusted Mortality Index (RAMI) as the principle measure of an organisation's mortality. We also have HSMR as a comparator with our peers. (Last year we used Dr Foster).



HSMR (Hospital Standardised Mortality Ratio) data for the Trust and peers (lower is better)

The Trust's RAMI for the most recent 12 month cumulative period (December 2014) is 88, which is equal to the National HES peer RAMI of 88.

The aggregate RAMI for both sites of the Trust are within statistical confidence limits with RAMI of 108, beneath that of the National HES peer that has a RAMI of 113.

Mortality rates for the weekday and weekend low risk diagnosis groups are within or beneath the statistical confidence limits. This data is derived from HED for the Summary Hospital Level Mortality Indicator (SHMI). The SHMI includes all deaths up to 30 days after hospital discharge and is currently 95.7 for the Trust.

Mortality Comparisons against National results

	Lowest	Highest	SWBH
Observed	396	4316	2046
Expected	663.7	4121.2	2128.2
Score (SHMI)	.88	.95	.93*

The data above compares our mortality figures against all other Trusts nationally.

A Trust would only get a SHMI value of one if the number of patients who died following treatment was exactly the same as the expected number using the SHMI methodology.

* The values for the Trust must be taken from 2 different periods as reported by HSCIC, and include the lowest and highest value for other Trusts from the reporting period, by way of comparison.

The Trust also monitors its SHMI value taken from a national benchmark data provider (HED) site and includes this within its various mortality and performance monitoring reports. This data is available for a more recent period than is available from the HSCIC website.

Mortality rates are an important indicator of quality of care and last year (2014/15) we set ourselves a target of reviewing 100% of all hospital deaths within 42 days. By reviewing the care given we can identify areas where learning can take place to improve outcomes for our patients. Although there has been an improvement in the numbers reviewed within 42 days we have not achieved our target and will keep this as a priority for 15/16.

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4
Deaths total	107	102	109	318	99	118	128	345	138	109	181	428	183	136	141	460
Reviewed	96	87	96	279	72	91	100	263	114	90	168	372	165	117	114	396
% Reviewed within 42 days	89	85	88	87	72	77	78	76	82	82	92	86	90	86	80	86

Deaths with Palliative Care

The table below provides information relating to the number of deaths at the Trust where there was a diagnosis of palliative care made.

Total number of deaths	Palliative Care	%
1586	304	19.16
Score (SHMI)	.88	.957

Palliative Care : Any diagnosis code = Z515

Sepsis

A success for 2014/15 was the implementation of Vital Pac, an electronic recording and monitoring system for patient's vital signs (temperature, pulse, blood pressure and respirations). The system identifies those patients whose vital signs trigger an 'early warning score' and alerts the need for intervention. This system is now on all acute wards in the Trust. The implementation of Vital Pac has also helped us to improve the identification of patients with sepsis. This was another area where we said we would improve. Our aim was to increase the percentage of patients being screened positive for sepsis receiving the Sepsis Six bundle of care to 50%. This was also a CQUIN for 2014/15 and the CCG set an exit trajectory of 65%. The trajectory was achieved but there remains work to be done and the CQUIN for 2015/16 focuses on the Emergency Department as well as the Acute Medical Units.

Data for Quarter 4 sepsis audit

Audit forms completed	Patients that trigger screening tool	% of patients that trigger screening tool	Patients where screening tool was used	% patients where screening tool was used	Patients requiring Sepsis Pathway	Patients with Sepsis Pathway commenced	% patients with Sepsis Pathway commenced	Patients that received bundle within Golden Hour	% patients that received bundle within Golden Hour
277	219	79%	87	40%	140	68	49%	59	87%

Infection Control

Target	Agreed target/rate [Year end]	Trust target/rate [Year end]	Compliant	Comments	
MRSA Bacteraemia	0	5	No	**Pre 48hrs** 2 = City Site 1 = Sandwell Site	**Post 48hrs** 2 = Sandwell Site
				All Pre and Post 48 hrs bacteraemias have a post infection review to identify issues and lessons learnt.	
C.difficile acquisition toxin positive	37	29	Yes	22 = Sandwell Site 7 = City site	
MRSA Screening - Elective	80% (locally agreed)	96.90%	Yes		
MRSA Screening - Non Elective	80% (locally agreed)	82.52%	Yes		
Post 48hrs MRSA Bacteraemia (rate per 100,000 bed days)	N/A	0.05		All Post 48 hrs bacteraemias have a post infection review to identify issues and lessons learnt.	
Post 48hr E Coli Bacteraemia (rate per 100,000 bed days)	N/A	0.18		All Post 48 hrs bacteraemias – urinary catheter related have a post infection review to identify issues and lessons learnt.	

Blood culture contamination rates (Target = 3% by Ward, dept. and site.)		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	City	2.3%	3.6%	2.6%	3.2%	2.0%	2.9%	2.5%	3.0%	3.3%	2.3%	4.1%	2.9%
	S'well	3.7%	2.8%	2.8%	2.9%	5.7%	4.2%	5.1%	2.7%	3.7%	3.5%	5.1%	3.1%
	It needs to be recognised that due to the clinical condition of some patients there is a risk of obtaining an unavoidable blood contaminant. However, any Clinician identified as taking a contaminated blood culture is required to attend for further training to reiterate practices. In addition to this, since August 2014 the team has introduced a training programme for all new doctors to the Trust.												

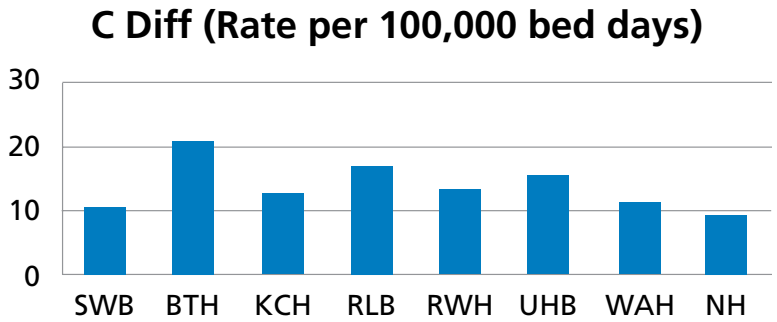
During 2014/15 there were a total of three ward closures that were attributed to diarrhoea and/or vomiting. Closures by site equated to one at City, two at Sandwell. The outbreaks involved a total of 39 patients and one member of staff. Wards were closed for a total period of 32 days with a range of between nine and 13 days dependent upon severity of the outbreak.

Key to maintaining standards is continued commitment and compliance with infection prevention and control policies by clinical and non-clinical Groups and healthcare personnel. Audit and training continues to be prioritised as a means of monitoring and delivering continuous improvements.

C difficile comparisons against national results

	Lowest	Highest	Average	SWBH
C Diff - number of reported infections	1	144	31.4	29
C Diff infection rate per 100,000 bed days	25.6	1.2	13.9	16.1

The data above compares our C Diff rates against all other Trusts who report C Diff infections. This includes specialist units.



Never Events

Last year we reported one Never Event which occurred in the previous financial year. 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.

The published list has been revised by NHS England but incidents which have occurred at the Trust, such as 'Wrong Site Surgery', 'Retained Instruments or Swabs' and 'Wrong Implant' will remain. The following table gives an overview of the Never Event that we reported:

Incident	What Happened	Where it happened	What we learned
Retained guide wire (January 2014; reported June 2014)	Retained guide wire is thought to be from a PICC line insertion undertaken at the end of January 2014.	This incident occurred at City Hospital under the care of ENT.	The root cause was a failure to follow the Trust policy on the introduction of a new device or procedure. There were inadequate safety controls to ensure appropriate governance process around the use of and introduction of a new device. The Insertion, Management and Removal of Midline Catheters policy has been updated, including the development of a Standard Operating Procedure (SOP) re device storage/distribution/access/ logging/who can insert/where the procedure takes place. Specific competency based training is now in place.

During the year a review of never event controls was carried out for those which have not happened at the Trust. This review examined controls in place which are intended to reduce the likelihood of these never events happening.

Incident Reporting

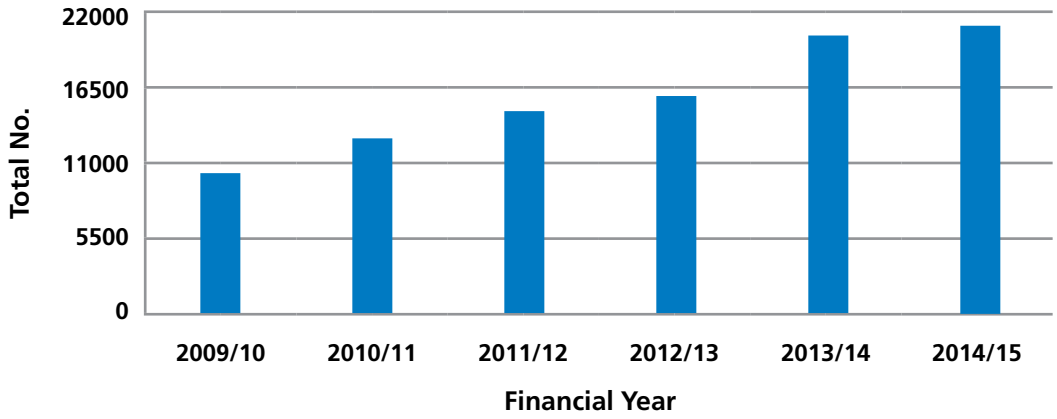
Safety culture or climate remains essential for the delivery of high quality care. We continue to submit incident data to the National Reporting & Learning System (NRLS) which is publically available and provides comparative data with like sized Trusts. For this reporting period (April-September 14) the NRLS has grouped acute non-specialist Trusts together meaning that we are benchmarked against 139 Trusts, where previously it was 38-40. The comparative data shows that as at the September 2014 report we remain in the highest 25% of Trusts with a reporting rate of 51.65 per 1000 bed days. This is a change from previous reports which showed us measured per 100 admissions.

Date	Average rate of reporting per 100 admissions	Best reporter/ 100 admissions	worst reporter/ 100 admissions	Number of incidents resulting in severe harm	Percentage of incidents resulting in severe harm	Number of incidents resulting in death	Percentage of incidents resulting in death
2011/12	6.29	9.82	2.34	86	1.15	14	0.2
2012/13	9.58	12.65	2.49	32	0.32	19	0.15
2013/14	11.13	12.46	1.72	24	0.2	16	0.1
2014/15*	51.65	74.96	0.24	14	0.2	3	0.0

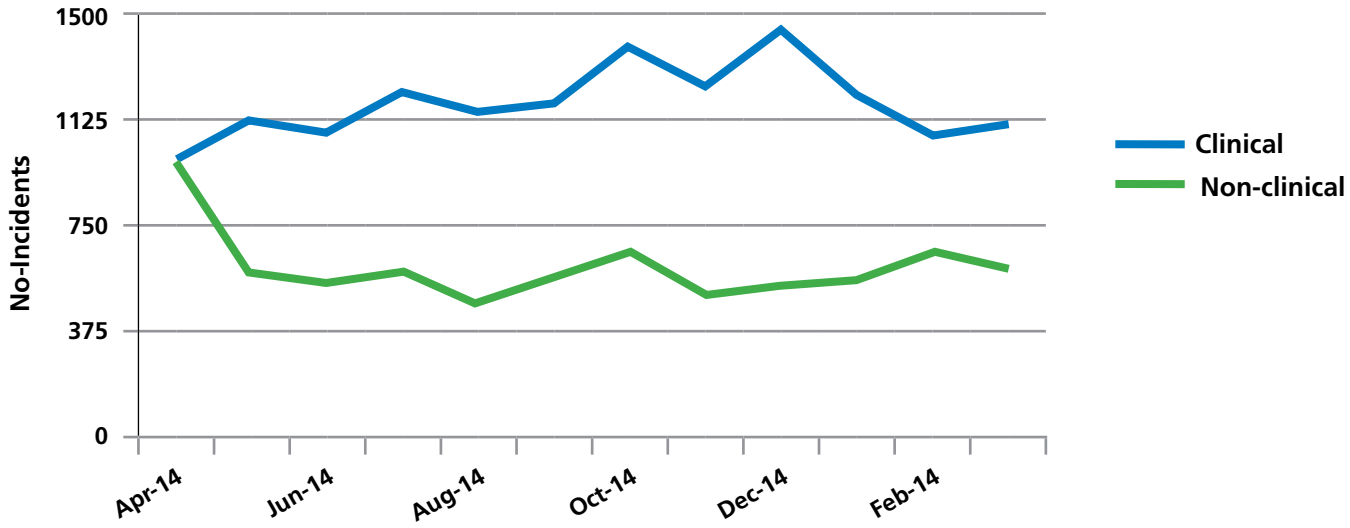
2014/15* this data has changed to be average rate of reporting per 1000 bed days.

The latest data (April - September 2014) shows we have improved our position in the rate of reporting remaining within the top 25% of large acute Trusts. The data shows an improving position for incidents which result in severe harm and which result in death. The table shows our position per 100 bed days as compared against the best and worst reporters and the previous financial year's position on reporting of degree of harm.

Total Incidents reported by financial year 2009/10 to 2014/15



Types of Incidents 2014/15



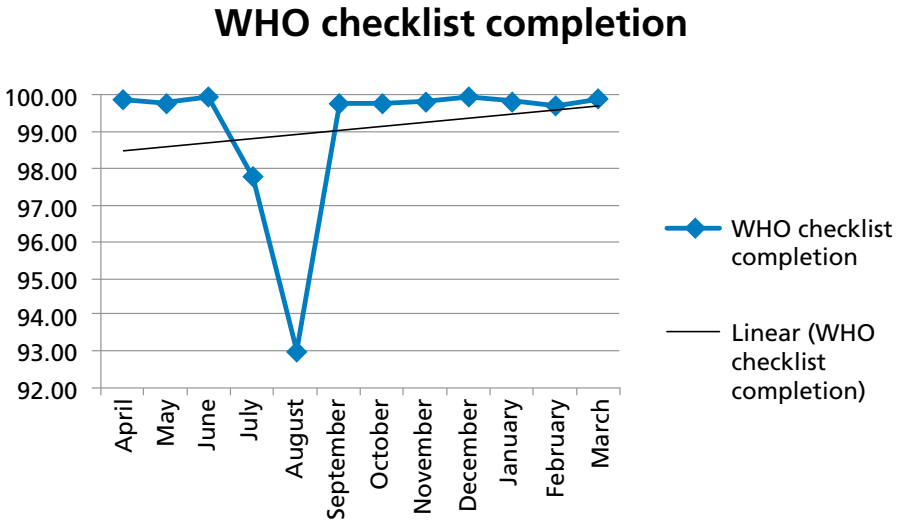
Incidents are generally categorised into clinical (patient safety) and non-clinical and then further categorised dependant upon their causative factor.

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 2014/15 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 2014/15	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of serious incidents reported	2	7	3	2	2	1	1	0	5	4	1	2



We have also strengthened the investigation review process around near miss never events, and share these with all clinical groups to strengthen existing processes and practices. We have done this by:

- 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 Manchester Patient Safety Framework tool.
- A review and update of policies and procedures in theatres.
- Incorporation of Never Events assurance audit as a CQUIN.

VTE

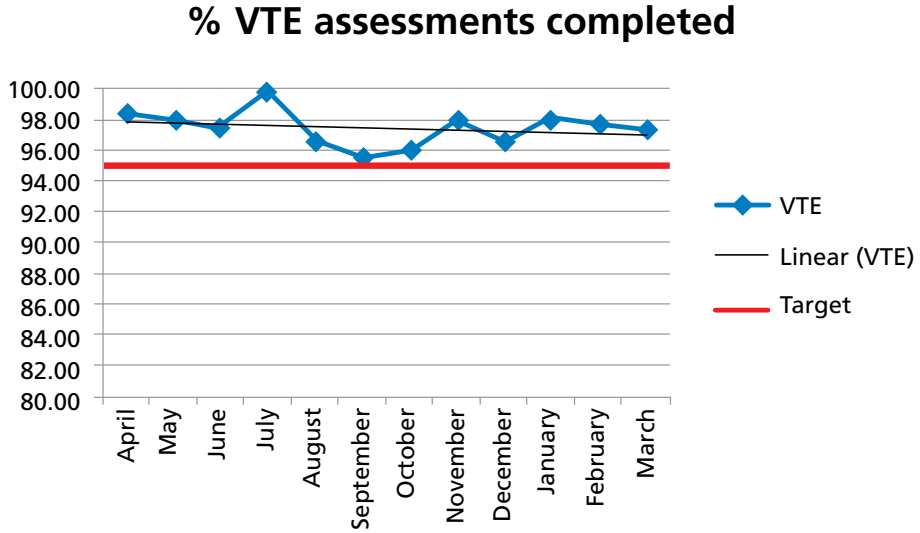
A venous thromboembolism (VTE) is a blood clot (thrombus) that forms within a vein. Commonly they are found in deep veins (deep vein thrombosis). If the thrombus breaks off and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs.

Since 2010, the Department of Health (DH) requires that VTE risk assessments take place for every patient, and that results are closely monitored in order to reduce the 25,000 preventable deaths that occur in UK hospitals every year.

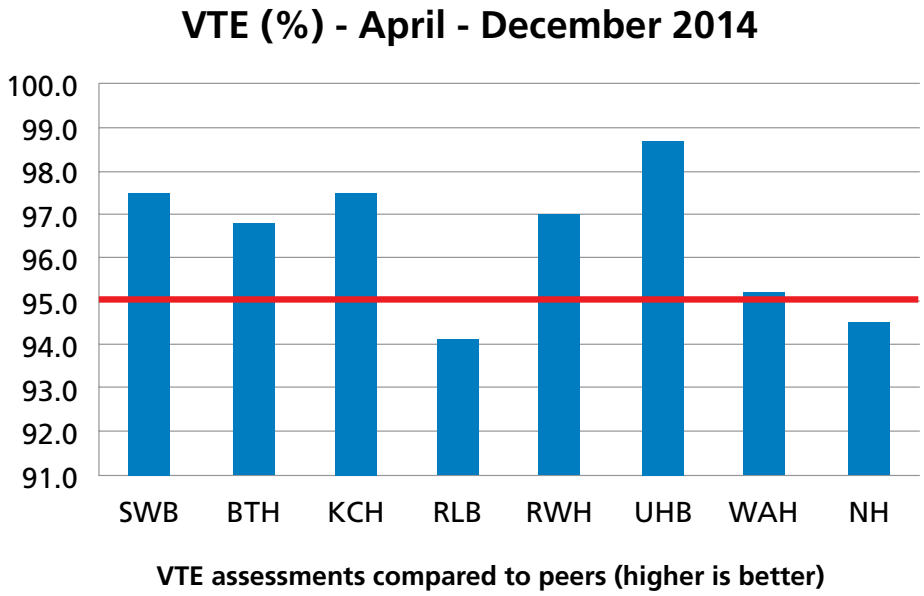
We are reporting our achievements against the national indicator. This gives us a percentage of 97.82%. We have calculated the percentage of patients risk assessed for venous thromboembolism (VTE) based on the number of adults admitted to hospital as inpatients in the reporting period who have been risk assessed for VTE. This gives us a percentage of 97.82%. Following an audit of our data we have identified a cohort of patients who received their initial VTE assessment after admission. This falls outside of our Trust policy definition of VTE assessment at the point of admission and which is based on the criteria set out in the national VTE risk assessment tool. Applying this definition gives us a percentage of 93.4% which is below the national target of 95%.

Lowest	Highest	Average	SWBH
91%	100%	96%	97.82%

The data above compares our VTE assessment compliance against all other Trusts and was sourced from data provided by NHS England.



VTE assessments completed (higher is better – Target 95%)



VTE assessments compared to peers (higher is better)

Safeguarding

Children's Safeguarding

Excellent partnership working in Sandwell's Multi-Agency Safeguarding Hub (MASH) saw an increase in the number of domestic abuse notifications requiring screening by the Domestic Abuse Lead Nurse leading to a recent support for extra funding to increase this team. SWBH has been successful in a joint charitable bid with Sandwell Women's Aid to provide specialist workers in the emergency department to support both clients and staff in the identification of domestic abuse.

Birmingham MASH commenced in July and although there is no SWBHT resource required, joint working has increased with the safeguarding children team, frontline practitioners and MASH staff to improve the quality of inter-agency referrals completed to ensure children and family's needs are better recognised and responded to in order to better safeguard children.

There have been two Safeguarding Children Care Quality Commission inspections during the summer which identified the need for the organisation to improve its provision of supervision for frontline staff in Emergency Department and midwifery so they are better equipped to safeguard vulnerable children and people. Other areas identified were mandatory safeguarding children training (an area the Trust had already recognised as requiring improvement), 72% of staff have received face to face training on how to recognise and refer issues of concern; 68% of key staff groups such as health visitors, paediatricians and community nurses have received more in-depth training.

The report praised the organisation's Paediatric Liaison Service which reviews all children's admission cards following attendance at the Emergency Department to ensure that all safeguarding concerns have been reported and will also refer on to health visitors and school health advisors for additional support a family or young person may need.

Our key challenges for 2015/16 are to work closely with external partners (local authority, police, school nurses etc) and internal departments such as the emergency department, maternity and paediatric wards to reduce child sexual exploitation, alert to cases of female genital mutilation by increasing awareness and training amongst staff.

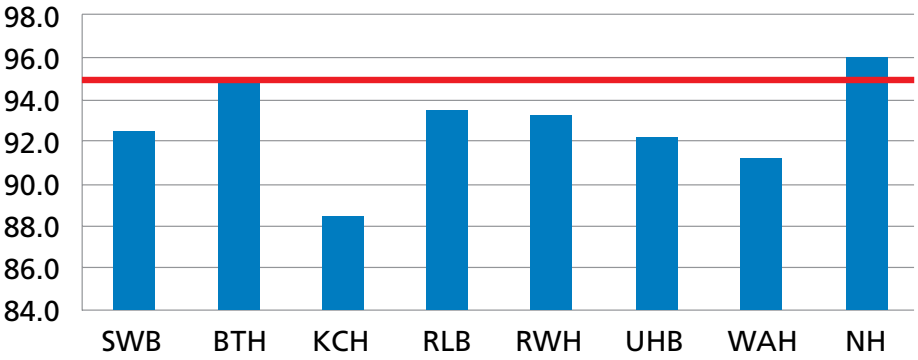
Safeguarding Adults

The Safeguarding Vulnerable Adults Team supports staff in the organisation to protect the most vulnerable and frail in our society. In 2014/15 the team received 780 referrals where staff needed advice/support or where harm needed to be investigated.

Safeguarding Vulnerable Adults Training continues as planned throughout 2014/15. All of our 7,500 staff received leaflets describing different forms of harm/abuse, how to recognise abuse and who to contact for support. 77.8% of senior staff (nurses, doctors etc) received classroom training on actions to take to protect patients. We have undertaken audits to review how we support adults at risk by reviewing five cases each quarter to identify any learning. We continue to raise the importance of patients and families being more involved in their care and in difficult /complex decisions where appropriate.

The Learning Disability Liaison Nurse continues to work across the Trust with patients from Sandwell, and the Chief Executive has made pledges to the Peoples' Parliament in Sandwell which includes: a system for identifying patients with learning disabilities on admission and provision of reasonable adjustments for patients with a learning disability. This has improved care for patients in both inpatient and outpatient areas.

Emergency Care 4-hour waits (%) - 2014 / 2015



Percentage of patients waiting 4 hours or less in the emergency department compared to peers (Higher is better – target 95%)

The national target for A&E waits is four hours. This means that we aim to ensure that 95% of patients will wait for no more than four hours within the Emergency Department. Although the majority of patients were seen within four hours on average we achieved 92.5%. This is less than year's figure of 94.4%. Nationally we saw how the additional pressures of the cold weather; norovirus and flu impacted on all A&E departments across the UK. We remain committed to improving our targets and we are working closely with the community teams to improve our integrated care pathways (see priorities for 2015/16). The only way we can know if we are getting it right is to ask, listen and involve patients, carers, relatives and the general public.

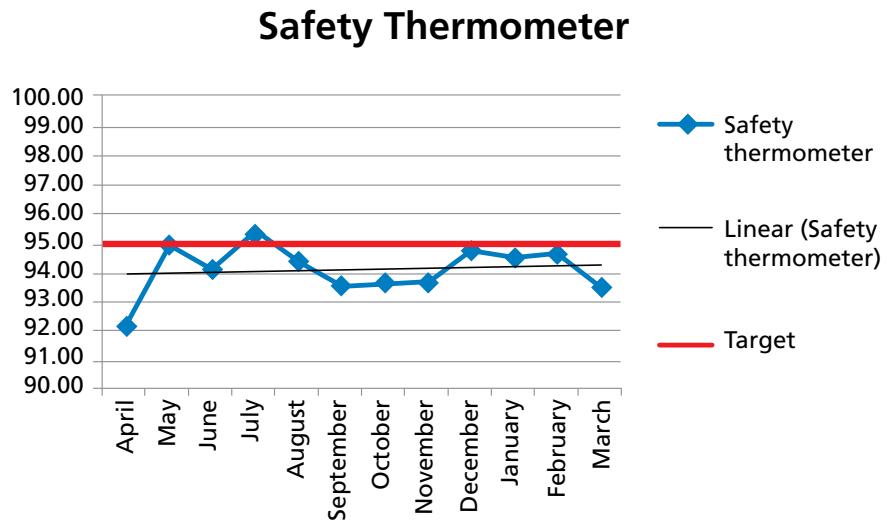
Accident and Emergency department at Sandwell General: This will become an Urgent Care Centre in 2018-19 when Midland Met opens.

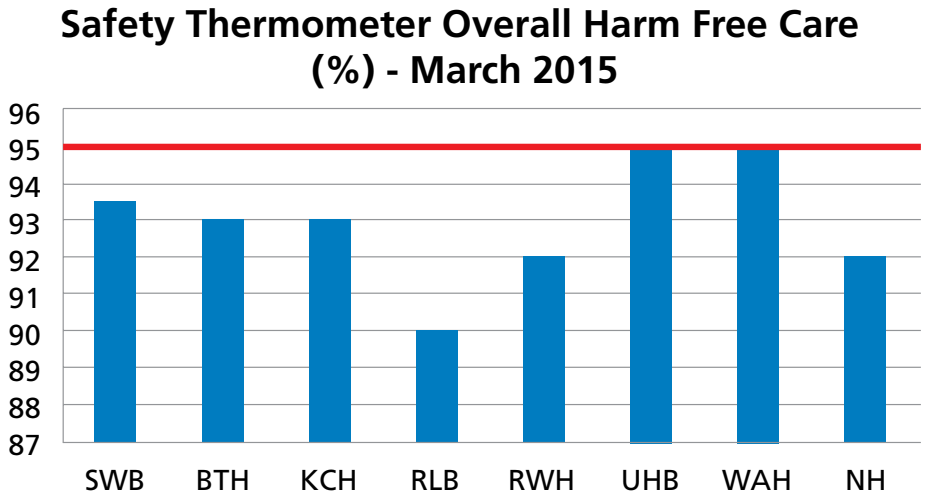
Safety thermometer

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.

This 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





Safety thermometer performance compared to peers (Target 95% Harm free care)

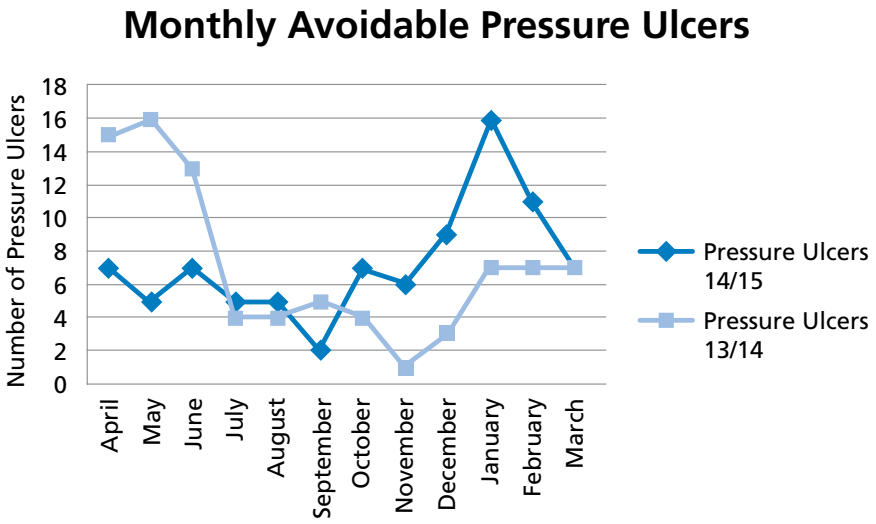
We intend to continue to improve the safety and enhance patient experience through specific attention to the reduction of harm events and through efforts to measurably improve care delivered.

The 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 2014/15 dipped mid-year, but it has improved to 93.5% which is just below the target with few patients sustaining more than one harm.

Pressure ulcer prevention is one of the key safety standards within the Trust 10/10 safety standards with a clear focus on assessment of all patients to identify if someone is at risk of developing pressure damage and implementing preventative strategies to prevent pressure ulcers developing. Following the implementation of a focussed pressure ulcer reduction campaign, the reduction in the incidence of avoidable hospital acquired pressure ulcer has been sustained with the exception of a small rise during December. This increase in incidence was investigated and it was identified that the increase was not related to a specific area in within the Trust. Many of our wards have achieved sustained elimination of pressure ulcers with the highest celebrating 800 days pressure ulcer free.

All severe pressure damage is reviewed to identify the cause and implement local actions reflecting the lessons learnt.



Following the sustained success of reducing pressure ulcer incidences within the hospital setting, focus of the pressure ulcer reduction campaign has been placed on reducing incidences within Sandwell community and patients under the care of our District Nursing teams with the achievement of 10% reduction this year.

End of life (palliative) care

2014/15 has seen positive developments in palliative care, which we believe has improved access to services for both patients and staff. We now deliver a seven day service where a clinical nurse specialist is available across both hospital sites and also in the community 8am – 4pm. Outside of these hours we also have an on-call service where we can offer telephone advice to staff out of hours. Our referrals out of hours are increasing and in 2015/16 we will be evaluating the impact of this service on the patient experience.

Our other key focus will be on updating and developing our written patient information which should be available in 2016, including reviewing the existing End of Life Care Pathway (care plan) in accordance with national guidelines and standards.

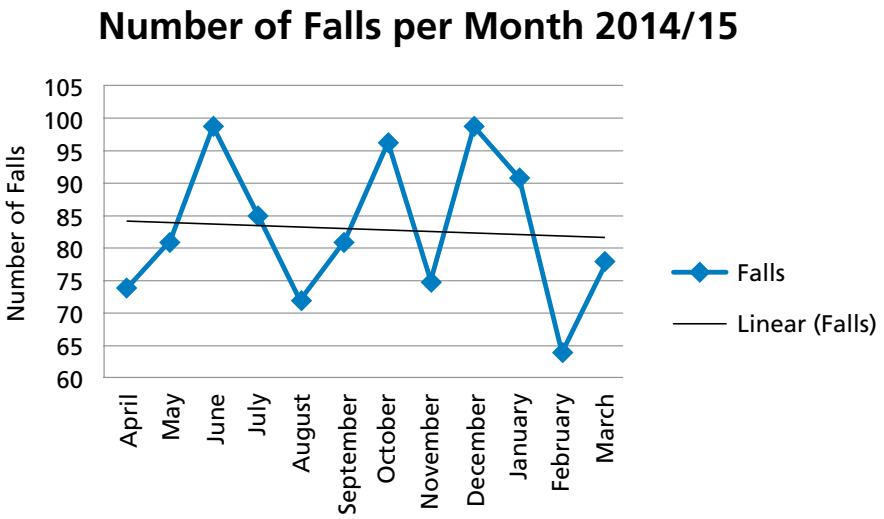
Preferred Place of Care Data 2014/15

The hospital and community palliative care teams strive to ensure that patients achieve their preferred place of care and death and this year has been no exception.

The national target is 63 % and over the last financial year, the percentage of patients who achieved their preferred place of care and death has fluctuated between 67% and 87% with the mean average being 76% for the year.

Falls

The number of falls in 2014/15 is 995. The number of falls resulting in harm to our patients (for example a hip fracture/ head injury) has reduced from 30 in 2013/14 to 25 in 2014/15. We investigate and review each serious incident to ensure any learning points are shared with staff and that practice is reviewed to reduce the risk of repetition for that patient or others. All staff receive prevention of falls training on induction and annual mandatory training. The organisation is currently undertaking a project of reviewing medication of those patients that are of high risk of falling.



Dementia

We have implemented a series of strategies to support an evidence based dementia care pathway:

- We continue to screen patients to determine risk of dementia which may lead the patient to undergo a further assessment. Our results have improved across the year and 90% of patients who need assessing are done so in a timely manner with the appropriate follow up.
- The environments of some of the wards across the inpatient areas have been improved to help those patients with dementia find their way and increase their independence.
- We have reviewed our guidance regarding patients who may require increased nursing supervision/support
- We continue to invest money in university training for staff and have employed activity co-ordinators to provide patients with dementia therapeutic activity to patients with dementia.
- We have hosted two dementia theatre events to raise awareness regarding the condition and role of carers which has received excellent reviews.

Our vision for the next twelve months is to encourage more activities for patients with dementia.

Measuring progress towards excellent patient and carer experience

We want to ensure our patients and their carers receive the very best experience possible. This is important for several reasons:

- It is everyone's constitutional right, as identified in the NHS Constitution 2010.
- Good patient experience is linked to better outcomes.
- It instils local and national confidence in the Trust, reinforcing our reputation as we move into new fields of care as an integrated provider.
- It will help to retain and recruit staff, as an organisation with a sense of wellbeing and is a place people want to work in.

We believe that delivering our promises 24/7 will deliver these recommendations.

We have captured our approach in our Staff and Patient Experience Strategy "Patient Knows Best" (PKB), a document that brings together these simple truths based on an important belief that our 'patients know best' as they have knowledge that we do not, because they know themselves better than we can.

Family and Friends Test (FFT)

The Trust participates in the national Family and Friends Test programme and has used the net promoter score generated by this to drive improvements in its services.

SWBH Inpatient score	National Average	National lowest	National Highest
72	72	33	93

SWBH ED score	National Average	National lowest	National Highest
52	54	-3	89

For staff, would you recommend this organisation to a friend or family member?

Strongly agree %	Strongly disagree %	Base number	National Strongly agree %	National strongly disagree %	National average score	National highest	National Lowest
68%	9%	1266	77%	8%	60%	98%	41%

NHS Choices

NHS Choices is a website that provides the Trust with valuable reflections from patients and their carers. These are used to provide feedback to clinical services whether positive or negative.

Urology at Sandwell District General Hospital ★★★★★

"I have been to Sandwell Hospital Accident and Emergency a few times over the past few years with kidney stones and always found the staff to be friendly, efficient and they always go that extra little bit to help. They treated me speedily and did their best to help. I would recommend Sandwell Hospital Accident and Emergency."

April 2015

Birmingham and Midland Eye Centre (BMEC) ★★★★★
Wonderful Service from Birmingham and Midland Eye Centre

"I wish to express how impressed I was at the care and service I was given by two doctors at the Birmingham and Midland Eye Centre on Friday, 6th March 2015. I have had a problem with watery eyes. The first doctor assessed my eyes in relation to her field of expertise, but then decided that they would like the drainage system of my eyes to be checked also. Instead of sending me home to wait for another appointment with a colleague, this doctor personally spoke to a second doctor, who saw me the same day. After consulting with each other, I am now booked in for a 3 snip punctoplasty. To witness true "joined up thinking" and collaboration in this way was fantastic. The doctor took extra time out of their day to initiate this, and the second doctor was kind enough to see me, even though I wasn't actually booked in to see them that day. I now have a diagnosis and a treatment forthcoming. I cannot thank these two doctors enough for their thoughtfulness and care."

D. Murphy. 11 March 2015

Patient Stories

Every month a real life patient story is shared with the Trust Board to accentuate good practice and learn from where we didn't meet expectations so we can put it right. The Board agreed that by October 2015 story-telling needed to become an evident feature of other layers of the management system.

Complaints

Patient Experience		
Complaints Received - Formal	No.	837

We remain committed to providing timely and proportionate responses to formal complaints which we receive about our services. Complaints provide us with information about how patients and their families have felt about their experience, giving us information which we can use to improve. Equally compliments let us know what people have found has been good.

The top themes of complaints received during 2014/15 were:

- All aspects of clinical treatment
- Attitude of staff
- Appointment delay/cancellation outpatient appointment
- Appointments delay/cancelled inpatient
- Communication/information to patient
- Admissions/discharges, transfers
- Transport services

The Patient Advice and Liaison Service (PALS) are dealing with more complex type of enquiries that were traditionally dealt with through the formal complaints route. We are also trying to support patients who may just need to sit down and talk through the issues with the doctor directly through PALS, as the patient may not necessarily want to register a formal complaint.

Category Type	2012/13	2013/14	2014/15
Appointments delay/cancelled/notification/time	269	337	423
All issues relating to clinical care/treatment	335	413	395
Formal complaint advice/referral	378	391	259

Complaints handling process

Throughout 2014 we have continued to develop the devolved model of complaints handling. Complaint co-ordinators support and 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. We have not consistently achieved this target but continue to work collectively to ensure that responses are timely and that complainants are kept informed. However, there is still further work to do.

As part of the renewed process for handling complaints, we are offering more meetings to try and resolve issues directly. These meetings are recorded so that no delays occur in transcribing and the complainant receives an accurate record of the conversation.

Information Governance

We are compliant across the Information Governance (IG) Toolkit requirements for 2014/15.

We successfully achieved 74%, which is a "Satisfactory" (GREEN) level, (Health and Social Care Information Centre) and a minimum Level 2 achieved for all requirements.

We will continue to build on this to strengthen our IG practices and processes and work towards attaining Level 3 compliance.

Review of Services

During 2014/15 we provided and/or subcontracted 46 NHS services.

We have reviewed all the data available on the quality of the care in these services.

Agreements between the Trust and the subcontracted providers require that the same high standards of care are given when giving care on our behalf. The health benefit and activity data undergo the same level of scrutiny as that delivered in the Trust.

The income generated by the NHS services reviewed in 2014/15 represents 100% of the total income generated from the provision of NHS services by Trust.

Providing data to Secondary Users

During 2014/14 we submitted data to Secondary Users for inclusion in Hospital Episode Statistics.

The information shared breakdown is below:

Admitted Care

Valid NHS Number	99.1%
Valid GP Practice	100%

Outpatient

Valid NHS Number	99.7%
Valid GP Practice	100%

A&E

Valid NHS Number	97.4%
Valid GP Practice	100%

Source: SUS DQ Dashboard 1415 M12.swf
Above percentages relate to April 2014 to March 2015

The reports of 19 national clinical audits were reviewed by the provider in 2014/15 and we to take the following actions to improve the quality of healthcare we provide:

Patient Reported Outcome Measures (PROMs)

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.

The CQC published Intelligent Monitoring data about Trusts. PROMs performance represents a key issue highlighted there for the Trust to improve upon.

Percentage reporting improvement

	Health Status Questionnaire Percentage improving			
	Finalised data for April 2012/March 2013 (Published August 14)		Provisional data for April 2012/March 2013 (Published February 15)	
	National	SWBH	National	SWBH
Hernia repairs	50.2%	49.3%	50.6%	42.9%
Hip replacement	89.7%	87.9%	89.3%	86.6%
Knee replacement	80.6%	73.7%	81.4%	74.3%

Average adjusted heath gain

	Health Status Questionnaire Average adjusted health gain			
	Finalised data for April 12 – March 13 (Published August 14)		Provisional data for April 13 – March 14 (Published February 15)	
	National	SWBH	National	SWBH
Hernia repairs	0.085	0.076	0.085	0.085
Hip replacement	0.438	0.420	0.436	0.45
Knee replacement	0.318	0.298	0.323	0.264
Varicose vein surgery	0.093	0.048	0.093	0.08

	SWBH below England average
	SWBH above England average

The finalised data for 2012/13 and the provisional data for 2013/14 shows that there are areas where the reported outcome is below the average for England.

In response, the Trust has taken the following action:

	Action taken
Hip & Knee replacement	Pre-operative questionnaires and an information leaflet explaining the importance of completing the pre-operative PROMs booklets are posted to patients at home with their admission letter for completion and return on the day of surgery. Patients attend a 'joint club' where advice and information is imparted. This includes discussion with patients so they are fully aware of the risk and benefits, as well as expected outcome. Audits of listing of patients are in place to ensure that they meet the criteria consistently for replacement and meet the current CCG guidance. A contact point after discharge is provided if there are any problems and there is direct access to clinic if needed. A six month follow up and review of performance after surgery is also in place.
Varicose vein surgery	Most varicose veins are now done by radiofrequency ablation. Questionnaires are offered to patients at every opportunity. All patients have a discussion regarding risk and benefits and information leaflets are being updated to include more information on PROMS and on what symptoms to expect post operatively and in what time frame.

Clinical Research

In 14/15 we recruited 2067 patients receiving NHS service care from our Trust, to participate in research approved by a research ethics committee for National Institute for Health Research (NIHR) Portfolio studies. With a further 800 for non-NIHR Portfolio studies.

Participation in clinical research demonstrates our ongoing commitment to improving the quality of care offered and to making a contribution to wider health improvement. Engagement with clinical research also demonstrates our commitment to testing and offering the latest treatments and techniques. It further ensures that clinical staff stay abreast of the latest treatment possibilities and active participation in research leading to successful patient outcomes.

Research is undertaken across a wide range of disciplines including Cancer (Breast, Lung, Colorectal, Haematology, Gynae-oncology, Urology), Rheumatology, Ophthalmology, Stroke, Neurology, Cardiovascular, Diabetes, Gastroenterology, Surgery, Dermatology and Women and Children's Health. We use national systems to manage the studies in proportion to risk and implement the NIHR Research Support Service standard operating procedures.

Participation in clinical audits

During 2014/15, we participated in 29 national clinical audits and two national confidential enquiries covering NHS services which the Trust provides.

We have reviewed all the data available to us on the quality of care in all of these services.

During that period Sandwell and West Birmingham Hospiitals NHS Trust participated in 97% of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham Hospitals NHS Trust participated in and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	Participated Yes /No	Percentage of eligible cases submitted (Provisional)
Women's & Child Health		
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Fitting Child (Care in Emergency Departments)	Yes	100%
Diabetes (National Paediatric Diabetes Audit)	Yes	100%
Epilepsy 12 Audit (Childhood Epilepsy)	Yes	98%
National Pregnancy in Diabetes Audit	Yes	100%
Acute care		
National pleural procedures audit (British Thoracic Society)	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Yes	90%

National Audits	Participated Yes /No	Percentage of eligible cases submitted (Provisional)
Severe trauma (Trauma Audit & Research Network)	Yes	60%
Adult Critical Care (Case Mix Programme)	Yes	100%
National COPD Audit (Secondary Care)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	64%
Long term conditions		
Diabetes (National Diabetes Audit) Adult	Yes	100%
Inflammatory Bowel Disease (IBD)	Yes	93%
Rheumatoid and early inflammatory arthritis	Yes	Ongoing
Heart		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	98%
Heart Failure (Heart Failure Audit)	Yes	50%
Cardiac Rhythm Management Audit	Yes	100%
Acute stroke (SSSNAP)	Yes	90%+
Cardiac arrest (National Cardiac Arrest Audit)	Yes	96%
Coronary angioplasty (NICOR Adult Cardiac interventions audit)	Yes	100%
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
Head & neck cancer (DAHNO)	Yes	100%
Oesophago- gastric cancer (National O-G Cancer Audit)	Yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion (Audit of patient information and consent)	Yes	100%
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
Other		
Elective Surgery (National PROMs Programme)	Yes	73%
Older people (Care in Emergency Departments)	Yes	100%
Standards for ulnar neuropathy at elbow (UNE) testing	No	NA
Mental health		
Mental health (Care in Emergency Departments)	Yes	100%
National Confidential Enquiries (Clinical Outcome Review Programmes)		
Medical & surgical programme - National Confidential Enquiry into Patient Outcome & Death (NCEPOD) The Trust participated in the following study in 2014/15 - Gastrointestinal haemorrhage - Tracheostomy care - Sepsis - Acute pancreatitis	 Yes Yes Yes Yes	 100% 88% 86% Ongoing
Maternal, infant and newborn clinical outcome review programme	Yes	100%

External Visits

Care Quality Commission (CQC) – Chief Inspector of Hospitals Visit

We are registered with the Care Quality Commission and do not have any conditions attached. In October 2014 we had a large scale inspection from the CQC – this included both acute hospitals and our community services. The CQC inspected but did not report on community paediatric service. The CQC will complete that inspection in June 2015.

The inspection took place between 14th and 17th October 2014, and unannounced inspection visits took place between 25th and 30th October.

Overall, we "require improvement". We were rated "good" for caring for patients and effective care but "require improvement" in being responsive to patients' needs and being well-led. We were rated in the safe domain as "inadequate".

Overall rating for this trust	**Requires Improvement**
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Key Findings

- Staff were caring and compassionate, and treated patients with dignity and respect.
- Shared learning from incident reporting needed to be improved across the organisation.
- Infection control practices were generally good but there were pockets of poor practice that needed to be addressed.
- Medicines management was inconsistent. Pharmacy support was good and staff valued the input of the pharmacists. However, across the trust, the safe storage of medicines was not robust. This was an area in which the trust had failed to meet its targets for 2013/14.
- The trust had consistently failed to meet the national target for treating 95% of patients attending the accident and emergency (A&E) department within 4 hours.
- Generally community services were good, but required improvement for safety.
- We were concerned about wards D26 and D11 at City Hospital, which were not meeting the basic care needs for patients.
- The trust had recognised that end of life care was an area for development for the Bradbury House Day Hospice.
- The mortuary on both sites had long-standing environmental issues that needed to be addressed.

Outstanding practice

- The iCares service within the community and the diabetic service. These were outstanding and had received national recognition. Critical care services were good overall, with both staff and patients feeling well supported.
- The compassionate and caring dedication for end of life care with regard to a minor, which was rated as outstanding, especially how the service used the wider healthcare team to meet the needs of the individual. We were confident that this level of support would be repeated in a similar situation.

Improvements required

- Review the levels of nursing staff across all wards and departments to ensure that they are safe and meet the requirements of the service.
- Ensure that all staff are consistently reporting incidents, and that staff receive feedback on all incidents raised so that service development and learning can take place.
- Ensure that all patient-identifiable information is handled and stored securely.
- Follow through from findings of safety audit data, and follow up absence of safety audit data.

- Address systemic gaps in patient assessment records.
- Take steps to improve staff understanding of isolation procedures.

We have taken the results of the CQC inspection very seriously and have published our improvement plan delivery of which is one of our key priorities for 2015/16. The full report from the CQC is available on our website www.swbh.nhs.uk. More information about it is set out in the first chapter of this report.

Health Education West Midlands visits

Health Education West Midlands (HEWM) visits are vitally important for the continued quality assurance of training we provide at Sandwell and West Birmingham Hospitals NHS Trust and ensure the development of good training practice for both undergraduate and postgraduate medical education.

Training undergraduate and post graduate staff plays a big part in ensuring safe, high quality care for our patients provided by caring and compassionate clinicians.

HEWM visited the trust five times within the last year, looking into areas such as the medical training provided in Radiology, Emergency Medicine, Paediatrics, Ophthalmology, and Trauma & Orthopaedics/Plastic Surgery. The University of Birmingham also visited the Trust for a routine quality assurance visit for undergraduate education during the past year.

Below is a selection of the positive feedback we received during these visits.

- The programme and department obtained excellent feedback from all trainees who unequivocally recommended their post. It was clear to the panel that the department prioritised training and adopted a holistic approach to the trainee experience.
- The college and clinical tutors are to be commended for their enthusiasm and involvement with training. The training opportunities and the environment were reported by the trainees to be generally very good. Local training was described as brilliant and supervision is very good.
- The Trust is commended for providing senior trainees with protected time to access specialist interest clinics. This is extremely well valued by trainees and is an area of best practice for paediatrics regionally.
- The panel noted that the change that has occurred within the department following the previous visit has been very positive with tremendous improvements and generally a very high standard of training.
- The panel recognised the progress the department had made since the previous QA visits. There was a noticeable refocus on education and training with a clearer clinical educational leadership and Trust engagement.
- The panel was confident that the Trust was delivering the undergraduate (UG) medical programme to all minimum standards, exceeding them in many areas and that there were no concerns about patient safety raised by students. The tone of the visit was very positive, with some impressive innovations displayed throughout. The panel was impressed with the enthusiasm from staff during the visit and several areas of good practice were demonstrated.

Cardiology external review

The Trust commissioned an Invited Service Review by the Royal College of Physicians. The review took place on 24th - 26th September 2014. There were specific areas that the Trust wanted to be the focus of the review. Therefore the terms of reference and scope of the review was set to include:

- Workforce
- Working Practices
- Team Working
- Clinic Utilisation
- Reconfiguration

The report highlighted that there are many hard-working, dedicated staff within the cardiology department of Sandwell & West Birmingham Hospitals NHS Trust and acknowledged the work done to date including improvements to the medical cardiology service relating to consultant appointments, leadership and job planning. There was also acknowledgement for heart failure and rehabilitation that were described as being examples of excellent practice within the wider service.

However there were equally areas where immediate improvement is needed and these were reported as being the essentials of a high quality service. These include shorter waiting times for outpatient appointments and meeting national clinical standards together with reconfiguration of invasive cardiology services on the City Hospital site should be the immediate priorities for the Trust. These aims are readily achievable with sufficient investment in time, capacity and capability of leadership and support of the specialty lead. An action plan has been developed highlighting the areas for improvement along with timescales for completion. This action plan includes the case for a whole service reconfiguration, which we expect to proceed during autumn 2015.

National Peer Review of Major Trauma Services: 2015

The national peer review of trauma services took place during the Spring of 2015. The two trauma units within the Trust, at City Hospital and Sandwell Hospital, were assessed independently.

The process and governance of major trauma care within the Trust is under the remit of a single major trauma group and the team responsible for presenting our services to the reviewers was the same for both visits. Accordingly, points raised by the team and identified by the reviewers have, in general, been common to both sites.

The visits occurred at a time when there continues to be ongoing reconfiguration of services between the acute sites within the Trust and the areas identified by the review were already known and contained within a work programme to attend to them.

The review focuses on three broad areas:

- Reception and resuscitation measures
- Definitive care measures
- Rehabilitation measures

Within these three areas are a number of benchmarks and all trauma units are assessed against these throughout the peer review process.

The SWBH team was identified for the clear and honest appraisal of our services and the open engagement with the peer reviewing teams at both sites. A number of points of good practice were identified in the way that care is organized and delivered.

The areas needing attention are graded as immediate risk, serious concern and concern.

Immediate risks

An immediate risk has been identified and included in our report although the required resolution spans the responsibilities of the major trauma centre services at University Hospital Birmingham NHS Foundation Trust (UHB NHS FT) and Sandwell and West Birmingham Hospitals NHS Trust (SWBH NHS).

Serious concerns

There are not any trauma team nurses who have been trained in the Advanced Trauma Nurse Course (ATNC) or equivalent, meaning that not all shifts have an appropriately trained trauma nurse on duty which could seriously compromise the quality of care for patients. (Both sites)

Response: There is agreement from the Emergency Department matron, supported by the Board, to train nurses through the accredited trauma course or to train to an equivalent standard via in-house training programme (or both) and to maintain the competency and training of nurses in trauma management.

Whilst only applicable to a small number of patients the administration of Tranexamic Acid (TXA) is a critical therapy in the trauma pathway for patients with significant haemorrhage. The reviewers were not assured that this is embedded in practice and this could seriously compromise the quality of care and affect clinical outcomes. (Both sites)

Response: In addition to targeted training of the multidisciplinary trauma team regarding early management of the bleeding patient, the trauma paperwork is being reformatted to provide distinct prompts to the team so that key interventions, some of which are uncommonly required, such as administration of TXA are highlighted. This change will also allow better data recording that will improve the quality of data submitted to Trauma Audit and Research Network (TARN).

There are delays in accessing CT scans for trauma patients beyond 30 minutes from request; there are also delays in reporting the scan results. These delays in undertaking and reporting of CT scans on major trauma patients may lead to significant adverse outcome for these patients. (Both sites)

Response: Imaging services need to implement more resilient processes for reporting (e.g. same model as stroke care) and be able to provide ongoing trauma specific data on process. The CT scanner at City Hospital needs replacing as the time taken to reconstruct the scans ready for reporting is excessively long. The capital investment for this to happen has not been confirmed to date but will form part of the tendered Managed Equipment Services (MES) provision over the next 12-18 months.

There are significant challenges in accessing referral pathways to the Major Trauma Centre (MTC) at UHB NHS FT for patients with neurological injuries. As a consequence patients do not get timely access to specialist care at the MTC. In the absence of timely transfer and provision of specialist support the reviewers were concerned that care is not delivered in the most appropriate care setting and this could seriously compromise the quality of care and affect clinical outcomes. As with the immediate risk, the required resolution is the responsibility of the major trauma centre services at UHB NHS FT and outside of the control of SWBH NHS Trust. (Both sites)

Response: This issue has been identified by many of the trauma units attempting to access services from UHB NHS FT for MTC patients and is expected to be identified by the peer review process as requiring resolution by UHB NHS FT and their commisioners.

Concerns

There is a lack of support services and resilience for Trauma Audit Research Network (TARN) staff and rehabilitation coordinators. (Both sites)

Overall response

The review is an important piece of work, which features on the organisation's risk register and is overseen by the Board. As trauma work is by its nature multi-specialty, we will govern our delivery of care through the new Theatres Management Board chaired by the Chief Operating Officer.

Emergency Department Consultant and Clinical Lead, Mr Prem John

Our priorities for 2015/16

Our approach

In this quality account, in our annual plan, and in submissions to the Trust Development Authority we identify the same 5 big priorities for action. These will be routinely reported to the Board, and feature in our Board assurance framework.

During 2015/16 we expect to agree a revised three year forward plan for safety, quality and patient experience. In that cycle will establish aims at a local level spanning every service.

1. Our Improvement Plan

The improvement plan sets out the Trust's response to the areas for action identified by the Care Quality Commission following their inspection of our services in October 2014. Every part of the organisation was found to be caring. Our adult community based services were rated 'good' by the inspection team and so were maternity services, critical care and end of life care. Other services at Sandwell and City Hospitals 'require improvement'. Through successful delivery of the improvement plan consistently good practice will be achieved across all services.

The key themes for our Improvement Plan are:

- We need to be better at learning across our organisation, spreading good practice and identifying why some wards, teams and departments are better able to deliver outstanding outcomes for patients – the solution to our issues is already being implemented somewhere in our Trust.
- We need to ensure that we consistently deliver the eesentials of great care, with disciplined implementation of policies on hand-washing, medicines security, end of life decision making, and personalised care observations – we have to get this right every time.
- We need to tackle our sickness and vacancy rates if we are to reduce gaps in our care, and ensure that all of our staff have time and space to be trained and to develop their skills – being fully staffed matters.
- We need to build on our best practice around local management and leadership, empowering capable local managers, and reducing hierarchies between executive and departmental leaders – communication can be better here and must be two-way.
- We need to do even more to evidence how our incident, risk management, and safety data inform the decisions that we make and the priorities that we set – we know where our issues are, and need to address them more quickly when they are identified.

2. Readmission

The reduction in the number of readmissions was one of our priorities last year. There is still a lot of work to be done and we will continue to work on identifying those who are at risk of readmission by using the LACE screening tool and providing supported care pathways for those that need them.

3. Year of the Outpatient (YOOP)

Our programme, notwithstanding its name, continues until we have delivered both the changes planned for 2014-2015, and the overall goal of improved patients satisfaction. We recognize that whilst tens of thousands of patients tell us about the quality of outpatient care, we both have high Do Not Attend rates and lower rates of satisfaction with our welcome and booking processes.

4. Community caseloads

This aim for improvement spans health visiting, district nursing and maternity services.

We will establish by the start of quarter 2 a trajectory for change. This is likely to combine:

- Additional recruitment
- Risk stratification of existing patients, along with GPs
- Setting discharge standards from services
- Looking again at our skillmix
- Improving productivity by use of tools used in other industries to tackle route-mapping

5. 10/10 Patient Safety Standards

We are exploring how to extend this concept into other parts of the Trust, such as theatres and outpatients, as well as community focused teams. However, we will not do so until we have convincingly delivered in all of our ward areas. During Quarter 2 of 2015/16 there will be a sustained multi-professional attempt to ensure that consistently we deliver not just the letter of these standards, but their spirit, which focuses on patients and their relatives being satisfied that the goal has been met.

Patient Afsana Akhtar, Chief Nurse, Colin Ovington, Surria Amin, Staff Nurse, Kim Kaur , Senior Nurse at the Ten out of Ten Safety Standard launch.

CCG CQUINS 2015/16

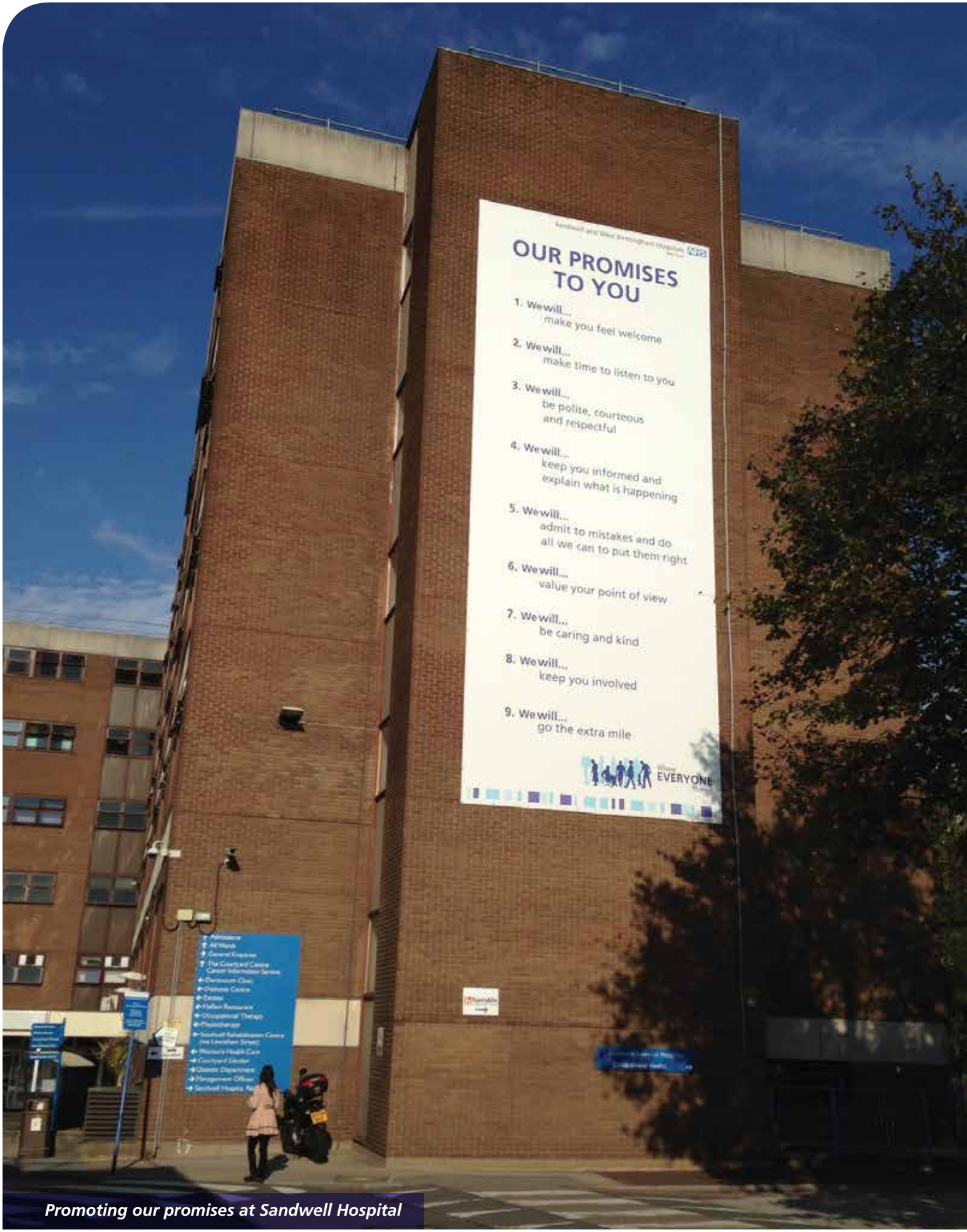
CQUIN	RATIONALE
National CQUIN – AKI (Acute Kidney Injury)	To improve the follow up and recovery for individuals who have sustained AKI, reducing the risks of readmission, re-establishing medication for other long term condition and improving follow up of episode of AKI, which is associated with increased cardiovascular risk in the long term.
National CQUIN - Sepsis	Providers are expected to screen for sepsis for all those patients for whom sepsis screening is appropriate, and to initiate intravenous antibiotics within 1 hour of presentation, for those patients who have suspected severe sepsis, red flag sepsis or septic shock.
National CQUIN - Dementia	i) Find, Assess & Refer; ii) Staff Training; iii) Supporting Carers; iv) Inform. The aim of this CQUIN is to ensure that people who are diagnosed as having dementia leave the hospital with a discharge letter that informs the GP and aimss to assist with care planning.
National CQUIN – Mental Health/A&E	To improve the diagnosis in A&E and reduce the rate of Mental Health re-attendances in A&E.
Local CQUIN – Dietetics - communication	Carry over from Q4 14/15.
Local CQUIN – Dietetics - RTT	Carry over from Q4 14/15.
Local CQUIN - Safeguarding	There is a need to ensure safeguarding practices support the needs of vulnerable children and adults. Therefore this indicator is aimed at ensuring that providers continue to embed safeguarding into practice, implement lessons learnt following a safeguarding event, reflect on practice and ensure that the voice of the child/adult is heard.
Local CQUIN – Dementia moves	The rationale for this CQUIN is an extension of the recommendations outlined in the Dementia Friendly Hospital Charter and the King's Fund programme, which looked at the environmental impact of hospital wards on patients diagnosed with Dementia. We want to limit the number of moves to ensure we minimise disorientation caused by repeated ward transfers.
Local CQUIN – Out of hours transfers	This CQUIN aims to offer an incentive to reduce avoidable transfers that occur during out of hours. This will increase patient experience of services. For this CQUIN we are classing 8pm – 6am as out of hours.

The last CQuin demonstrates our commitment to improving the patient experience. Involving our patients, relatives, carers and community to improve services is central to our success as an organisation. It is at the heart of all we do and we know that it is only by working together in this fashion that we can truly achieve the best for those in our care.

In addition the indicators above, we have agreed:

- Specialist services CQuins with NHS England
- Key performance indicators for quality with our CCG

Data on all of these indicators is published monthly in the Intergrated Performance Report of the Trust's Board held in public.



Promoting our promises at Sandwell Hospital

6. Our finances and investments

Directors' Report

This year our report includes in one document the Trust's finances, our quality account, and the annual report of our charity. We are producing the report in June, not September, to help improve timely public scrutiny and accountability, as we move towards a foundation trust governance model. In that vein, our member's leadership group started life this last year and in 2015/16 we will improve opportunities for staff to take on governor style responsibilities. The report format as a whole places far greater emphasis than ever before on our workforce, their stories, awards and achievements. That reflects the view of the Board that it is our NHS colleagues across the Trust who are the heartbeat of the organisation.

The performance of NHS trusts is measured against four primary financial duties:

- the delivery of an Income and Expenditure (I&E) position consistent with the target set by the Department of Health (DH) (the breakeven target);
- not exceeding its Capital Resource Limit (CRL);
- not exceeding its External Financing Limit (EFL);
- delivering a Capital Cost Absorption Rate of 3.5%.

These duties are further explained as follows:

Breakeven Duty

For 2014/15, the Trust proposed an amended income and expenditure target surplus of £4.653m increased from an original target of £3.146m. Against this target, the Trust met its main budgetary objective by delivering an underlying surplus of £4.653m.

For the purpose of measuring statutory accounts performance, the Trust generated a surplus in year of £4.585m.

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 treatment for donated and government grant funded capital assets. These technicalities are explained in the detailed notes to the Trust's published 2014/15 Statutory Accounts (separate document).

Figure 6.1 shows how the Trust's underlying performance is made up. The surplus in the published Statutory Accounts is, in part, a minor technical adjustment and does not affect the assessment of the Trust's performance against the duties summarised above (ie I&E breakeven, CRL, EFL, capital cost absorption).

Figure 6.1

Income and Expenditure Performance	2014/15	2013/14
	£000s	£000s
Income for Patient Care Activities	403,189	396,256
Income for Education, Training, Research & Other Income	43,401	42,766
Total Income	**446,590**	**439,022**
Pay Expenditure	(292,253)	(291,589)
Non Pay Expenditure including Interest Payable and Receivable	(144,427)	(145,221)
Public Dividend Capital (PDC) Dividend	(5,325)	(4,717)
Total Expenditure (including Impairments and Reversals)	**(442,005)**	**(441,527)**
Surplus/(Deficit) per Statutory Accounts	4,585	(2,505)
Exclude Impairments and Reversals	(263)	8,922
Adjustment re donated gov't grant asset reserve elimination	331	334
Surplus for DH Monitoring (Target Performance)	**4,653**	**6,751**

Although impairments and reversals are not counted towards measuring I&E performance, they must be included in the Statutory Accounts and on the face of the Statement of Comprehensive Income (SOCI). Impairments and reversals 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 true values so that users of its financial statements receive a fair and true view of the Statement of Financial Position (Balance Sheet). DH holds allocations centrally for the impact of impairments and reversals.

Although the overall performance of the Trust's I&E was in line with plan, local positions within Clinical Groups and directorates, showed considerable divergence to plans. This was subject to considerable scrutiny in-year, both by the accountable officers and by the Board's Finance and Investment Committee. A revised approach to budget setting for 2015/16 has been implemented to seek to set a more realistic and mutually understood plan at a local level. However, much of the 2014/15 variation reflected extrinsic factors including delays in transfers of care, higher than anticipated emergency demand, in year grants to tackle winter pressures, as well as matters under the control of the Trust such as delayed implementation of savings schemes. On a full year basis we met our expectation.

CRL

Further detailed information on capital spend is shown below at Table Figure 6.5. The CRL sets a maximum amount of capital expenditure a trust may incur in a financial year (April to March). Trusts are not permitted to overshoot the CRL although the trust may undershoot. Against its CRL of £17.330m for 2014/15, the Trust's capital expenditure was £17.295m, thereby undershooting by £0.035m and achieving this financial duty.

EFL

The 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 overshoot the EFL although the trust is permitted to undershoot. Against its EFL of £11.130m, the Trust's cash flow financing was £10.932m, thereby undershooting by £0.198m and achieving this financial duty.

Capital Cost Absorption Rate

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 SOCI as PDC dividend (as shown in Figure 6.1), an amount which trusts pay back to DH 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 being set automatically at 3.5% and accordingly the Trust has achieved this financial duty.

Income from Commissioners and other sources

The main components of the Trust's income £446.590m in 2014/15 are shown above in Table 1 and below in Table 2 which shows an overall increase of £7.567m, 1.7%.

89% was received from Clinical Commissioning Groups (CCGs) - £344.057m - and from NHS England (NHSE) - £53.706m. The latter's main income in 2013/14 was included in CCGs income.

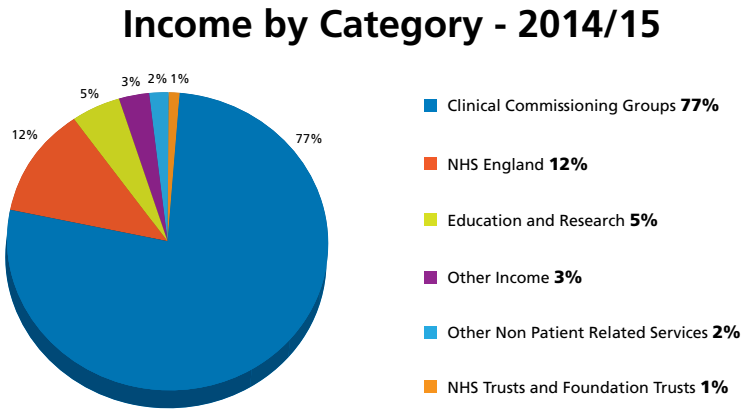
Income increased from CCGs and NHSE by £5.684m, 1.5%, in respect of direct patient care whilst other income sources were broadly stable and/or are too small to have a material impact on the financial performance of the Trust.

Figure 6.2

Sources of Income	2014/15	2013/14
	£000s	£000s
NHS England	53,706	53,399
NHS Trusts and Foundation Trusts	2,600	1,380
Clinical Commissioning Groups	344,057	338,680
NHS Other (including Public Health England and Prop Co)	1,107	0
Non-NHS Patient Income	1,719	2,797
Education & Research	21,005	21,754
Other Non-Patient Related Services	10,122	9,927
Other Income	12,274	11,085
Total Income	446,590	439,022

Within Figure 6.3, the pie chart below, the largest element 77% of the Trust's resources flowed directly from CCGs and 12% from NHSE with the next significant element 5% 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.

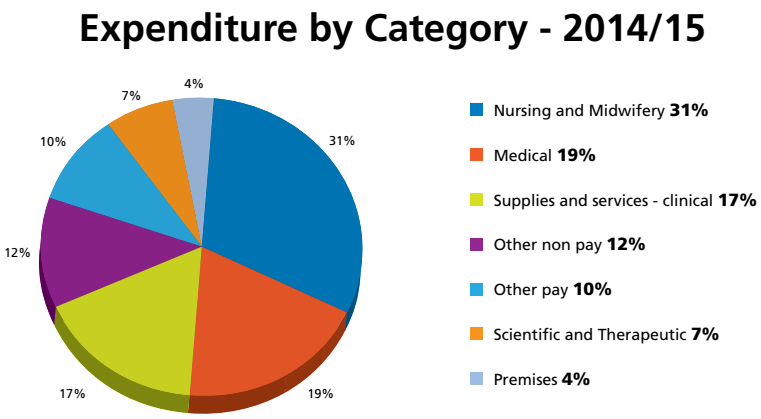
Figure 6.3



Expenditure

Figure 6.4, the pie chart below shows that 67% of the Trust's cost was pay and, within this, the three largest groups were nursing and midwifery 31%, medical staff 19% and scientific and therapeutic 7%. The remaining 33% of operational expenditure was non pay, the largest element of which was clinical supplies and services which included drug costs at 17%.

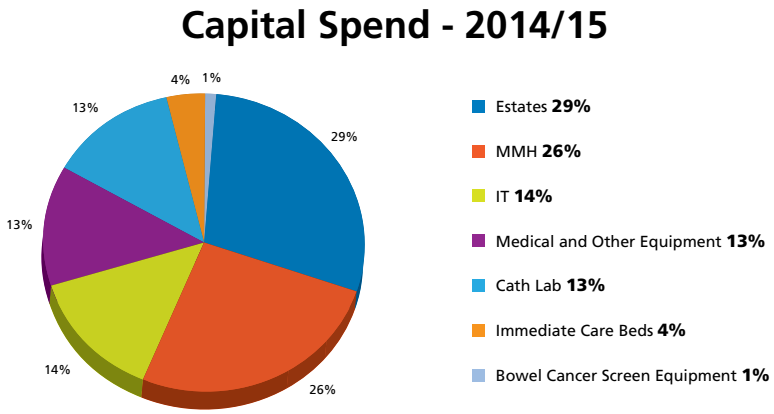
Figure 6.4



Use of Capital Resources

Capital expenditure differs to day to day operational budgets and involves tangible and non-tangible items costing more than £5,000 and having an expected life of more than one year. In total, the Trust spent £17.295m on capital items during 2014/15. A breakdown of this expenditure is shown in the pie chart below. This underspend reflects revised in year plans to rephrase expenditures into 2015/16.

Figure 6.5



The Trust spent a significant proportion - 55% - of its capital budget on the Midland Metropolitan Hospital (MMH) and Estates. Specifically, £9.472m was spent on MMH and upgrading the Trust's Estate, including ensuring compliance with statutory standards. Medical and Other Equipment accounted for £2.268m while £2.468m was spent on Bowel Cancer Screening equipment and Catheter Lab. IT spend totalled £2.387m of which £1.295m was for VNA PACS. £0.702m was expended on additional Intermediate Care Beds.

Sickness Absence

Figure 6.6

Staff Sickness Absence	2014	2013
Total Days Lost	66,120	64,130
Total Staff Years	6,492	6,526
Average Working Days Lost	10.2	9.8

Staff sickness data will be provided on a national basis by DH for 2014/15 and covers the calendar year ended 31 December 2014 (31 December 2013 for prior year comparative data).

Audit

The Trust's External Auditors are KPMG LLP. They were appointed for 2014/15 and 2015/16 by the Audit Commission. Further to the demise of the Audit Commission, the Trust itself will be responsible for the appointment of its auditors from 2016/17.

The cost of the work undertaken by the Auditor in 2014/15 was £133k including VAT. The fee in respect of auditing charitable fund accounts was excluded from this sum, but included £12k for audit of the Quality Accounts and a review of VAT amounting to £7k.

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 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.

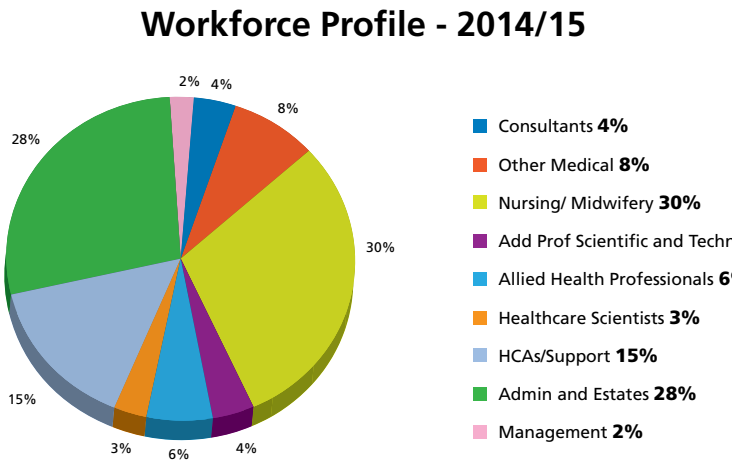
The members of the Audit and Risk Management Committee at 31 March 2015 were Gianjeet Hunjan (Chair), Sarindar Singh Sahota, Olwen Dutton, Harjinder Kang and Paramjit Gill.

We provide services in the heart of our communities through places like the Lyng in West Bromwich

7. Our workforce and partners

Our current and future workforce profile

The Trust is one of the largest teaching Trusts in the Country employing over 7,000 staff for the delivery of acute and community services. Approximately 70% of our workforce has a direct clinical role, and our management workforce remains a very small, though critical part, of our employee numbers. You can see the makeup of our workforce in the pie chart below:



Our workforce is typical of most NHS provider organisations with female staff making up the majority of employees, in our case 78% of our workforce. 42% of colleagues have worked in our organisation for more than 10 years and only 12% of the workforce has less than 12 months service. The Trust seeks to retain its talented and skilled employees and has invested significantly in education, learning and development right across the Trust, increasing by 40% in the past 12 months. However, we have further to go to reduce turnover in some areas, and especially in newly qualified nursing staff.

Over the next five years the scale and shape of our workforce will change. This reflects the needs of our patients, changes in career paths, and roles within the NHS, as well as the future funding arrangements across public services. As a Trust we have been very open with employees and partners about the need to change, and the support that will be provided to develop careers in existing disciplines, or to change career. During 2015 we will publish our future strategy on education and learning. This will help to make explicit the "offer" from the Trust to existing mid-career staff, as well as new joiners thinking about coming to work at the Trust.

An engaged and effective organisation

The organisation is widely acknowledged for its long term commitment to employee engagement and currently acts on staff feedback through one of the most comprehensive real-time staff feedback systems in the country known as 'Your Voice'. This year the survey has gone from strength to strength, and informed changes and improvements, such as the Trust's approach to managing sickness and handling workforce change.

In 2014 the NHS staff survey showed improvement against 2013 in key areas related to team working, feeling valued and agreeing that their role makes a difference to patients. Staff ability to contribute towards improvements at work is ranked in the best 20% of all acute Trusts and staff motivation at work is ranked as above average.

The Your Voice staff survey uses the following five free text questions in addition to the same nine questions used in the national NHS staff survey:

- What top two things could we introduce or improve to make you more positive about working at the Trust?
- What are the two most significant things that you would like to pursue within your area of work to make your service even better for patients?
- How do you feel about working for the Trust?
- Do you know what the Your Voice results are for your area of work?
- Are you aware of any changes that have happened as a result of Your Voice?

These questions enable local management teams to respond on a 'You said, we did' basis and for us to be able to monitor our progress. To date each area of the Trust has completed the survey twice and we have seen that where teams have responded positively to the issues raised by staff, their engagement score has improved considerably. Our pioneering approach to staff engagement 'Listening into Action' continues to be widely used and is now being used to help address issues raised through the Your Voice survey.

Because we have such an extensive array of data on staff views it is possible to paint a more complex picture than simply operating at a Trust level of analysis. We use this linking data on safety and quality to views of patients and staff. It is very clear that some teams, and some local leaders, are leading the way in motivating and engaging their teams. We need to build on that success in the months ahead.

Our staff survey results continue to show a more positive picture for staff from BME backgrounds than for our workforce as a whole. This analysis is important to us, and will be undertaken with increasingly regularity on local data, to ensure that we are tackling areas of poor practice in line with our wider commitments to diversity and equality. In October 2014 we agreed some priorities for this work, and these continue to be the focus of discussion within our Board and elsewhere. The Trust is completing a very detailed EDS2 exercise in support of that plan, and this is currently being reviewed with the help of our Local Interest Group. We are confident of meeting our obligations under the new standards for 2015/16 set out by NHS England.

Staff Key Performance Indicators

A range of workforce KPIs are included in the Trust's Performance Management Framework which include specific targets against which all Groups/Directorates are performance managed. These form part of routine Board and local reporting, as well as received additional scrutiny at the Board's workforce committee and through JCNC. Our partnership with staff-side is an important and distinctive strength of the Trust and one that benefits from consistent attention.

Appraisal and Revalidation

We are committed to ensuring that all of our employees have received an annual appraisal. In 2013/14 we achieved 100% coverage by the end of May. This year 2014/15, we have not yet achieved our target of 100%. Our year end position was 90.36%, and at the end of May 200 employees remain outstanding, having been escalated to potential conduct action through a failure to undertake this basic duty.

During 2015/16, we are deploying a new appraisal process in the Trust. This more comprehensively addresses both performance and potential. For leaders it also incorporates 360-degree feedback, as is required for consultant staff. The Trust continues to make good progress with medical revalidation and prepare for new duties in respect of nursing staff.

The Trust is ranked with the best 20% in the 2014 National Staff Survey for the number of employees (87%) responding that they have had an appraisal in the last 12 months. However, we want to make sure that the quality of the appraisal matches our success with quantity.

Sickness Absence

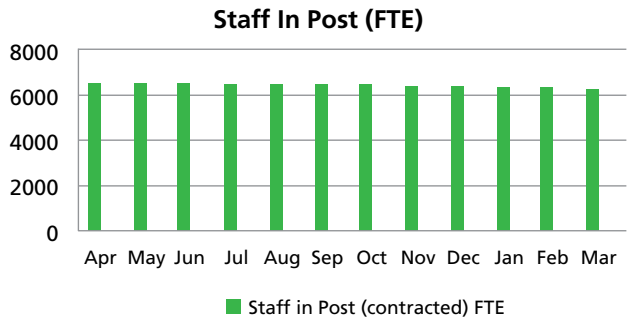
Our sickness absence rate is currently above the Trust's target with the current year to date figure at 4.69% which is an increase on last year's figure. Only one clinical group – Surgery B – are below 4%. Their success is what we are looking to replicate across our Trust. In 2014/15 we failed to meet our goal to cut rates, and will redouble our efforts as a top ten priority in 2015/16.

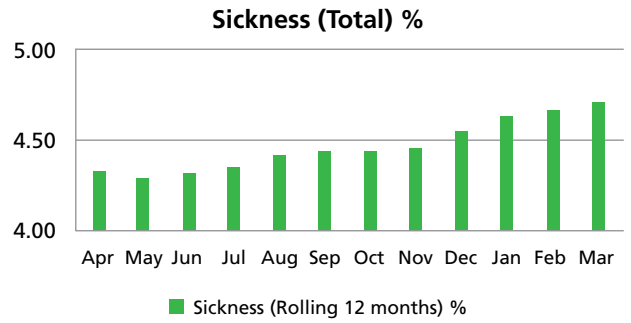
Current position:

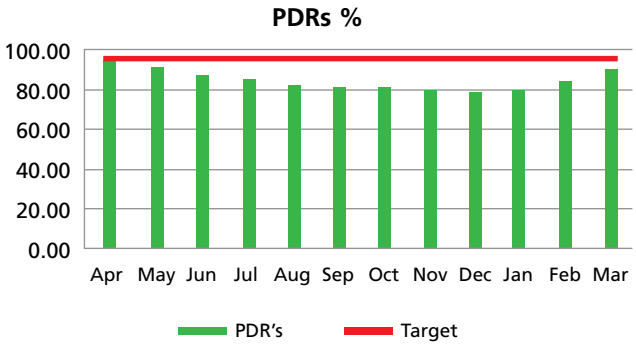
- There is a high level of musculoskeletal and mental health issues among the long term sick in particular.
- There is significant sickness among the small number of staff still directly affected by the workforce change process

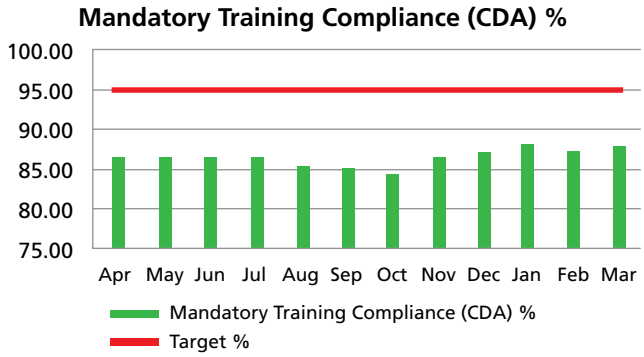
In 2015/16 we will be:

- Focusing on compliance with basic process like return to work interviews
- Ensuring that sickness thresholds are met and long term sickness is tackled collaboratively
- Investing further in musculoskeletal services and publicizing more widely our mental health services to staff
- Enacting the wider Sickness Action Plan agreed by the Trust's Board in spring 2015









Training and Development, including mandatory training

Training and Development of our current workforce is essential to the success of our organisation. We want to become the best integrated care organisation in the country and to achieve that we have to ensure that our staff have the right level of knowledge and skills to carry out their roles safely and with the right levels of competence. We have developed a comprehensive induction programme that is linked to our statutory and mandatory training matrix. This ensures all new employees are trained and developed to have the same level of knowledge and skills as our currently employed staff.

In addition to statutory and mandatory training we offer career development programmes that include vocational training via the apprenticeship framework, further and higher education programmes that are accessed via the development review/ appraisal process. This provides all staff with the opportunity to develop their skills so that they can provide a better service which will ultimately lead to better patient care. In 2014 we signed off a training plan that partially met the training requirements for staff. In 2015, not only did we sign off a plan that fully meets the training needs of staff, we actually published it - this provides transparency and ensures equality of opportunity. We also increased the training spend to over £800,000.

- We currently engage with 36 local schools and four colleges, regional Job Centre Plus and local charities such as St Basil's to provide work experience opportunities, we plan to do more.
- We supported 100 apprenticeships but within a restricted framework list and at restricted levels. We plan to do more.
- We provide functional skills in maths and English reading, writing and listening skills and we have purchased an e-learning solution that will not only enhance our current provision but will enable us to support more staff.
- We developed a 360 degree feedback process and incorporated it into the organisation. This will be offered on a three yearly basis to all Trust leaders and become embedded over the next year.
- We designed the SWBHT Leadership Competency Framework. This has been fully developed and forms the basis of the 360 degree appraisal however it needs to be fully embedded within the organisation over the next year.
- We offer MBTI for individuals and teams and have ensured MBTI is fully incorporated into Trust leadership programmes.

Workforce Redesign

During 2014/15 the Trust delivered the first phase of a workforce change programme, Safe and Sound. This programme has the ambition of delivering the best integrated services, whilst maintaining safe staffing levels and preparing the organisation for the future. During the past year the organisation reduced its establishment by 260 posts. This meant that 152 colleagues were redeployed in to new roles within or outside the Trust, and a small number of staff remain in trial periods or are at risk of redundancy.

During this timeframe the Trust has also strengthened its quality and safety standards. Investment has been made in 20 WTE more registered nurses in addition to converting a further 20 WTE unregistered posts to registered posts. This has been to meet minimum safe staffing levels. In addition the Trust has invested significantly in an additional 60 WTE nursing posts in community based services enabling the opening of two new intermediate care wards based in Rowley Regis Hospital and Sheldon.

The changes were implemented in line with the Trust's organisational change policy and included statutory consultation. The Trust is committed to maximising opportunities to redeploy staff affected into suitable alternative roles. The WTE reduction has been achieved through:

- Natural turnover;
- A comprehensive redeployment plan that matched staff at risk of redundancy to vacancies; and
- Skills development programmes for staff redeployed into new or different roles.
- Eliminating the use of agency work other than in disciplines where a national shortage exists;
- Significantly reducing the use of overtime; extra hours and bank work; and
- Reducing staffing numbers through productivity without compromising on safety and quality.

In the second phase of the workforce change programme, there will be a further reduction of just over 200 posts with a similar process of redeployment and skills development where appropriate. This second phase includes a review of patient administration (including medical secretaries), the Informatics department (the Trust's IT) and schemes across clinical groups and communities. The formal consultation launched in April 2015.

Equality and Diversity

The Trust is committed to achieving equality both as an employer and as a provider of services. We are determined to ensure that our policies and practices meet the needs of all service users as well as those of our staff.

Over the last few years we have introduced a number of initiatives and measures to improve the experiences and outcomes for our patients and staff. These include:

- Introduction of designated baby feeding facilities.
- Introduction of our Customer Care Promises to improve patient confidence and experience in our care delivery.
- Introduction of in-house patient experience surveys across all clinical settings.
- Improved Signage and accessibility to our buildings, wards, departments and car parks to enable equal access for all our patients, visitors and staff.
- Introduction of website access and route plans to our hospitals and departments via 'DisabledGo' website, the links is on the Trust website.

Initiatives to improve our services to vulnerable adults and those with dementia and Learning Disability:

- Introduction of dementia-friendly wards.
- Appointment of activity coordinators to interact with dementia patients.
- Appointment of a Learning Disability Liaison Nurse.
- The successful integration of Community Services into the acute trust.
- Enabling a seamless approach to care and service delivery for all patients.
- Increased staff awareness of the Equality, Diversity and Human Rights agenda via our in-house training programmes (91.03% of our staff have received training to date).
- Equality, Diversity and Human Rights training is now included in the Trust Mandatory Training programmes to ensure that all staff access the training.

Building knowledge and capacity

We have hosted two Equality and Diversity conferences for staff as part of our awareness campaign. The conferences attracted an average turnout of approximately 120 staff members at each. The topics covered included :

- An African police officer giving his experience of how he was accepted as being gay.
- A personal experience from a transgender woman.
- Trust solicitor answering questions about the Equality Act.
- A session on the Equality Delivery System.
- A short play from a company called re cre8, members of the cast were all young ex-offenders who were involved in mainly gangs and knife crime, showing how their background and previous experiences had impacted on their offending.

One of the themes of the conferences was Disability and we had speakers from young carers and from a person with a learning disability and communication difficulties.

Improved patient menu choices

Our patient and community engagement enabled us to improve the food we provide for our patients. During one of the engagement events with members of the Chinese community, they identified the fact that the Trust did not offer rice as a standard item on the menus and when a Chinese person is ill, rice is very important for them to eat. The Trust now offers rice as a standard menu choice.

Improved the diversity of our chaplaincy/spiritual care team

We have appointed our faith specialist chaplains for Sikhs and Muslim women and children, and have introduced a 'Bank of Locum chaplains' to enable us to provide a wider range of faith specialist chaplain's e.g. Buddhists and black Christians.

To ensure that the diverse needs of our patients and staff are integrated into our work at all times we have introduced a Cultural Ambassador programme, which aims to ensure fairness in how BME employees are treated in formal processes. Ambassadors will act as mentors to affected employees and join panels for formal processes. They will work alongside our new investigations unit for disciplinary and grievance procedures.

This shows that the Trust is compliant with its Equality duties but more importantly it shows that the Trust is committed to meeting the diverse needs of both its services users and its employees. Equality, Diversity and Human Rights is a corporate function and remains a key priority of the Trust.

Sustainability Update 2014/15

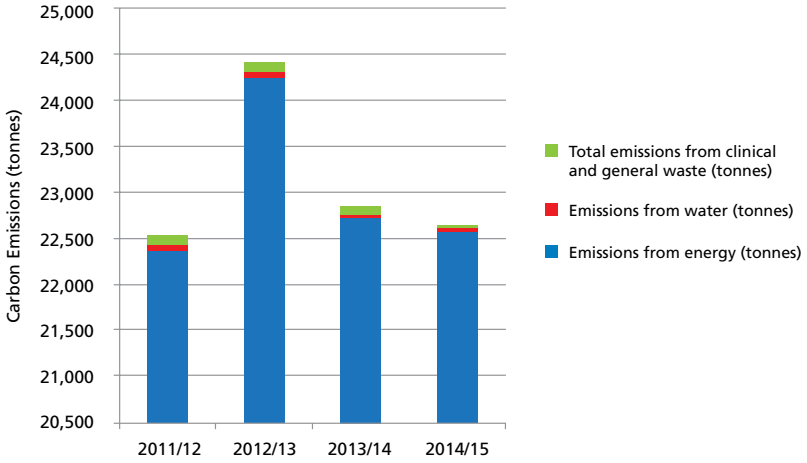
As with previous years, our Trust has continued to demonstrate its commitment to sustainability, minimising our impact on the environment and working to reduce carbon emissions. We are working to deliver our Sustainability Action Plan and believe that sustainability should be engrained within the organisation. Providing health care that won't cost the Earth is our mission.

Our Performance

The table below shows our carbon footprint over the last four years, with significant reductions made since 2013. We have reduced and stabilised our energy consumption through implementing a number of initiatives including: introducing LED lighting and controls across the Trust, replacing boilers for more energy efficient models, installing photovoltaic solar panels on the roof of the Birmingham Midland Eye Centre (City Hospital) and Rowley Regis to generate renewable electricity and reduce consumption from the national grid, staff engagement, and closure of buildings as part of an estate rationalisation plan.

We have also significantly reduced carbon emissions from waste - from 2014 onwards we sent zero general waste to landfill. The Trust's general waste is now directed to a materials recycling facility where it is separated for recycling or reprocessing.

Carbon Emissions from Energy, Water and Waste 2011/12 to 2014/15



Our Sustainability Plans

As part of the Trust's Public Health Plan agenda, in 2014 we set stretching targets for 2017 - to stabilise energy consumption, reduce the amount of waste we send to landfill, and improve on our NHS good corporate citizen assessment score – all of which we are on track to deliver.

To continue our sustainability progress, we are also working to implement Sustainable Travel Plans for all of our sites (focusing on facilitating staff towards more healthy and sustainable modes of travel), investing in further energy saving technologies, managing our Building Management Systems so they are more energy efficient, replacing some of our existing chillers, and wider staff engagement.

Partners

Our partnerships locally

To deliver education for our workforce and to support we work alongside a number of key institutions. We join trade union and recognised professional associations on our JCNC, which is chaired by a non-executive director – Harjinder Kang. Medical education is provided alongside the University of Birmingham at both undergraduate and postgraduate level. Feedback from trainees is treated very seriously by the organisation. Nursing staff join us from Birmingham City University and the University of Wolverhampton. We undertake placements and joint training with other organisations, and accommodate medical staff with links to the Armed Forces including reservists.

58 schools fall within our catchment, and we work to provide placements for young people. Our apprentice scheme provides accelerated access for some into a variety of roles within the Trust, both non-clinical and increasingly clinical.

Live and Work Scheme

During 2014/15 a crucial new partnership has been added to these longstanding traditions, with the opening of our Live and Work Centre opposite Sandwell Hospital. This facility is run for us by St Basils, through whom we offer supported accommodation to young people undertaking apprenticeships with us.

Launch photo of the apprentices and organisational partners behind the Live and Work Centre on Hallam Street

Sandwell University Training College

In 2015/16, the Sandwell UTC will open in West Bromwich. This is a college focused on developing young people aged between 14 and 18, and it has a particular focus on health and social care skills.

This is an exciting project for Trust staff, both in terms of children who want to maintain a generational interest in the NHS, and through the opportunity it provides for us to support those thinking of a career in health.

The Trust has been active in developing the curriculum for the new UTC, and is committed to working with the University of Wolverhampton who sponsor the school to make it an important local success.

Sandwell University Training College Centre. Image courtesy Associated Architects

Right Care, Right Here

Right Care, Right Here continues to be a crucial local service partnership for the Trust. The board of RCRH now has an independent chair, and the Trust contributes to the cost of a programme office to support the work of the partnership. In 2014/15 partners have been active in their support of the approval of the Midland Metropolitan Hospital OBC in July 2014. During 2015/16 RCRH will oversee the collaborative development of the urgent care system which will support that hospital development, and whose success is crucial to the sizing of it.

The Trust is working with GP partners to put in place systems to allow clinicians in the hospitals to book appointments for patients in need with local general practices. We see this as a pivotal change in the local NHS landscape, allowing true urgent care integration to develop. In the year ahead we will also look to build on the urgent care mental health partnerships that we have funded and promoted during 2014/15. Alongside the Black Country Partnership, and Birmingham and Solihull Mental Health Trust, we were proud to present our case for increased and long term funding of these vital services to the Sandwell Health and Wellbeing Board. The commitment made by the Sandwell and West Birmingham CCG to fund psychiatric liaison in the long-term, allowing substantive recruitment, is an important change in the last twelve months in the local NHS landscape.

Beyond this collaboration, we work closely with specialist centres locally, whilst we ourselves deliver a number of regional specialty services. We have reached agreement with University Hospitals Birmingham to improve cancer services locally, with the Trust making a major investment to ensure that the scale and governance of services is commensurate with need. Cancer services at Sandwell and West Birmingham can be further improved, and the Board's focus on this, through our risk register, is an indication of the bottom up governance of quality, safety and risk that we want to develop more generally. During 2015/16 we will review renal provision through our sites to ensure that equal access is being offered across our local population, and that we are taking due account of future growth and need in how we offer care.

8. Our charity's contribution to going the extra mile

The Trust charity – review of 2014/15

The Trust's umbrella charity is 'Sandwell and West Birmingham Hospitals NHS Trust Charities', which is made up of a mixture of funds and subsidiaries.

This includes funds for the purpose of research, to support NHS staff, to benefit patients, for health promotion and for elderly care. Charitable funds should be spent on schemes that are not usually funded through existing NHS financial arrangements.

Our vision is to enhance the experience of all people accessing SWBH including staff, patients and their families. We will do this by providing additional facilities and supporting innovative projects that create a comfortable and secure environment.

We have also agreed the strategic priorities for the charity to provide a clear platform to generate income and to ensure appropriate spending of the charity's funds.

Our priorities for spending charitable funds are:

1 – Infrastructure

- Improving the Trust's environment and making capital improvements to facilities.
- Supporting integrated care across the estate of SWBH and allied providers.

2 – Education

- Supporting the educational development of clinical and non-clinical staff.
- Aim to secure the long term future of health and social care in Sandwell and West Birmingham to support education within the local community

3 – Innovation

- Help the trust to be a leader of innovation, pump priming activities, running pilots and testing out new ideas and technologies for care that enhances outcomes for local people.

4 – Community resilience

- Support communities to improve their health outcomes, enabling them to provide outstanding, compassionate care independent of statutory providers.

Looking ahead

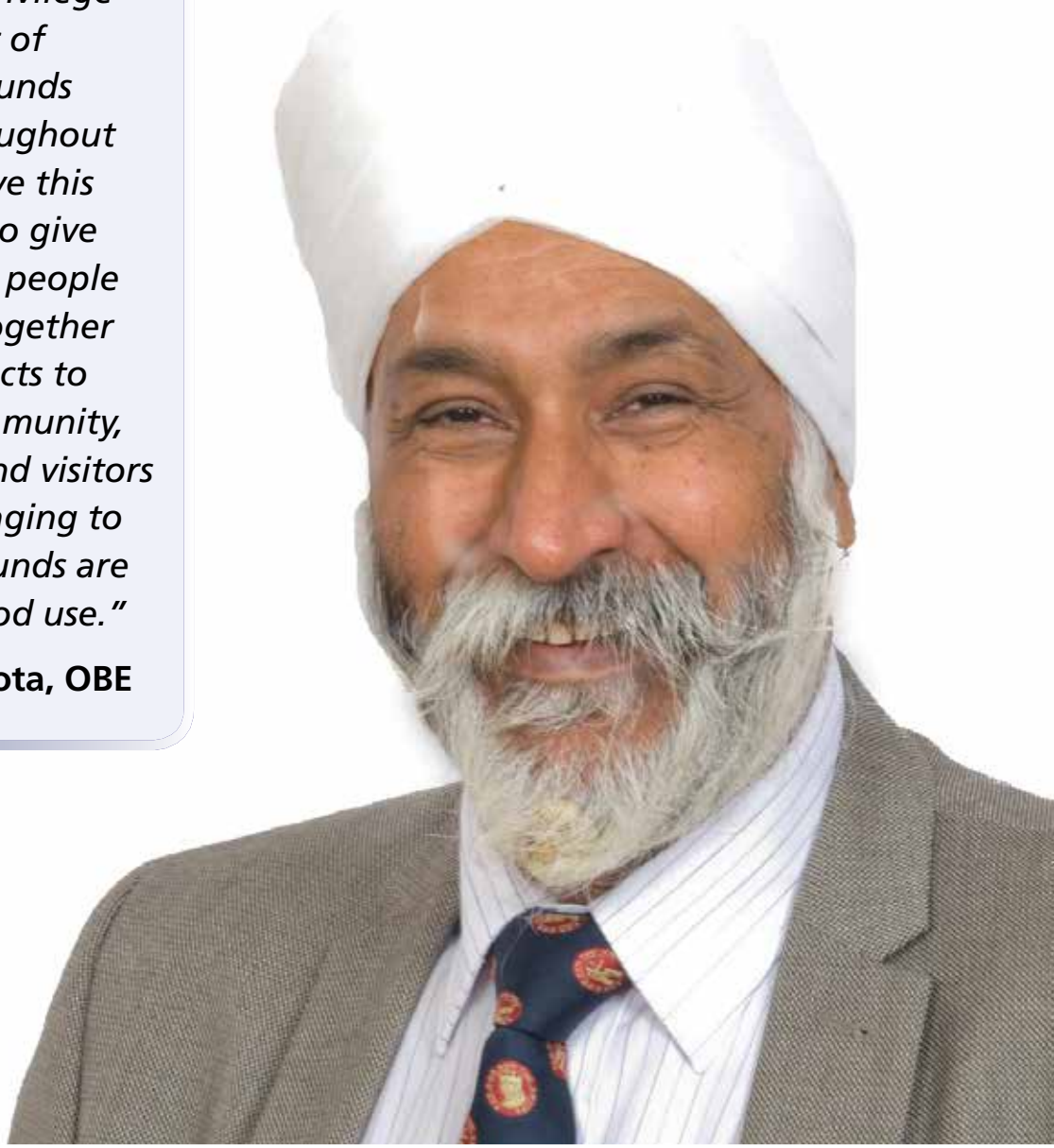
In the year ahead we will:

- Relaunch our charity's brand with an integrated marketing and communications campaign to raise its profile.
- Increase awareness of the brand, engage and involve staff in becoming active in fundraising opportunities.
- Build and sustain a significant annual income to support the charity.
- Establish a "Pennies from Heaven" scheme enabling staff to donate to the charity through salary/direct debit.
- Deliver an effective grant making strategy.
- Develop an appeals fundraising programme.
- Launch a revised benefits membership scheme.
- Develop improved links with the local community.
- Develop links with employers to generate commercial and CSR opportunities.
- Ensure the bid schemes are supported to keep on track.
- Develop the charity to become one of the leading healthcare charities in the region.

Throughout the final quarter of the year, project leads for the bids have been ordering the relevant equipment and setting up the new programmes, many of which are being implemented straight during quarter 1 of 2015/16.

"It has been a privilege to serve as Chair of the Charitable Funds Committee throughout the year. We have this year been able to give out over £1m to people who have put together innovative projects to support the community, patients, staff and visitors and it is encouraging to see how these funds are being put to good use."

Dr Sarindar Sahota, OBE



Bidding programme

In October 2014 we opened our bidding process in order to give funds to charitable projects (schemes that are not usually funded through existing NHS financial arrangements) that support the charity's strategic priorities. We received over 80 bids for small and large grants, many of which were developed in partnership with local community groups and stakeholders. Through the application process we agreed to fund 17 small schemes, and 14 large schemes including specialist equipment.

Small scheme grants

Project	Team	Award (£)
Furniture for mental health room at City ED	Emergency Department	1000
Interactive portable lifestyle display aimed at stroke prevention	Early Support Stroke Discharge Team	4301
Faculty Development in Simulation	Anaesthetics	4800
Hoverjack for Moving & Handling Training	Workforce	5000
Training programme to improve communication within maternity	Obstetrics and Gynaecology	5000
Virtual rehabilitation – Stroke Unit SLT (Speech and Language Therapy)	Speech and Language Therapy / Stroke team	5080
SWBH Singing Programme	Strategic Planning & Business Development	2000
Hospital Preparation Pack for local primary schools	Paediatrics	5000
Activity packs to support siblings on the neonatal unit	Neonates	1500
Targeting Diabetes HbA1c outcomes using the Libre flash sensor.	Diabetes Centre- City Hospital	3730
New equipment to support a High Risk Foot Biomechanics clinic	Foot Health	11,000
Patient programme for stroke patients (Bridges)	Early Support Stroke Discharge Team	3954
Soho/Victoria Friends & Neighbours community support	Occupational Health	3954
The Learning Works marketing programme	Workforce	5000
Asian X-PERT Diabetes Programme	Diabetes	5000
Sandwell Healthy Hearts Community Champions Project	Dept of Clinical Biochemistry and SMRU	5000
Blinds for Henderson re-ablement unit conservatory	Henderson Re-ablement Unit	4000

Large scheme grants

Project	Team	Cost (£)
Invest to Save - portable bladder scan	Community Continence Service	26,980
Ultrasound equipment at The Lyng (note link to pain management proposals)	Pain Management	43,500
Purchase of a Hand Held Image Intensifier (Mini C-Arm Imaging)	Directorate B: Orthopaedics and Orthotics	68,200
Ultrasound at the Front Door	Acute Medicine	51,440
Equipment for ambulatory pleural service and mobile diagnostic equipment for suspected lung cancer	Respiratory Medicine	100,000
Portable fibroscan machine	Gastroenterology	36,000
Residential pain management programme – funding to pump-prime a Midlands centre	Pain management	40,000
Community pharmacy-led diabetes renal clinic	Medicine – Diabetes & Endocrinology	45,000
Sobriety Units for Acute Alcohol related problems – proportion of funding to be given to allow a pilot scheme	Acute Medicine, Medicine Group	250,000
'Meet and Greet' service for patients and visitors – proportion of funding to be given to allow a pilot scheme	Strategy	243,000
Integrated response to Domestic Abuse within EDs at Sandwell and City Hospitals	Safeguarding	250,000
Equipment to allow jaundiced babies to be held while having treatment	Neonatal/women and child health	60,000
TB screening for homeless people in Sandwell and West Birmingham	MXU	30,000
BMEC Development of Nurse Led Uveitis Clinic	BMEC	25,000

Throughout the final quarter of the year, project leads for the bids set up their new programmes, many of which were implemented earlier this year.

Perryfields High School raises £500 for the SWBH Charity

Perryfields High School in the West Midlands has raised a fantastic total of £500 for the Sandwell and West Birmingham Hospitals (SWBH) Charity through a number of fundraising events including a cake sale, a dance show and an all-time student's favourite - a non-uniform day in honour of one of their favourite teachers. Teacher Graham Newson, along with his wife, colleague Di Green and two smartly dressed students paid a visit to City Hospital in May last year to hand over the cheque in support of the Oncology department. Graham who is an Oncology patient at SWBH said he was 'delighted with the amount raised and that the support of the school was outstanding'. A total of 1,200 students got involved with the fundraising events in support of their teacher. The cake sale which went down a storm, helped to raise most of the £500. There was something for everyone to get involved with throughout the weeks of fundraising and the fantastic amount raised goes to show what a caring school it is. The Perryfields visitors were greeted by the SWBH Charity's Fundraising team and Chemotherapy Sister Amanda Downes. There were smiles and laughter all round as the cheque presentation was made in the beaming sunshine.

Asda's Easter Surprise at Sandwell Hospital

Last April, children at Sandwell General Hospital were delighted when the Easter bunny paid them a visit on the paediatrics unit. Local Asda stores generously donated Easter goodies including stuffed animals and arts and crafts to entertain the children over the Easter period. Paula Beddoe and Lisa Pearson, Community Life Champions for Asda Tipton and Asda Great Bridge paid the unit a visit, arms filled with gifts for the children. Lisa said "we always enjoy our visits to the children's unit and really hope they all enjoyed their gifts!" The Asda stores in Oldbury, Tipton and Great Bridge are working with Sandwell and West Birmingham Hospitals (SWBH) Charity to provide extra support to the children's unit which is one of the largest in the region.

ED Nurses leading the way with eyecare

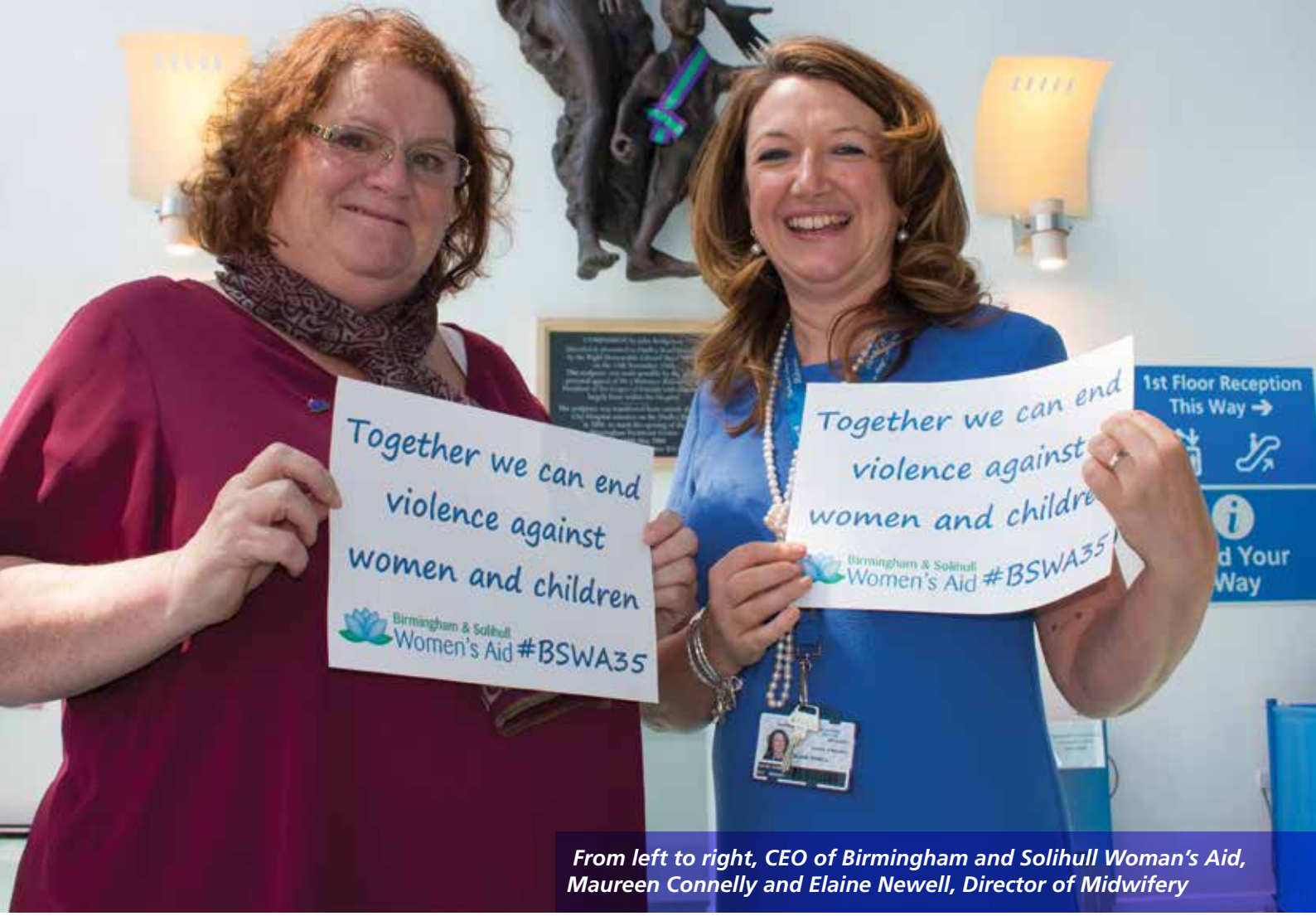
Nurses in the Emergency Department at Birmingham and Midland Eye Centre will soon be taking the leading role in treating patients with Acute Anterior Uveitis flare ups, a painful inflammation of the middle layers of the eye, thanks to Sandwell and West Birmingham Hospitals charitable funds. The new model of working utilises the skills of nurse practitioners and is led by Birmingham Midland Eye Centre is only one of two services providing the same level of care in the country. The new service aims to ensure patients are treated quickly, allowing treatment to be started rapidly which will help to improve outcomes for the patient.

Charitable funds buy new liver scanner

Thanks to support from the Trust's charitable funds and the League of Friends we will now be able to more easily scan patients to assess the extent of any liver damage. In 2012 charitable funds also helped to buy a liver scanner for Sandwell Hospital. The FibroScan gives instant results and avoids the need for an uncomfortable and potentially harmful biopsy. The new scanner is based at City but unlike the one at Sandwell, the new one is portable, meaning it can also be used in community locations and on the wards, where that better suits the patient.

Cancer Services Choir

Singing is proven to improve your mood, breathing and well- being and patients, carers and staff have reaped the benefits with the setting up of a choir to prove it's not all doom and gloom when you have cancer. Meeting every two weeks for rehearsals at the church hall opposite Sandwell Hospital, the charitable funds have supported the choir by paying for practice premises, uniforms and transport which has enabled them to performs several gigs across the region and increase their profile.



From left to right, CEO of Birmingham and Solihull Woman's Aid, Maureen Connelly and Elaine Newell, Director of Midwifery

Tackling Domestic Violence

Domestic violence and abuse is an ongoing major public health issue with devastating consequences for its victims.The NHS plays an important role in addressing domestic violence and abuse; however, it's recognised that there is sometimes insufficient focus placed on supporting victims of domestic violence and abuse beyond the first aid provided by front line staff.

The NHS increasingly spends more time dealing with the impact of domestic violence and abuse, more than almost any other agency and is often the first point of contact for victims. It's here that A&E departments can play a pivotal role in identifying, responding to and helping prevent further domestic violence and abuse.

The Trust has decided to tackle the problem of domestic violence and abuse head-on by successfully securing funding from the Trust's charity for a new integrated response service.

Specialist support staff from Sandwell Women's Aid are working at Sandwell and City A&E departments to provide expert crisis response and refer victims and their children for ongoing support.

This enhances the safeguarding of both adults and children and supports the trust in delivering local and national policies. Having specialist domestic abuse support workers working in partnership with front line staff in A&E also reduces some of the daily pressures seen within A&E departments.

Wellbeing Fair for Cancer patients and carers

Now in its fourth year and continually growing this much loved event, held at West Bromwich Football Club, gives patients, carers and their families the opportunity to come together in a relaxed and engaging environment and focus on their well -being pre, during and post cancer treatments.

Packed with informative sessions, speakers and taster sessions in Tai Chi, hand and arm massage, yoga, laughter and entertainment, the day celebrates the patients and families journeys to date and provides a stimulating and positive outlook on dealing with cancer.

Fundraising

Fundraising activity has taken place throughout the year. The Trust held a Snowflake appeal to raise almost £100 for patients in hospital during the festive period. Patients, visitors and staff were invited to make a wish and hang it on the tree in the lead-up to Christmas. This has been continued with the Breast Unit as their Tree of Life.

Marks & Spencer, Sutton Coldfield, granted SWBH as their chosen 2015/16 charity. The store has worked with the fundraising team to develop a series of fundraising events and promotions (including a Sky Dive Challenge) to support the Trust in recognition of the vital care their colleague received during his treatment for lung cancer.

Steve Smith, fundraising officer accepts cheque from Shaana Shabir, Asda Perry Barr

Asda Perry Barr granted SWBH as their chosen charity donating funds and gifts over Easter.

Tesco, New Square West Bromwich donated gifts to be raffled off in support of the charity and are working with the fundraising team to explore new opportunities and generate more revenue.

New Square, Centre Management, West Bromwich are working in conjunction with the fundraising team to explore new event opportunities on their site, engaging local retailers and communities.

The Trust joined up with the British Heart Foundation (BHF) to raise funds for the Trust heart fund and for BHF during the wear it, beat it campaign.

Funds were also raised for the Cancer team's wellbeing event planned for July 2015 and for the FINCH department's charity fund raising over £900 in total.

W.B.A player Victor Anichebe presents toys to Sandwell Childrens Ward

Sports Trust UK organised a charity football match and gala dinner to raise money for Sandwell Children's ward.

Pure Gym West Bromwich, have partnered with the fundraising team to develop a series of money making fitness challenges to support the charity.

Legacies and Donations

Generous donations and legacies and have continued to support the Trust's charity and we remain ever grateful for the support of patients, employees and relatives who give significant funds to help further the charity's aims. We have also received donations of toys from local businesses and sports clubs including West Bromwich Albion.

£228,318.37 was donated by the late Margaret Joan Pearce to the Cancer Development Fund.

£705.00 was donated in the memory of the late D Sanders to the Coronary Care Unit.

£1650.00 was donated in the memory of the late Graham Newsome from Graham's wife Michelle and his past pupils at Perryfields and Britannia High Schools to the BTC Oncology Department, Sandwell..

"I cannot speak highly enough of the treatment that Graham received. The care and compassion shown to both me and Graham was excellent. I am really pleased that the donation can go specifically to the hardworking, dedicated and supportive team that helped Graham throughout his treatment and to the benefit of other patients who are going through very difficult treatments". Michelle Newson, Graham Newson's wife.

STATEMENT OF FINANCIAL ACTIVITIES

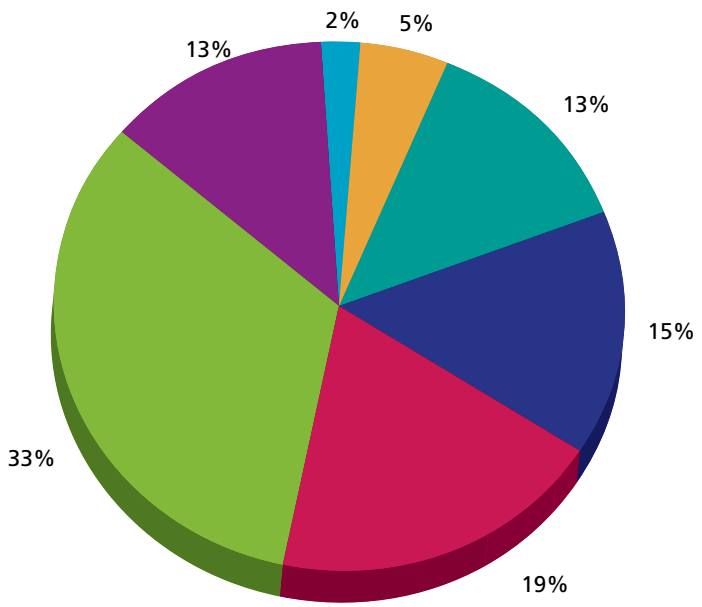
	Unrestricted Funds	Restricted funds	Total Funds	2013/14
	£000	£000	£000	£000
INCOMING RESOURCES				
Incoming resources from generated funds:				
Voluntary Income:				
Donations	1,138	167	1,305	952
Legacies	99	228	327	461
Investment income	31	20	51	134
TOTAL INCOMING RESOURCES	**1,268**	**415**	**1,683**	**1,547**
RESOURCES EXPENDED				
Costs of generating funds:				
Investment management costs	7	6	13	7
Charitable activities:				
Patients welfare and amenities	313	47	360	537
Staff welfare and amenities	198	70	268	234
Research	0	182	182	228
Total Charitable Activities	511	299	810	999
Governance costs	29	18	47	41
TOTAL RESOURCES EXPENDED	**547**	**323**	**870**	**1,047**
NET INCOMING / (OUTGOING) RESOURCES BEFORE OTHER RECOGNISED GAINS OR LOSSES	721	92	813	500
Other recognised gains and losses:				
Gains/(losses) on revaluation and disposal of investment assets	171	110	281	22
NET MOVEMENT IN FUNDS	892	202	1,094	522
Reconciliation of Funds				
Total funds brought forward	3,229	2,600	5,829	5,307
TOTAL FUNDS CARRIED FORWARD	**4,121**	**2,802**	**6,923**	**5,829**

STATEMENT OF FINANCIAL ACTIVITIES

	Unrestricted Funds	Restricted funds	Total Funds	2013/14
	£000	£000	£000	£000
FIXED ASSETS				
Investments	2,662	1,708	4,370	4,511
TOTAL FIXED ASSETS	2,662	1,708	4,370	4,511
CURRENT ASSETS				
Debtors	133	8	141	114
Cash at bank and in hand	**1,397**	**1,127**	**2,524**	**1,292**
TOTAL CURRENT ASSETS	1,530	1,135	2,665	1,406
LIABILITIES				
Creditors falling due within one year	71	41	112	88
NET CURRENT ASSETS / (LIABILITIES)	1,459	1,094	2,553	1,318
NET ASSETS	4,121	2,802	6,924	5,829
THE FUNDS OF THE CHARITY				
Restricted Income Funds	0	2,802	2,802	2,600
Unrestricted Income Funds	4,121	**0**	**4,121**	**3,229**
TOTAL FUNDS	**4,121**	**2,802**	**6,923**	**5,829**

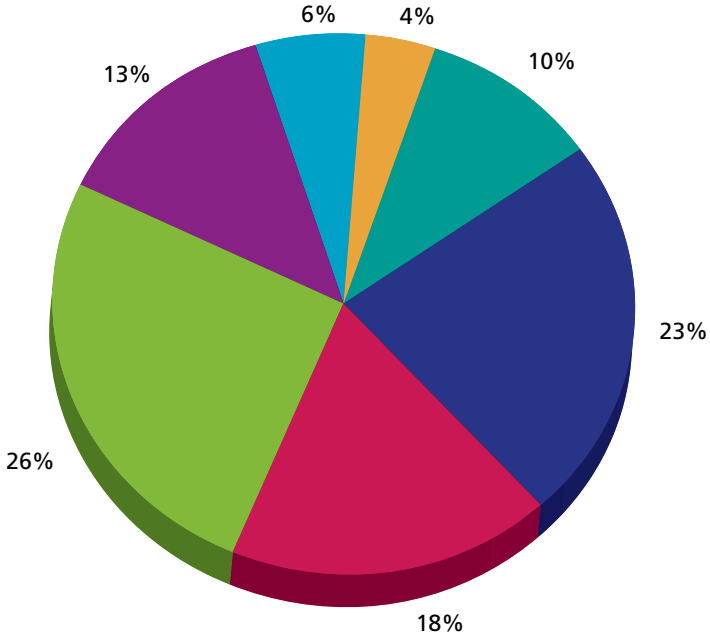
Charity Investment Portfolio 2014/15

Current portfolio



- Fixed Interest **15%**
- UK Equities **19%**
- Overseas Equities **33%**
- Hedge Funds **13%**
- Commodities **2%**
- Property Assets **5%**
- Cash **13%**

Proposed portfolio



- Fixed Interest **23%**
- UK Equities **18%**
- Overseas Equities **26%**
- Hedge Funds **13%**
- Commodities **6%**
- Property Assets **4%**
- Cash **10%**

9. Our future and the year ahead

Our annual plan for 2015/16

Every team in the Trust develops a plan for the year ahead. Putting these together, the Board agrees an annual plan, which reflects our contracts with commissioners and the mandate for the NHS approved by Parliament. Our annual plan for 2015/16 is ambitious; it contains thirty commitments, including the five quality priorities cited in our quality account. A copy of our annual plan is on the front-page of the Trust website, and that plan on a page is annexed to this report.

Our long term plans

During 2014/15 we published and agreed some long term plans for the Trust. These covered public health, research and development, our workforce and financial models. In 2015/16 we expect to publish similarly important documents on education, quality and safety. The Trust's executive is responsible for delivering on these plans, and the committees of the Trust Board track in-year compliance against these longer term goals.

In a number of fields we need to take action now, with a view to 2018 or 2020. In particular, we have identified three major drivers of improvement in healthcare:

- **Our workforce:** The Trust is committed to increasing investment in staff wellbeing and training. Whilst it is recognised that we will employ fewer people in 2020 than we do today, we are committed to retaining and redeploying skilled staff best able to deliver care, even as services change to meet the Five Year Forward View published by NHS England.
- **Our information technology:** During 2014/15 we approved a major investment in technology through our Electronic Patient Records business case. This will move to procurement in 2015, and deployment by the middle of 2017. IT skills will be a key workforce requirement, and increasingly we will use technology to support safety and standardisation of care.
- **Our estate and service configuration:** By 2018-2019 we expect to be delivering emergency and acute care from one location: The Midland Metropolitan Hospital in Smethwick. During 2015 we are investing to complete service changes at Rowley Regis. Redevelopment plans for Sandwell and the Sheldon Block at City Hospital are well advanced. In autumn 2015, we will make significant changes to the location of acute inpatient services for cardiology and general surgery.

Our 2020 Vision

In 2014 we adopted a definition of integrated care, which was extensively consulted upon by National Voices among patients and service users across the NHS. This suggests:

> *"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."*

During 2014/15 we have been consulting patients and staff about our long term plans. Building on that definition we have developed a strategy called our 2020 Vision. In 2015 we will consult upon that locally. It describes how our services will change to reflect changes in the population and the need to develop more services at home.

The vision is very much in line with the Right Care, Right Here philosophy that underpins health and social care joint working locally. What our vision clearly shows is the opening of the Midland Met in 2018 is an enabler to our future, not the driving force for changes at the Trust. Our purpose is for the people we care for see their care as integrated, and delivering the outcomes that are important to their health and their needs.

Beyond 2020

The population served by the Trust will grow and age in the years ahead. Similarly across the Black Country and throughout Birmingham we will see rising needs for care. The NHS faces profound workforce challenges, perhaps especially in general practice. These issues mean that it is very important that organisations work closely together to design future services around the needs of patients: getting better outcomes for more people, but spending less money in doing so.

The Trust continues to contribute to that wider thinking across the West Midlands about how we develop our workforce, with local universities and colleges, and how we change services to meet needs. In particular we are working closely with:

- Both local mental health providers to ensure that adult and paediatric services are available to support physical care, the treatment of which can often identify wider psycho-social needs which need support and attention.
- General practices, optometrists and community pharmacies, who provide more than 90% of the care offered by the local NHS, and on whom our services depend. The Trust can both contribute to recruitment into these services, and improve the quality of working life for partners by how we operate alongside them.
- Peer care providers, especially neighbouring Trusts in Walsall and in Dudley, with whom we share common values and care models, and on whose support our future plans for Midland Met very much depend. More than a million people are served by the Trusts acting together, and we believe that there are further benefits from close collaboration in the future.

Design of the planned Midland Met Hospital

Annual plan 2015/16 on a page

Includes our top 10 | Thirty key metrics in all

10 metrics with monthly Board focus

Safe, High Quality Care

- Reduce readmissions
- Achieve the gains promised within our
- 10/10 programme
- Tackle caseload management in community teams

Accessible and Responsive

- Deliver our plans for significant improvements in our universal Health Visiting offer
- Work within our agreed capacity plan for the year ahead

Care Closer to Home

- Implement our Rowley Regis expansion plans (Rowley Max), so that by March 2016 we have in place our RCRH model on the site

Good use of resources

- Create balanced financial plans for all directorates, and deliver Group level I&E balance on a full year basis

21st Century Infastructure

- Agree EPR Outline Business Case, and initiate procurement process, whilst completing infrastructure investment programme
- Reach financial close on Midland Metropolitan Hospital

An effective organisation

- Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness

Our priorities across the Trust's six strategic objectives

- Improving outpatients by implementing phase 2 of our Year of Outpatients programme
- Meeting the improvement requirements agreed with the CQC
- Meet national wait time standards, and deliver from October a guaranteed maximum six week outpatient wait
- Double the number of safe discharges each morning, and reduce by at least a half the number of delayed transfers of care in Trust beds
- Implement Advice and guidance support for GPs in all specialties, and expand use of video technology to consult with patients
- Expand iCares and heart failure services to provide improved provision in West Birmingham
- Ensure that we improve the ability of patients to die in a location of their choosing, including their own home
- Support agreed projects with selected GP partners through the CCGs 'push sites' initiative
- Respiratory medicine service sees material transfer into community setting
- Implement successfully and safely the new tariff regime
- Develop our capital plan, and execute spend in line with that plan
- Reform how corporate services support frontline care
- Reform how corporate services operate to create efficient transactional services by April 2016
- Complete consultation on, implement and evaluate the reconfiguration of interventional cardiology and acute surgery between our acute sites
- Develop, agree and publicise final location plans for services in the Sandwell Treatment Centre
- Finalise and begin to implement our RCRH plan for the current Sheldon block
- Finalise our long term workforce plan
- Create time to talk within our Trust, so that engagement is improved
- Agree and begin to implement our three year Education Plan
- Complete the second year of our leadership development programme

10. Appendices

Annual Governance Statement

1. Scope of responsibility

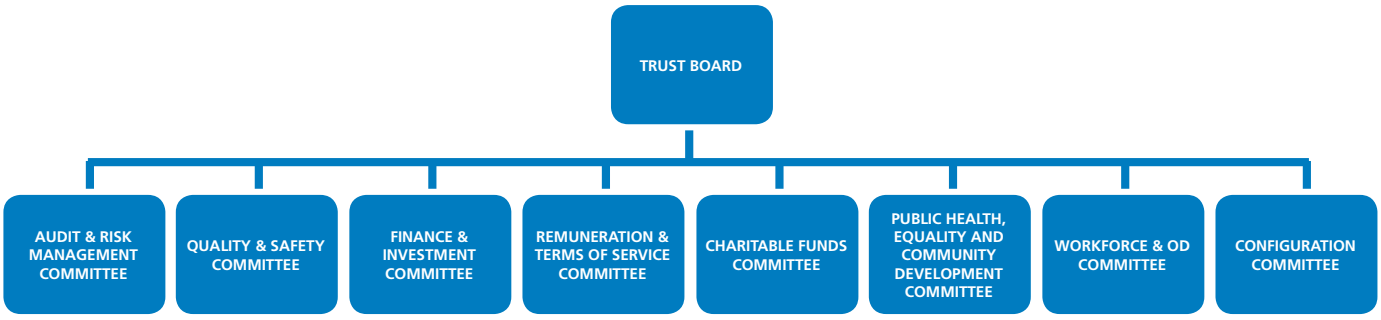
1.1 The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding 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. During 2014/15, this accountability has been augmented by more explicit obligations around the duty of candour, as well as my responsibilities within the Board in respect of fit and proper persons.

1.2 Our internal controls reflect both a duty to work in partnership with others, and the necessity to do so to manage risks and inter-dependencies. In the last year, this has necessitated involvement in the Right Care, Right Here Executive and Board, which oversees strategic change in our local system. The Trust has been represented by our Chief Operating Officer in the System Resilience Group which brings together statutory partners to ensure delivery of the mandate. On a weekly basis myself and the CCG accountable officer have discussed progress in this regard, along with representatives to the two local authorities with whom the Trust works.

2. The governance framework of the organisation

2.1 The organisation is led strategically by the Trust Board. In 2014/15 we are in the second year of a governance model which we consulted upon in spring 2013 and implemented in mid-year. This model is shown overleaf. It is designed to balance in-year control, with a long-term focus which is prospective and holds executive directors to account for the compliance of in year actions to multi-year plans. I discuss below an assessment of that approach as have now completed over a year working with it.

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 As reported last year we set out to accomplish some specific changes with our revised Board governance model:

- To ensure that quality and safety was at the heart of our agenda, and that the management of national wait time standards was part of that work. The quality and safety committee took responsibility for this portfolio, and this has been successful in ensuring that all service delivery matters are appraised monthly in one place.

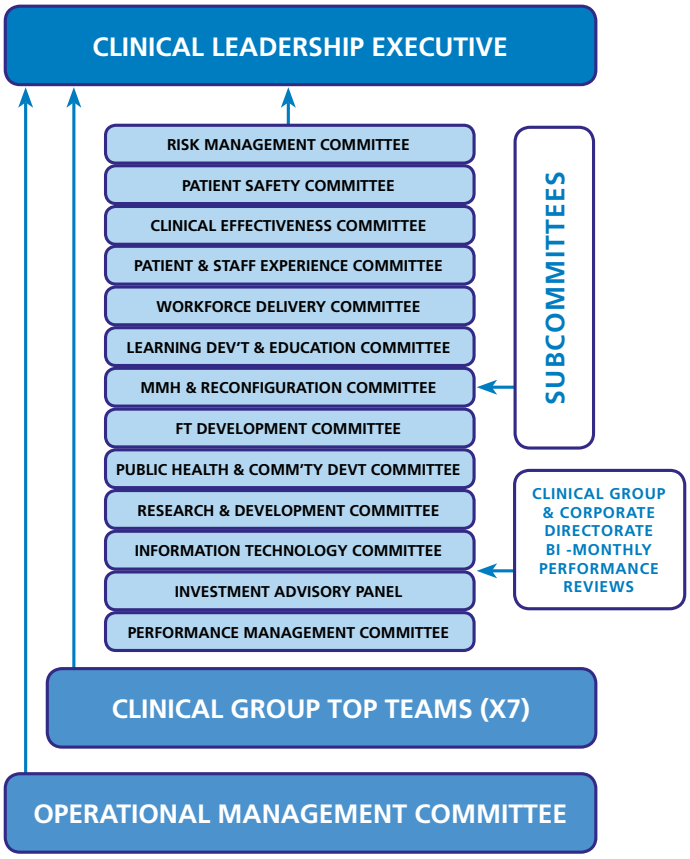
- To ensure that our finance and investment committee could focus both on option appraisal for major business cases, as well as its work supporting the delivery of cost reductions, and the reform of our finance function. This has been achieved, with an escalation in the regularity of oversight through this committee to reflect delivery issues in Q1 and Q2.

- To create a single clear focus on staffing, workforce and the development of the organisation, through a dedicated committee with that purpose. This has undoubtedly driven Board focus on these matters, although the true effectiveness of these changes will be demonstrated, or otherwise in the year ahead, now that we have appointed to our Board-level Director of Organisational Development, and will from April 2015 operate through a single workforce directorate.

- To broaden the remit and impact of the prior Audit Committee and ensure that it supports our full Board's focus on revised risk management arrangements. Those revisions are assessed below. The centrality of the Trust's Risk Register to our governance at Board level during 2014-2015 is very evident in both the agendas, minutes, and specific service changes or advanced as a result.

- To oversee the 'to time, to budget' approach to the Midland Metropolitan development, which was supported by HMG in July 2014. The project remains on time and on budget.

2.3 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.



2.4 The risk management committee and operational management committee commenced work in early 2014. Both have manifestly driven cross directorate working, as well improved focus on risk mitigation within the Trust. A review by the Clinical Leadership Executive has concluded that three clinical cross cutting groups are needed in addition to the above system focusing respectively on services for children, theatres management and critical care provision Trustwide. These will be implemented during early 2015/16.

2.5 Bi-monthly performance reviews take place with Clinical Groups. These are attended by the full executive to reflect a single delivery conversation. During 2015/16 we will work to ensure that consistently this model is adopted at directorate level. Similarly, corporate functions have bi-monthly performance reviews with the Chief Executive, focused on their functional delivery in support of clinical teams. During 2015/16 we will work to incorporate very direct clinical directorate feedback into those processes. Our annual priorities and plan for 2015/16 reflects specifically on the need to reform corporate functions to better support and improve frontline delivery.

2.6 The Trust has and continues to seek to develop local, frontline and clinical leadership. We have completed the first of a three year leadership development programme, supported by the Hay Group. Supporting improved capacity and capability in our leadership teams is crucial to further improving our control systems. The Board's workforce committee has the role of overseeing this work.

3. THE RISK & CONTROL FRAMEWORK

Risk management and mitigation systems

3.1 The Trust has a clearly developed annual plan, with specific milestones and performance indicators which are reviewed by the Board each quarter. On a monthly basis the board and all of its committees assess delivery using a suite of indicators, shown at Trust, group and directorate level. Operational performance is independently reported through the finance director's team. The annual plan's key risks are reflected in the Board's Assurance Framework. This too is discussed quarterly by the full Board. The Audit and Risk Management Committee has led work, in both formal meetings and in informal workshops, to develop the BAF as a key tool for control and assurance. I am satisfied by how our system has worked in 2014/15, and the improvement discussions are well reflected in our 2015/16 BAF, which we would expect to be even more central in driving our Board's agenda and time.

3.2 Risk registers have been comprehensively refined Trust-wide during 2014/15. This has been supplemented by a very active communications campaign internally. During Quarter 4 2014/15 all Trust risk registers are now published on our internal intranet and file system, and as such any employee can have access to our overall risk position and to specific risks. This has resulted in good evidence that the risk register process drives change and mitigation. We have further work to do to ensure that risks are well reflected in local registers when they are cross-organisational issues. I am satisfied that cross organisational issues are well represented in the corporate risk register seen routinely by the Board. The recent Care Quality Commission report, published 26 March 2015, makes no specific change recommendations around risk management processes, but reflects our self-assessment that we are working to improve the salience and impact of our systems.

3.3 High value risks, unmitigated high risks, and low likelihood, high impact risks are considered by the Audit and Risk Management Committee in detail. Every Board meeting during 2014/15 has considered specific high value risks. We intend to focus even more time on pre-mitigated red risks to test whether the mitigation plans approved in the risk entry are managed to time, and risk scores re-assessed in light of that review.

3.4 An important driver of our risk framework is incident reporting. The Trust is a notably high reporter of incidents. We have undertaken anonymous survey work during 2014/15 with staff to review perceptions of our incident system, which suggests high levels of confidence in its impact on decision making. That data as well as more informal feedback does suggest we have more work to do on mid-level incidents, and closing the action planning loop from them. That is in hand, and is a matter of Board focus. The full Executive receives incident reports from the preceding 24 hours, alongside our clinical groups. From March 2015, all employees are able to run report queries from our incident reporting system, although trend information is also centrally analysed and assessed.

3.5 In 2014/15, the clinical audit and internal audit processes and plans were aligned through the Audit and Risk Management Committee. The audit plans were delivered in large part, and where delays occurred this was reported and approved as tolerable. Action follow through has been tightened considerably in year, and an inherited backlog of audit recommendations has been closed by year end. The Trust-wide system of audit half days will be used during 2015/16 to ensure similar traction for local clinical audit recommendations. A clear and well embedded system for national audit recommendations is in place, and overseen through our Clinical Effectiveness committee.

Accounts, including our quality account

3.6 As in prior years, we have a clear and well understood process for settling our financial and quality accounts. These are presently in draft form and internal review suggests compliance with mandated guidance. For 2014/15, we will publish our accounts by the end of Q1, rather than Q2, in line with standard Foundation Trust practice. Our quality account will form a distinct, but integrated, part of our annual report. The Trust's charity will also be reported to this timescale and in this way.

Information security and data protection

3.7 There are clear arrangements for information security within the Trust, including distinct roles for our SIRO (director of governance) and Caldicott Guardian. Breaches and near miss issues are clearly identified and acted upon, and drawn as required to the attention of the relevant Board committee. Our risk register now reflects an assessment of those issues. Whilst no issues have arisen to date with system integrity or security, this is a high rated risk for us, and extensive investment and oversight of infrastructure is in place for Q1 and Q2 of the year ahead.

We have completed a self-assessment of our Information Governance Toolkit status, and identified room for improvement in specified areas. This improvement work will be managed through the director of governance, with direct quarterly input from the Chief Executive. Our overall intent is to transition from policy and training, into much more active local stress testing of our resilience arrangements.

Data quality

3.8 My 2013/14 AGS identified material concerns in respect of data quality and described the programme of work undertaken in year and into 2014-2015 to address that. This included, but was not limited to, the introduction of an electronic reporting system for mixed sex accommodation, significant changes to RTT data collation and reporting, alterations to emergency care reporting on assimilation of the CCG contracted service in April 2014, and a full review of practice in cancer wait times. The introduction of a data quality kite-mark is a emblematic change in signalling the focus, on an ongoing basis, of the Board, on these issues. The position is improved, and my assessment, with advice, is that our data quality is now on a par with NHS providers in the sector. To gain specific assurance on the quality and accuracy of elective waiting time data the Intensive Support Team were invited to visit the Trust, completing their visit in April 2014; the terms of reference main specification was to review the data submission for external assurance on data completeness. The IST took a thorough review of information systems, the process involved a detailed flow map of all documentation, business rules and information filters with the information department and made a number of recommendations to strengthen the integrity of the Trust's data which have been acted upon where needed. We wish to go further to improve the position, and this work will be fully reflected in our audit plan and operational plans for 2015/16.

Counter-fraud and probity

3.9 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. Successful prosecutions of former Trust employees have been undertaken in year.

An active register of interests is in place at senior level. A clear declarations system operates within the Trust, and procurement activities have a visible register of conflicts of interest. We continue to explore how to develop this system so that it is comprehensive to all employees.

Whistleblowing and duty of candour

3.10 In May 2014, we completed a review of our whistleblowing arrangements and made significant changes to them, including the introduction of a staff helpline and more clear-cut guidance on internal options whose advice staff could seek, including non-executive directors. We have reviewed the implications of the in-year Francis Report on this topic, and will make further operational modifications to our approach during 2015/16, reflecting a review of the new arrangements by the Board at the beginning of April 2015.

Employee employment checks, professional registration lapses and revalidation

3.11 The Board's workforce committee has responsibility for ensuring both policy and practice in CRB and other employment checks is suitable. An extensive audit was conducted in late 2013/14 in this regard. I am satisfied that our arrangements are suitable, notwithstanding some record gaps for low risk staff transferred from the prior PCT in 2009.

A small number of registration lapses have been identified in year, all within days. Each has been assertively managed and resolved.

The Trust remains green rated for its implementation of both consultation revalidation and educational supervisor accreditation. Work is in hand to prepare for nursing and midwifery obligations in coming years.

The fit and proper persons test has been extensively reviewed within the Board, with advice. The Trust will meet its duties from 1 May 2015.

Safeguarding and DOL

3.12 We have benefitted during 2014/15 from our own internal review of our practices, as well as work with both Safeguarding Boards in Birmingham and Sandwell. Geographical reviews by the Care Quality Commission have taken place, as well as Ofsted inspections. Each carries a similar message of improvement from a low base. The right actions and systems in place, notwithstanding data sharing issues for emergency attendees from out of area which remain a national weakness locally manifested. The Board has a scorecard for Safeguarding improvement that is wishes to achieve, which focuses not only on training and notifications, but on wider indicators of progress in ensuring that the whole organisation is involved and engaged in these issues.

Having reviewed our systems to monitor and report deprivation of liberty arising from recent case law, a PHSO finding against the Trust from 2012, and in view of our regulator's inspection, I am satisfied by the sufficiency of our arrangements.

Equality and diversity systems

3.13 During 2014/15 we undertook a comprehensive EDS2 self-assessment in support of the Board's approved equality plan (October 2014). The LIG process is ongoing, and we are confident of complying with our obligations under the standard NHS contract for 2015/16. The Board oversaw publication of our annual equality report to time and standard. Changes in how we collect outpatient data at attendance in clinic will materially improve during 2015/16 our protected characteristics data for those receiving our services. Work in this domain is overseen by the a full Board committee, led by the Trust's Chairman.

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. I note that the recommendation in 2013/14, to focus renewed attention on strengthening risk management systems, has been well reflected in our work in the succeeding twelve months, and to good effect.

In 2013/14 I identified three areas of ongoing concern within the Annual Governance Statement. Each has been improved to the point, where I consider that they can be managed as 'business as usual':

- 18 week data integrity: Not only is the Trust now reporting high volumes of non-admitted patients, but we have implemented electronic systems that reduce our risk of data entry error. The Intensive Support Team have reviewed many of our long wait patients, and our work has been helped by external hires into our own staff. There remain legacy issues for us, which continue to receive focused effort from the Chief Operating Officer and her team.

- Never Event Controls: There can be no room for complacency, notwithstanding a year free of Never Events. We have reviewed all listed events and have identified controls and risk mitigations in place. In two instances, theatre listing and prescribing control, our solutions are second best due to IT constraints until 2017. That said, our control environment, and culture on these issues, is altered from the 2013 position.

- Non-pay accruals: The finance team have investigated and satisfied themselves about the consistency of reporting practices across our Groups. As such I am content that our data is timely and reflects best endeavours to balance receipted and anticipated expenditures.

4.2 The Trust has had its regulatory risk status elevated during 2014/15. Whilst our CQC Intelligent Monitoring rating improved to the best feasible (6), our inspection visit identified an overall Requires Improvement rating. At the same time deteriorating emergency care standard performance led to TDA escalation. I am satisfied that we have clear plans to tackle the issues cited. There is neither denial nor delay about these issues, nor can strong delivery in most areas of practice defray the need to improve in others.

4.3 We have continued a strong tradition of good financial performance. At Trust level we achieved key indicators, including our I&E target for 2014-15, which we marginally exceeded due to exceptional items. It remains the case that delivery is achieved only in part through the plan we set, and delivery at directorate level remains mixed. However, in the context of the straightened circumstances of NHS finances, this remains a successful position. Crucially to be my judgement, the improvement in Trust delivery of finance in the latter part of 2014/15 reflects effective action, as well as impactful Board oversight. Notably for pay, the organisation has demonstrated that it can take steps to safely change use, and spend.

4.4 Engagement with both the Health and Safety Executive, and the Information Commissioner's Office, during 2014/15 has resulted in approved plans to address issues identified by them – respectively in respect of sharps injuries, and data protection breaches. The sufficiency of our control environment is demonstrated by the pace of remedy, as well as the senior level focus these problems attracted. We are vigilant to deviation and act upon it.

4.5 In year we have focused very strongly on staffing control and assurance. We have fully revised our nursing establishments and undertaken considerably scrutiny of their compliance with both the Safe Staffing reporting tool, and NICE guidance on ratios. We implemented changed controls in respect of agency staffing, and standardised risk assessment protocols for focused care where one to one nursing was required. The Board sought to drive improvements in sickness rates and vacancy/time to fill. The latter has been more successful than the former, albeit both initiatives remain high priorities in the year ahead. In summary, the control environment in respect of staffing – that it is a managed position, driven by risk assessments, is a strong one and improved from prior years. National audit work, as well intensive assessment of our processes because of our long term workforce plan, provides additional confidence in our approach.

4.6 Our systems for exercised control over safe clinical practice are extensive, and the strong infection control and mortality position achieved by the Trust suggests that they are effective. Our mortality review system, coverage of VTE assessment and MRSA screening, and improved pressure ulcer, c-difficile and falls positions, all confirm both that we are focused on improving standards, and that we are consistently curious about scope to further improve our position. Neither CCG, TDA nor CQC scrutiny has suggested specific improvements needed in those systems, and in some facets we are identified as a regional role model.

4.7 There are however five areas of control concern which will require work during 2015/16.

- The Trust's Improvement Plan, published simultaneously with the CQC review of the organisation, identifies a small number of areas where control lapses are identified: Hand-washing compliance, notes and medicines security. Each will be governed within our public framework for tackling this plan, and we have confidence that the measures we have already put in place, and will have in situ not later than the end of October 2015 provide a sound basis for change.

- That work, and other work over the last two years, identifies an improved, but still not satisfactory position, in ensuring 100% compliance with our policies and best practice around Do Not Resuscitate documentation. This will be the focus of extensive additional focus during 2015/16 to ensure that the practice common in much of the Trust is consistently achieved organisation wide. As with the consent position above, we want to move to outstanding practice.

- We have a strong Trust level business continuity plan, and experience in the last two years of handling in practice major technology outage issues. However, there remain concerns and assurance gaps in respect of both local planning, and testing/simulation activities for significant if not major incidents. We will work to close those assurance gaps during the coming year.

- Our continued reform of financial functions has identified opportunity to strengthen further our systems, and controls, in respect of non-pay expenditure. This project will take place during early 2015/16 as part of work to secure both cost improvement, and an organisation where it easier for frontline staff to make things happen.

- The governance of small to medium scale capital project implementation is being strengthened to ensure timely delivery, and better prospective assessment of delivery. This is relevant to IT and estate projects. Weaknesses are reflected in our capital undershoot in the last three years.

4.8 In addition to the above list, the material deterioration in delayed transfers of care (they have doubled in 2014/15 vs. 2013/14) indicates slippage in intra-organisational governance and grip. Steps in place with Sandwell Metropolitan Borough Council and the SWB CCG provide a sound basis to expect continued improvement. The same confidence assessment is not possible in respect of Birmingham City Council. Whilst data on delays is accurately recorded, control assurance requires confidence in delivery and delivery improvement. This is not yet assured. The Trust's contribution to improvement must be acknowledged, but as failure represents a material risk to finances, quality of care, and standards compliance it is appropriate to highlight the challenge posed in West Birmingham by this position.

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 **4th June 2015**

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

TRUST BOARD

Chair: Trust Chairman

Frequency: Twelve times a year

Membership: Seven Non Executive Directors; Seven Executive Directors, including two advisory Executive Directors (non voting), a Non Executive Designate and the Trust Secretary

BOARD MEMBER	DATE												TOTAL
	3/4/14	1/5/14	5/6/14	3/7/14	7/8/14	4/9/14	2/10/14	6/11/14	4/12/14	8/1/15	5/2/15	5/3/15	
Richard Samuda (Ch)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	12/12
Clare Robinson#1	✔	✔	✔	✔	✔	A	✔	✔	✔	✔			9/10
Olwen Dutton	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	12/12
Gianjeet Hunjan	✔	✔	✔	✔	✔	✔	✔	A	✔	✔	✔	✔	11/12
Sarindar Sahota	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	12/12
Harjinder Kang	✔	✔	✔	✔	✔	✔	A	✔	✔	✔	✔	✔	11/12
Paramjit Gill#2		A	✔	✔	✔	✔	A	✔	A	A	✔	✔	7/11
Toby Lewis	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	12/12
Roger Stedman	✔	✔	✔	✔	A	✔	✔	✔	✔	✔	✔	✔	11/12
Colin Ovington	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	12/12
Tony Waite	✔	✔	✔	✔	✔	✔	✔	A	✔	✔	✔	✔	12/12
Rachel Barlow	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	12/12
Mike Hoare*	✔	✔	✔	✔	✔	✔	✔	✔	A	✔	✔	✔	11/12
Kam Dhami*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	12/12
Raffaela Goodby*#3												✔	1/1

KEY:

✔	Attended
A	Apologies tendered
	Not in post or not required to attend
*	Not in post or not required to attend
#1	Resigned February 2015
#2	Commenced in May 2014
#3	Commenced February 2015

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, including a specific meeting to review and approve the annual accounts.

Membership: Five Non-Executive directors (excluding the Chair), although all Non Executives are given an open invite to attend should they wish. The Directors of Finance and Governance and the Chief Nurse have a standing invitation to attend and other Executives may attend when requested.

Attendance:

DIRECTOR	DATE					TOTAL
	24/4/14	5/6/14	31/7/14	30/10/14	30/1/15	
Gianjeet Hunjan (Ch)	✔	✔	✔	✔	✔	5/5
Sarindar Sahota	✔	✔	A	✔	✔	4/5
Olwen Dutton	A	A	A	✔	✔	2/5
Clare Robinson	✔	✔	✔	✔	A	4/5
Harjinder Kang	✔	✔	✔	A	✔	4/5

KEY:

✔	Attended
A	Apologies tendered

QUALITY & SAFETY COMMITTEE

Chair: Vice Chair

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: Four Non-Executive Directors and five of the Executive Directors with specialist advisers in attendance when required.

DIRECTOR	DATE											TOTAL
	25/4/14	30/5/14	27/7/14	29/8/14	26/9/14	31/10/14	28/11/14	19/12/14	30/1/15	27/2/15	27/3/15	
Olwen Dutton (Ch)	✔	✔	A	✔	✔	✔	✔	✔	A	✔	✔	9/11
Sarindar Sahota	✔	✔	✔	✔	A	✔	A	✔	A	✔	✔	8/11
Richard Samuda	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	11/11
Gianjeet Hunjan	✔	✔	✔	✔	✔	✔	✔	✔	A	✔	✔	10/11
Colin Ovington	✔	A	✔	✔	✔	✔	✔	✔	✔	✔	✔	10/11
Kam Dhami	✔	✔	✔	✔	✔	A	A	✔	✔	✔	✔	9/11
Tony Waite	✔	✔	✔	✔	A	✔	✔	✔	A	✔	A	8/11
Rachel Barlow	A	✔	A	✔	✔	✔	✔	A	✔	✔	✔	8/11
Roger Stedman	A	A	✔	✔	✔	✔	✔	✔	✔	✔	✔	9/11

KEY:

✔	Attended
A	Apologies tendered
Note: June meeting was cancelled	

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 with additional meetings scheduled as needed.

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

DIRECTOR	DATE								TOTAL
	30/5/14	26/6/14	25/7/14	29/8/14	26/9/14	28/11/14	30/1/15	27/2/15	
Clare Robinson (Ch) #1	✔	✔	✔	A	✔	✔	A		5/7
Richard Samuda (Ch) #2	✔	✔	✔	✔	✔	✔	✔	✔	8/8
Harjinder Kang	✔	✔	✔	A	✔	A	✔	✔	7/8
Tony Waite	✔	✔	✔	✔	✔	✔	✔	✔	8/8
Rachel Barlow	A	✔	A	A	✔	A	✔	A	3/8

KEY:

✔	Attended
A	Apologies tendered
	Not in post or not required to attend
#1	Resigned February 2015
#2	Assumed chair of Committee from February 2015

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. In 2015/16, the schedule provides for four meetings.

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

DIRECTOR	DATE			TOTAL
	17/5/14	13/9/14	6/12/14	
Sarindar Sahota (Ch)	✔	✔	✔	3/3
Richard Samuda	✔	✔	✔	3/3
Clare Robinson	✔	A	✔	2/3
Toby Lewis	✔	✔	✔	3/3
Tony Waite	✔	✔	✔	3/3
Colin Ovington	✔	A	✔	2/3

KEY:

✔	Attended
A	Apologies tendered
Note: March meeting was cancelled	

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 usually.

Membership: Three Non Executive Directors and three Executive Directors, including the Chief Executive. From 2015/16 the Director of OD will join the Committee.

DIRECTOR	DATE			TOTAL
	17/5/14	13/9/14	6/12/14	
Harjinder Kang (Ch)	✔	✔	✔	3/3
Richard Samuda	✔	✔	A	2/3
Paramjit Gill	A	A	✔	1/3
Toby Lewis	✔	✔	✔	3/3
Rachel Barlow	✔	✔	✔	3/3
Colin Ovington	A	A	✔	1/3

KEY:

✔	Attended
A	Apologies tendered
Note: March meeting was rescheduled to April 2015	

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 usually.

Membership: Two Non-Executive Directors, the Chief Executive, Director of Finance & Performance Management and Medical Director.

DIRECTOR	DATE				TOTAL
	25/4/14	27/6/14	3/9/14	31/10/14	
Richard Samuda (Ch)	✔	✔	✔	✔	4/4
Clare Robinson	✔	✔	A	✔	3/4
Toby Lewis	✔	✔	✔	✔	4/4
Tony Waite	✔	✔	✔	✔	4/4
Roger Stedman	A	A	✔	A	1/4

KEY:

✔	Attended
A	Apologies tendered

Note:
- February meeting was rescheduled to April 2015
- August and December meetings cancelled

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: Four times per year usually.

Membership: Three Non-Executive Directors, the Medical Director, Chief Executive and Chief Nurse. From 2015/16, the Director of OD will join the Committee.

DIRECTOR	DATE			TOTAL
	29/5/14	29/9/14	27/11/14	
Richard Samuda (Ch)	✔	✔	✔	3/3
Sarindar Sahota	✔	✔	✔	3/3
Gianjeet Hunjan	✔	A	A	1/3
Toby Lewis	✔	✔	✔	3/3
Colin Ovington	A	✔	✔	2/3
Roger Stedman	✔	A	✔	2/3

KEY:

✔	Attended
A	Apologies tendered
Note: March meeting was cancelled	

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.

MEMBERS	1/5/14	8/9/14#1
Richard Samuda	✔	✔
Clare Robinson	✔	✔
Sarindar Sahota	✔	✔
Gianjeet Hunjan	✔	✔
Paramjit Gill	A	✔
Olwen Dutton	A	✔
Harjinder Kang	✔	✔

KEY:

✔	Attended
A	Apologies tendered
#1	Virtual meeting held

Annual Accounts For The Year Ended 31 March 2015

These accounts are for Sandwell and West Birmingham Hospitals NHS Trust for the year ended 31 March 2015.

Directors

The following have been Directors of the Trust during the year:

Chair	-	Richard Samuda	
Vice Chair	-	Olwen Dutton	
Vice Chair	-	Clare Robinson	- resigned 28 February 2015

Executive Directors:			
Chief Executive	-	Toby Lewis	
Chief Operating Officer	-	Rachel Barlow	
Finance Director	-	Antony Waite	
Medical Director		Roger Stedman	
Chief Nurse	-	Colin Ovington	
Director of Governance	-	Kam Dhami	
Director of Workforce Organisational Development	-	Raffaela Goodby	- appointed 11 February 2015
Director of Strategy & Organisational Development	-	Mike Sharon	- resigned 02 April 2014

Non-Executive Directors	-	Gianjeet Hunjan	
	-	Sarindar Singh Sahota	
	-	Harjinder Kang	
	-	Paramjit Gill	- appointed 14 April 2014
	-	Michael Hoare	

Bankers

Government Banking Services
West Wing
Somerset House
Strand
London
WC2R 1LB

Auditors

KPMG LLP
Chartered Accountants
8th Floor
One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

The Birmingham & Midland Eye Centre (BMEC)

Sandwell and West Birmingham NHS Trust -Annual Accounts 2014/15

FOREWORD TO THE ACCOUNTS Sandwell and West Birmingham NHS Trust

These accounts for the year ended 31 March 2015 have been prepared by the Sandwell and West Birmingham Hospitals NHS Trust under National Health Service Act 2006 c. 41 Schedule 15: Preparation of annual accounts in the form which the Secretary of State has, with the approval of the Treasury, directed.

Birmingham Treatment Centre

Statement of Comprehensive Income for year ended 31 March 2015

	NOTE	2014/15 £000s	2013/14 £000s
Gross employee benefits	9.1	**(292,253)**	(291,589)
Other operating costs	7	**(142,315)**	(142,873)
Revenue from patient care activities	4	**403,189**	396,256
Other operating revenue	5	**43,401**	42,766
Operating surplus		**12,022**	4,560
Investment revenue	11	**109**	129
Other (losses)	12	**0**	(193)
Finance costs	13	**(2,221)**	(2,284)
Surplus/(deficit) for the financial year		**9,910**	2,212
Public dividend capital dividends payable		**(5,325)**	(4,717)
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**4,585**	(2,505)

Other Comprehensive Income

	2014/15 £000s	2013/14 £000s
Impairments and reversals taken to the revaluation reserve	**2,421**	7,429
Net gain on revaluation of property, plant & equipment	**0**	1,486
Total comprehensive income for the year*	**7,006**	6,410

Financial performance for the year

Retained surplus/(deficit) for the year	**4,585**	(2,505)
a) IFRIC 12 adjustment (including IFRIC 12 impairments)	**0**	(1,108)
b) Impairments (excluding IFRIC 12 impairments)	**(263)**	10,030
c) Adjustments in respect of donated gov't grant asset reserve elimination	**331**	334
Adjusted retained surplus	**4,653**	6,751

A Trust Reported NHS financial performance position is derived from its RetainedSurplus/ (Deficit), but adjusted for the following:

a) *The revenue cost of bringing PFI assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10) - NHS Trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. The Trust is better off under IFRS than UK GAAP. PFI building did not have any reversal of impairment in 2014/15 valuation.*

b) *The Trust is required to revalue its Land and Building on a regular basis as a result of the IFRS implementation and this has resulted in a reversal of impairment of its Building and land by £2.68m, £2.42m of which was absorbed by the revaluation reserve which has been built up over the years. However, a reversal of impairment of £0.26m has been recognised in the I&E account. Reversal of impairments are specifically excluded from measurement of the Trust's financial performance.*

c) *Due to change in accounting requirement, elimination of donated and government grant reserve has resulted in net decrease of its income by £0.33m. Therefore, the reduction of income resulting from the application of change to donated and government grant account treatment, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. This is not considered part of the organisation's operating position.*

The notes on pages 131 to 157 form part of this account.

Statement of Financial Position as at 31 March 2015

	NOTE	31 March 2015 £000s	31 March 2014 £000s
Non-current assets:			
Property, plant and equipment	14	**233,309**	226,403
Intangible assets	15	**677**	886
Investment property	17	**0**	0
Other financial assets	22	**0**	0
Trade and other receivables	21.1	**890**	1,011
Total non-current assets		**234,876**	228,300
Current assets:			
Inventories	20	**3,467**	3,272
Trade and other receivables	21.1	**17,128**	17,448
Other financial assets	22	**0**	0
Other current assets	23	**0**	0
Cash and cash equivalents	24	**28,382**	41,808
Sub-total current assets		**48,977**	62,528
Non-current assets held for sale	25	**0**	0
Total current assets		**48,977**	62,528
Total assets		**283,853**	290,828
Current liabilities			
Trade and other payables	26	**(46,761)**	(55,138)
Other liabilities	27	**0**	0
Provisions	33	**(4,502)**	(8,036)
Borrowings	28	**(1,017)**	(1,064)
Other financial liabilities	29	**0**	0
DH revenue support loan	28	**0**	0
DH capital loan	28	**(1,000)**	(2,000)
Total current liabilities		**(53,280)**	(66,238)
Net current assets/(liabilities)		**(4,303)**	(3,710)
Total assets less current liablilities		**230,573**	224,590
Non-current liabilities			
Provisions	33	**(2,986)**	(2,562)
Borrowings	28	**(26,898)**	(27,915)
DH capital loan	28	**0**	(1,000)
Total non-current liabilities		**(29,884)**	(31,477)
Total assets employed:		**200,689**	193,113
FINANCED BY:			
Public Dividend Capital		**162,210**	161,640
Retained earnings		**(13,758)**	(19,484)
Revaluation reserve		**43,179**	41,899
Other reserves		**9,058**	9,058
Total Taxpayers' Equity:		**200,689**	193,113

The notes on pages 131 to 157 form part of this account.

The financial statements on pages 127 to 130 were approved by the Audit and Risk Management Committee on 4th June 2015 and adopted by the Trust Board and signed on its behalf

Toby Lewis
Chief Executive: .....  ..... Date: **4th June 2015**

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2015

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**161,640**	**(19,484)**	**41,899**	**9,058**	**193,113**
Changes in taxpayers' equity for 2014/15					
Retained surplus for the year	0	4,585	0	0	**4,585**
Impairments and reversals	0	0	2,421	0	**2,421**
Transfers between reserves	0	1,141	(1,141)	0	**0**
Reclassification Adjustments					
New temporary and permanent PDC received - cash	570	0	0	0	**570**
Net recognised revenue/(expense) for the year	**570**	**5,726**	**1,280**	**0**	**7,576**
Balance at 31 March 2015	**162,210**	**(13,758)**	**43,179**	**9,058**	**200,689**

Balance at 1 April 2013	**160,231**	**(20,260)**	**34,356**	**9,058**	**183,385**
Changes in taxpayers' equity for the year ended 31 March 2014					
Retained (deficit) for the year	0	(2,505)	0	0	(2,505)
Net gain on revaluation of property, plant, equipment	0	0	1,486	0	1,486
Impairments and reversals	0	0	7,429	0	7,429
Transfers between reserves	0	1,372	(1,372)	0	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	1,909	0	0	**1,909**
Reclassification Adjustments					
New temporary and permanent PDC received - cash	1,409	0	0	0	1,409
Net recognised revenue for the year	**1,409**	**776**	**7,543**	**0**	**9,728**
Balance at 31 March 2014	**161,640**	**(19,484)**	**41,899**	**9,058**	**193,113**

Statement of Cash Flows for the Year ended 31 March 2015

	2014/15 £000s	2013/14 £000s
Cash Flows from Operating Activities		
Operating surplus	**12,022**	4,560
Depreciation and amortisation	**13,363**	13,673
Impairments and reversals	**(263)**	8,922
Donated Assets received credited to revenue but non-cash	**(51)**	(213)
Interest paid	**(2,221)**	(2,218)
Dividend paid	**(5,170)**	(4,327)
(Increase)/Decrease in Inventories	**(195)**	332
(Increase)/Decrease in Trade and Other Receivables	**391**	(6,965)
Increase/(Decrease) in Trade and Other Payables	**(10,383)**	13,395
Provisions utilised	**(3,331)**	(5,643)
Increase in movement in non cash provisions	**185**	2,529
Net Cash Inflow from Operating Activities	**4,347**	24,045
Cash Flows from Investing Activities		
Interest Received	**109**	131
(Payments) for Property, Plant and Equipment	**(15,388)**	(22,985)
(Payments) for Intangible Assets	**0**	(210)
Net Cash (Outflow) from Investing Activities	**(15,279)**	(23,064)
Net Cash Inform / (outflow) before Financing	**(10,932)**	981
Cash Flows from Financing Activities		
Gross Temporary and Permanent PDC Received	**570**	1,409
Loans repaid to DH - Capital Investment Loans Repayment of Principal	**(2,000)**	(2,000)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(1,064)**	(1,081)
Net Cash (Outflow) from Financing Activities	**(2,494)**	(1,672)
NET (DECREASE) IN CASH AND CASH EQUIVALENTS	**(13,426)**	(691)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**41,808**	42,499
Cash and Cash Equivalents (and Bank Overdraft) at year end	**28,382**	41,808

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014/15 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. The Board of Sandwell and West Birmingham Hospitals NHS Trust acts as a corporate trustee for the Charitable Funds, but in accordance with IAS 1 Presentation of Financial Statements it is not material to the accounts and has therefore not been consolidated. (See note 1.4.1.)

1.4 Critical accounting judgements

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. (Further information is provided in Note 1.4.2 Key sources of estimation uncertainty.)

1.4.1 Key sources of estimation uncertainty

The following are the critical judgements, apart from those involving estimations (see 1.4.2 below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Following Treasury's agreement to apply IFRS 10 to NHS Charities from 1 April 2013, the Trust has established that as it is the corporate trustee of the Sandwell and West Birmingham Hospitals NHS Trust Charities, charity number 1056127, it effectively has the power to exercise control so as to obtain economic benefits.

Total donations received during 2014 / 2015 were £1.305m and total resources expended were £0.869m which are only 0.17% of the Trust's Exchequer Funds. There were legacies of £0.327m received during 2014/15.

IAS 1, Presentation of Financial Statements, says that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material and this guidance is reiterated in the NHS Manual for Accounts 2014/15.

Thus, In line with IAS 1, charitable funds are not consolidated into Sandwell and West BirminghamHospitals NHS Trust's accounts on grounds of materiality.

1.4.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

A model provided by the Department of Health has been used to calculate the effect of bringing the PFI scheme on to the Trust balance sheet. This is not expected to yield a result that is materially different from other means of calculation.

A desktop asset valuation and review of remaining lives of the Trust's estate was conducted by the District Valuer using data from BCIS (Building Cost Information Services) and RICS (Royal Institute of Chartered Surveyors). This methodology meets the requirements of International Accounting Standards (IAS) 16 Property, Plant and Equipment and does not deviate from the principles therein.

1.5 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of costs incurred to date compared to total expected costs.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Equipment is depreciated on current cost evenly over the following estimated life of the asset:

Asset	Years
Software Licences	0 to 4
Plant & Machinery	0 to 10
Transport Equipment	0 to 10
Information Technology	0 to 5
Furniture & Fittings	0 to 10

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.11 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.12 Government grants

The value of assets received by means of a government grant are credited directly to income Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.14 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS trust's Statement of Financial Position.

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using the cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.16 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS trust's cash management.

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms 1.3% for employee early departure obligations.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 39.

1.19 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.20 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.21 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.22 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset..

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques as recent market transaction.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly

1.23 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation. OR
- The amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets.

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.24 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.25 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.26 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 42 to the accounts.

1.27 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.28 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.29 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.30 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014/15. The application of the Standards as revised would not have a material impact on the accounts for 2014/15, were they applied in that year:

IFRS 9 Financial Instruments - subject to consultation - subject to consultation

IFRS 13 Fair Value Measurement - subject to consultation

IFRS 15 Revenue from Contracts with Customers

2. Operating segments

The Board, as 'Chief Operating Decision Maker', has determined that the Trust operates in one material segment which is the provision of healthcare The Board, as 'Chief Operating Decision Maker', has determined that the Trust operates in one material segment which is the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure.

The provision of healthcare (including medical treatment, research and education) is within one main geographical segment, the United Kingdom, and materially from Departments of HM Government in England.

The Trust has only one business segment which is provision of healthcare. A segmental analysis is therefore not applicable.

3. Income generation activities

The Trust does not undertake any income generation activities where full cost exceeded £1m or was material to the financial performance of the Trust.

4. Revenue from patient care activities

	2014/15 £000s	2013/14 £000s
NHS Trusts	**162**	205
NHS England	**53,706**	53,399
Clinical Commissioning Groups	**344,057**	338,680
Foundation Trusts	**2,438**	1,175
Department of Health	**0**	0
NHS Other (including Public Health England and Prop Co)	**1,107**	0
Non-NHS:		
Private patients	**193**	153
Overseas patients (non-reciprocal)	**230**	219
Injury costs recovery	**1,175**	1,523
Other	**121**	902
Total Revenue from patient care activities	**403,189**	396,256

5. Other operating revenue

	2014/15 £000s	2013/14 £000s
Recoveries in respect of employee benefits	**714**	1,230
Patient transport services	**259**	251
Education, training and research	**21,005**	21,754
Charitable and other contributions to revenue expenditure -non- NHS	**36**	36
Receipt of donations for capital acquisitions - Charity	**51**	213
Non-patient care services to other bodies	**9,062**	8,197
Income generation	**4,766**	4,002
Other revenue	**7,508**	7,083
Total Other Operating Revenue	**43,401**	42,766
Total operating revenue	**446,590**	439,022

6. Overseas Visitors Disclosure

	2014/15 £000s	2013/14 £000s
Income recognised during 2014/15 (invoiced amounts and accruals)	**230**	219
Cash payments received in-year (re receivables at 31 March 2014)	**11**	0
Cash payments received in-year (iro invoices issued 2014/15)	**43**	0
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	**0**	0
Amounts added to provision for impairment of receivables (iro invoices issued 2014/15)	**187**	0
Amounts written off in-year (irrespective of year of recognition)	**162**	96

7. Operating expenses

	2014/15 £000s	2013/14 £000s
Services from other NHS Trusts	**573**	745
Services from CCGs/NHS England	**86**	91
Services from other NHS bodies	**2,736**	1,854
Services from NHS Foundation Trusts	**7,401**	4,975
Total Services from NHS bodies*	**10,796**	7,665
Purchase of healthcare from non-NHS bodies	**1,438**	1,476
Trust Chair and Non-executive Directors	**85**	66
Supplies and services - clinical	**73,094**	68,538
Supplies and services - general	**5,819**	6,005
Consultancy services	**2,230**	2,689
Establishment	**4,764**	4,903
Transport	**1,619**	1,161
Service charges - ON-SOFP PFIs and other service concession arrangements	**1,006**	973
Business rates paid to local authorities	**1,799**	1,482
Premises	**16,801**	14,875
Hospitality	**0**	0
Insurance	**98**	131
Legal Fees	**191**	321
Impairments and Reversals of Receivables	**(9)**	(22)
Inventories write down	**50**	151
Depreciation	**13,126**	13,404
Amortisation	**237**	269
Impairments and reversals of property, plant and equipment	**(263)**	8,922
Audit fees	**133**	140
Other Auditor's Remuneration - Taxation Services	**7**	12
Clinical negligence	**6,676**	7,221
Research and development (excluding staff costs)	**297**	246
Education and Training	**1,102**	1,145
Change in Discount Rate	**(14)**	123
Other	**1,233**	977
Total Operating expenses (excluding employee benefits)	**142,315**	142,873
Employee Benefits		
Employee benefits excluding Board members	**291,090**	290,428
Board members (Executive Directors)	**1,163**	1,161
Total Employee Benefits	**292,253**	291,589
Total Operating Expenses	**434,568**	434,462

8 Operating Leases

The Trust does not hold a material value of operating leases as the majority of higher value leases are defined as finance leases. Residual operating leases relate to low value items of equipment.

8.1 Trust as lessee

	2014/15			
	Land	Other	**Total**	2013/14
	£000s	**£000s**	**£000s**	£000s
Payments recognised as an expense				
Minimum lease payments			**90**	93
Total			**90**	93
Payable:				
No later than one year	13	85	**98**	93
Between one and five years	52	101	**153**	190
After five years	117	0	**117**	0
Total	**182**	**186**	**368**	283
Total future sublease payments expected to be received:			**0**	0

9 Employee benefits and staff numbers

9.1 Employee benefits

	2014/15		
	Total	**Permanently employed**	**Other**
	£000s	**£000s**	**£000s**
Employee Benefits - Gross Expenditure			
Salaries and wages	**250,736**	223,773	26,963
Social security costs	**17,819**	17,136	683
Employer Contributions to NHS BSA - Pensions Division	**25,102**	24,393	709
Termination benefits	**79**	79	0
Total employee benefits	**293,736**	**265,381**	**28,355**
Employee costs capitalised	**1,483**	1,483	0
Gross Employee Benefits excluding capitalised costs	**292,253**	**263,898**	**28,355**

	Total	**Permanently employed**	**Other**
Employee Benefits - Gross Expenditure 2013/14	**£000s**	**£000s**	**£000s**
Salaries and wages	245,008	220,668	24,340
Social security costs	19,169	18,389	780
Employer Contributions to NHS BSA - Pensions Division	27,887	27,008	879
Termination benefits	0	0	0
Total employee benefits	292,064	266,065	25,999
Employee costs capitalised	475	475	0
Gross Employee Benefits excluding capitalised costs	291,589	265,590	25,999

9.2 Staff Numbers

	2014/15 Total Number	Permanently employed Number	Other Number	2014/15 Total Number
Average Staff Numbers				
Medical and dental	**805**	750	55	791
Ambulance staff	**0**	0	0	0
Administration and estates	**1,469**	1,322	147	1,518
Healthcare assistants and other support staff	**1,847**	1,603	244	1,494
Nursing, midwifery and health visiting staff	**2,245**	1,951	294	2,234
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**744**	720	24	1,141
Social Care Staff	**0**	0	0	0
Other	**0**	0	0	0
TOTAL	**7,110**	**6,346**	**764**	7,178
Of the above - staff engaged on capital projects	**25**	25	0	7

9.3 Staff Sickness absence and ill health retirements

	2014/15 Number	2013/14 Number
Total Days Lost	66,120	64,130
Total Staff Years	6,492	6,526
Average working Days Lost	10.18	9.83

	2014/15 Number	2013/14 Number
Number of persons retired early on ill health grounds	**7**	6
	£000s	£000s
Total additional pensions liabilities accrued in the year	**468**	488

9.4 Exit Packages agreed in 2014/15

	2014/15			2013/14		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	1	0	1	0	0	0
£10,000-£25,000	1	0	1	3	0	3
£25,001-£50,000	0	0	0	4	0	4
£50,001-£100,000	1	0	1	4	0	4
£100,001 - £150,000	0	0	0	2	0	2
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	**3**	**0**	**3**	13	0	13
Total resource cost (£s)	**78,914**	**0**	**78,914**	715,819	0	715,819

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

9.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

10 Better Payment Practice Code

10.1 Measure of compliance

	2014/15 Number	2014/15 £000s	2013/14 Number	2013/14 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**121,899**	**154,330**	111,261	133,953
Total Non-NHS Trade Invoices Paid Within Target	**111,495**	**141,219**	102,542	124,099
Percentage of NHS Trade Invoices Paid Within Target	**91.47%**	**91.50%**	92.16%	92.64%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,787**	**27,132**	2,041	**24,654**
Total NHS Trade Invoices Paid Within Target	**2,903**	**20,812**	1,792	**19,923**
Percentage of NHS Trade Invoices Paid Within Target	**76.66%**	**76.71%**	87.80%	80.81%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust did not make any payments in respect of this in 2014/15 nor 2013/14

11 Investment Revenue

	2014/15 £000s	2013/14 £000s
Bank interest	**109**	129
Total investment revenue	**109**	129

12 Other Gains and Losses

	2014/15 £000s	2013/14 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**0**	(193)
Total	**0**	(193)

13 Finance Costs

	2014/15 £000s	2013/14 £000s
Interest		
Interest on loans and overdrafts	**21**	38
Interest on obligations under finance leases	**3**	40
Interest on obligations under PFI contracts:		
- main finance cost	**1,437**	1,488
- contingent finance cost	**710**	652
Total interest expense	**2,171**	2,218
Provisions - unwinding of discount	**50**	66
Total	**2,221**	2,284

14.1 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
2014/15								
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Cost or valuation:								
At 1 April 2014	**44,171**	**167,905**	**967**	**99,496**	**3,712**	**25,061**	**1,992**	**343,304**
Additions of Assets Under Construction	0	0	0	0	0	0	0	**6,303**
Additions Purchased	0	4,255	0	4,043	121	2,364	5	**10,788**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	51	0	0	0	**51**
Additions Leased	0	206	0	0	0	0	0	**206**
Disposals other than for sale	0	0	0	(2,169)	0	(63)	0	**(2,232)**
Upward revaluation/positive indexation	(6,816)	(13,724)	(69)	0	0	0	0	**(20,609)**
Reversal of Impairments	385	2,012	24	0	0	0	0	**2,421**
At 31 March 2015	**37,740**	**160,654**	**922**	**101,421**	**3,833**	**27,362**	**1,997**	**340,232**
Depreciation								
At 1 April 2014	**7,261**	**6,856**	**13**	**78,359**	**2,921**	**20,194**	**1,297**	**116,901**
Disposals other than for sale	0	0	0	(2,169)	0	(63)	0	**2,232)**
Upward revaluation/positive indexation	(6,816)	(13,724)	(69)	0	0	0	0	**(20,609)**
Impairments	0	1,273	12	0	0	0	0	**1,285**
Reversal of Impairments	(445)	(1,103)	0	0	0	0	0	**(1,548)**
Charged During the Year	0	6,698	44	4,602	198	1,421	163	**13,126**
At 31 March 2015	**0**	**0**	**0**	**80,792**	**3,119**	**21,552**	**1,460**	**106,923**
Net Book Value at 31 March 2015	**37,740**	**160,654**	**922**	**20,629**	**714**	**5,810**	**537**	**233,309**
Asset financing:								
Owned - Purchased	37,740	139,344	922	19,902	714	5,810	537	**211,272**
Owned - Donated	0	394	0	727	0	0	0	**1,121**
Owned - Government Granted	0	951	0	0	0	0	0	**951**
On-SOFP PFI contracts	0	19,965	0	0	0	0	0	**19,965**
Total at 31 March 2015	**37,740**	**160,654**	**922**	**20,629**	**714**	**5,810**	**537**	**233,309**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
At 1 April 2014	17,953	23,441	431	71	0	0	3	**41,899**
Movements (specify)	385	936	7	(45)	0	0	(3)	**1,280**
At 31 March 2015	**18,338**	**24,377**	**438**	**26**	**0**	**0**	**0**	**43,179**

14.2 Property, plant and equipment prior - ear

	Land	Buildings excluding dwellings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
2013/14								
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Cost or valuation:								
At 1 April 2013	37,132	151,136	898	99,416	3,697	22,926	1,718	**316,923**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	1,805	0	79	0	0	25	**1,909**
Additions Purchased	4,997	9,646	0	4,091	72	2,162	249	**21,217**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	213	0	0	0	**213**
Disposals other than for sale	0	0	0	(4,303)	(57)	(27)	0	**(4,387)**
Revaluation	0	0	0	0	0	0	0	**0**
Impairments/negative indexation charged to reserves	(45)	(1,129)	0	0	0	0	0	**(1,174)**
Reversal of Impairments charged to reserves	2,087	6,447	69	0	0	0	0	**8,603**
At 31 March 2014	**44,171**	**167,905**	**967**	**99,496**	**3,712**	**25,061**	**1,992**	**343,304**
Depreciation								
At 1 April 2013	0	0	0	77,425	2,704	19,003	1,122	**100,254**
Disposals other than for sale	0	0	0	(4,109)	(57)	(27)	0	**(4,193)**
Revaluation	(605)	(881)	0	0	0	0	0	**(1,486)**
Impairments/negative indexation charged to operating expenses	10,224	4,378	0	0	0	0	0	**14,602**
Reversal of Impairments charged to operating expenses	(2,358)	(3,295)	(27)	0	0	0	0	**(5,680)**
Charged During the Year	0	6,654	40	5,043	274	1,218	175	**13,404**
At 31 March 2014	**7,261**	**6,856**	**13**	**78,359**	**2,921**	**20,194**	**1,297**	**116,901**
Net Book Value at 31 March 2014	36,910	161,049	954	21,137	791	4,867	695	**226,403**
Asset financing:								
Owned - Purchased	36,910	139,525	954	20,070	766	4,852	695	**203,772**
Owned - Donated	0	401	0	1,021	0	15	0	**1,437**
Owned - Government Granted	0	966	0	0	0	0	0	**966**
Held on finance lease	0	0	0	46	25	0	0	**71**
On-SOFP PFI contracts	0	20,157	0	0	0	0	0	**20,157**
Total at 31 March 2014	**36,910**	**161,049**	**954**	**21,137**	**791**	**4,867**	**695**	**226,403**

14.3 Property, plant and equipment

The Trust received donated assets to the value of £51k during the year, £39k via Sandwell And West Birmingham Hospital's charitable funds and £13k from the League of Friends, both in respect of medical equipment.

The Trust's property assets (land and buildings) were revalued during the year by the District Valuation Service and using Modern Equivalent Asset valuation techniques with a valuation date of 31st March 2015. Valuation was undertaken with reference to the size, location and function of existing buildings and the basis on which they would be replaced by Modern Equivalent Assets.

Asset lives for currently held assets are as follows:

Asset	Years
Buildings excluding dwellings	4 to 81
Dwellings	6 to 40
Plant and machinery	0 to 11
Transport equipment	0 to 7
Information technology	0 to 5
Furniture and fittings	0 to 10

15.1 Intangible non-current assets

	Computer Licenses	Patents	Total
2014/15			
	£000s	**£000s**	**£000s**
At 1 April 2014	**2,901**	**185**	**3,086**
Additions Purchased	**0**	28	**28**
At 31 March 2015	**2,901**	**213**	**3,114**
Amortisation			
At 1 April 2014	**2,200**	**0**	**2,200**
Charged during the year	237	0	**237**
At 31 March 2015	**2,437**	**0**	**2,437**
Net Book Value at 31 March 2015	**464**	**213**	**677**
Asset Financing: Net book value at 31 March 2015 comprises:			
Purchased	464	213	**677**
Total at 31 March 2015	**464**	**213**	**677**

15.2 Intangible non-current assets prior year

	Computer Licenses	Patents	Total
2013/14			
Cost or valuation:	**£000s**	**£000s**	**£000s**
At 1 April 2013	2,691	164	2,855
Additions - purchased	210	21	231
At 31 March 2014	2,901	185	3,086
Amortisation			
At 1 April 2013	1,931	0	1,931
Charged during the year	269	0	269
At 31 March 2014	2,200	0	2,200
Net book value at 31 March 2014	701	185	886
Net book value at 31 March 2014 comprises:			
Purchased	699	185	884
Donated	2		2
Total at 31 March 2014	701	185	886

15.3 Intangible non-current assets

Asset lives for intangible assets (purchased computer software) range from 0 to 5 years. Assets are initially recognised at cost and amortised over the expected life of the asset. They have not been revalued.

An intangible asset in respect of Carbon Emission Credits is included in the Trust's accounts to reflect the receipt and consumption of these credits. They are valued at market price at 31st March 2015.

The Trust does not hold any revaluation reserve balances in respect of intangible assets.

16 Analysis of impairments and reversals recognised in 2014/15

	2014/15 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Changes in market price	(263)
Total charged to Annually Managed Expenditure	**(263)**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(263)**
Total Impairments charged to SoCI - Departmental Expenditure Limit	**0**
Total Impairments charged to SoCI - Annually Managed Expenditure	**(263)**
Overall Total Impairments	**(263)**

17 Investment property

The Trust did not hold any investment property in 2013/14 or in 2014/15.

18 Commitments

18.1 Capital commitments

Contracted capital commitments at 31 March 15 not otherwise included in these financial statements:

	31 March 2015 £000s	31 March 2014 £000s
Property, plant and equipment	**1,749**	1,128
Total	**1,749**	1,128

18.2 Other financial commitments

The Trust has not entered into any non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements).

19 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payable £000s
Balances with Other Central Government Bodies	1,286	0	3,625	0
Balances with Local Authorities	443	0	0	0
Balances with NHS bodies inside the Departmental Group	11,156	0	9,500	0
Balances with Bodies External to Government	4,243	890	35,653	26,898
At 31 March 2015	**17,128**	**890**	**48,778**	**26,898**
Prior period:				
Balances with Other Central Government Bodies	8,254	0	14,218	0
Balances with NHS Trusts and FTs	2,829	0	2,088	0
At 31 March 2014	**11,083**	**0**	**16,306**	**0**

20 Inventories

	Drugs	Consumables	Work in Progress	Energy	Total
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**1,503**	**1,537**	**0**	**232**	**3,272**
Additions	33,304	7,401	0	0	**40,705**
Inventories recognised as an expense in the period	(33,173)	(7,228)	0	(59)	**(40,460)**
Write-down of inventories (including losses)	(50)	0	0	0	**(50)**
Balance at 31 March 2015	**1,584**	**1,710**	**0**	**173**	**3,467**

21.1 Trade and other receivables

	Current		Non-current	
	31 March 2015	31 March 2014	31 March 2014	31 March 2014
	£000s	£000s	£000s	£000s
NHS receivables - revenue	**9,016**	11,083	**0**	0
NHS prepayments and accrued income	**2,007**	514	**0**	0
Non-NHS receivables - revenue	**1,667**	2,198	**0**	0
Non-NHS prepayments and accrued income	**2,802**	2,020	**0**	0
Provision for the impairment of receivables	**(1,384)**	(1,578)	**(260)**	(285)
VAT	**1,286**	657	**0**	0
Other receivables	**1,734**	2,554	**1,150**	1,296
Total	**17,128**	17,448	**890**	1,011
Total current and non current	**18,018**	18,459		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with NHS Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

There are no material individual receivables which are neither past due nor impaired.

21.2 Receivables past their due date but not impaired

	31 March 2015	31 March 2015
	£000s	£000s
By up to three months	**884**	1,001
By three to six months	**520**	537
By more than six months	**260**	285
Total	**1,664**	1,823

21.3 Provision for impairment of receivables

	2014/15	2013/14
	£000s	£000s
Balance at 1 April 2014	**(1,863)**	(2,038)
Amount written off during the year	**210**	153
Amount recovered during the year	**66**	321
(Increase)/decrease in receivables impaired	**(57)**	(299)
Balance at 31 March 2015	**(1,644)**	(1,863)

Impairment of receivables is based on an assessment of individual amounts receivable taking into account the age of the debt and other known circumstances regarding the debt or the debtor.

22 Other Financial Assets - Current/ Non Current

The Trust does not hold any other financial assets.

23 Other current assets

The Trust does not hold any other current assets.

24 Cash and Cash Equivalents

	31 March 2015 £000s	31 March 2015 £000s
Opening balance	**41,808**	42,499
Net change in year	**(13,426)**	(691)
Closing balance	**28,382**	41,808
Made up of		
Cash with Government Banking Service	**28,359**	41,781
Cash in hand	**23**	27
Cash and cash equivalents as in statement of financial position	**28,382**	41,808
Cash and cash equivalents as in statement of cash flows	**28,382**	41,808
Patients' money held by the Trust, not included above	**3**	1

25 Non-current assets held for sale

The Trust does not hold any non current assets for sale.

26 Trade and other payables

	Current		Non-current	
	31 March 2015 £000s	31 March 2015 £000s	**31 March 2015 £000s**	31 March 2015 £000s
NHS payables - revenue	**1,407**	8,767	**0**	0
NHS accruals and deferred income	**7,306**	1,756	**0**	0
Non-NHS payables - revenue	**1,864**	11,330	**0**	0
Non-NHS payables - capital	**8,121**	6,220	**0**	0
Non-NHS accruals and deferred income	**24,651**	20,664	**0**	0
Social security costs	**2,779**	2,865	**0**	0
PDC Dividend payable to DH	**105**	0	**0**	0
VAT	**0**	1	**0**	0
Tax	**528**	2,918	**0**	0
Other	**0**	617	**0**	0
Total	**46,761**	55,138	**0**	0
Total payables (current and non-current)	**46,761**	**55,138**		
Included above:				
outstanding Pension Contributions at the year end	**318**	3,763		

For 2014/15, PDC dividends payable to the Department of Health were underpaid and balances due to Department of Health are as follows:

PDC dividend: balance receivable/(payable) at 31 March 2015	(105)
PDC dividend: balance receivable/(payable) at 31 March 2014	50

27 Other liabilities

The Trust does not hold any other liabilities.

28 Borrowings

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Loans from Department of Health	**1,000**	2,000	**0**	1,000
PFI liabilities:				
Main liability	**1,017**	998	**26,898**	27,915
Finance lease liabilities	**0**	66	**0**	0
Total	**2,017**	**3,064**	**26,898**	**28,915**
Total other liabilities (current and non-current)	**28,915**	**31,979**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2015		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	1,000	1,017	**2,017**
1 - 2 Years	0	2,210	**2,210**
2 - 5 Years	0	4,867	**4,867**
Over 5 Years	0	19,821	**19,821**
TOTAL	**1,000**	**27,915**	**28,915**

29 Other financial liabilities

The Trust does not hold any other financial liabilities.

30 Deferred revenue

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Opening balance at 1 April 2014	**4,138**	2,118	**0**	0
Deferred revenue addition	**4,858**	4,138	**0**	0
Transfer of deferred revenue	**(4,138)**	2,118)	**0**	0
Current deferred Income at 31 March 2015	**4,858**	4,138	**0**	0
Total deferred income (current and non-current)	**4,858**	4,138		

31 Finance lease obligations as lessee

The Trust does not hold any Finance lease obligation as leasse as at 31 March 15

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2015 £000s	31 March 2015 £000s	**31 March 2015 £000s**	31 March 2015 £000s
Within one year	**0**	66	**0**	66
Minimum Lease Payments / Present value of minimum lease payments	**0**	66	**0**	66
Included in:			**0**	66
Current borrowings			**0**	66

31 Finance lease obligations as lessee

The Trust does not hold any Finance lease obligation as leasse as at 31 March 15

Amounts payable under finance leases (Other)	Minimum lease payments		Present value of minimum	
	31 March 2015 £000s	31 March 2015 £000s	**31 March 2015 £000s**	31 March 2015 £000s
Within one year	**0**	66	**0**	66
Minimum Lease Payments / Present value of minimum lease payments	**0**	66	**0**	66
Included in:			**0**	66
Current borrowings			**0**	66

32 Finance lease receivables as lessor

The Trust does not hold any Finance lease as lessor.

33 Provisions

		Comprising:				
	Total	**Early Departure Costs**	**Legal Claims**	**Restructuring**	**Other**	**Redundancy**
2013/14						
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2014	**10,598**	780	356	2,481	6,981	0
Arising during the year	**2,893**	384	256	472	775	1,006
Utilised during the year	**(3,331)**	(92)	(183)	(79)	(2,977)	0
Reversed unused	**(2,708)**	(26)	(38)	(2,402)	(242)	0
Unwinding of discount	**50**	14	0	0	36	0
Change in discount rate	**(14)**	(4)	0	0	(10)	0
Balance at 31 March 2015	**7,488**	**1,056**	**391**	**472**	**4,563**	**1,006**
Expected Timing of Cash Flows:						
No Later than One Year	**4,502**	91	391	472	2,542	1,006
Later than One Year and not later than Five Years	**835**	362	0	0	473	0
Later than Five Years	**2,151**	603	0	0	1,548	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2015	70,329
As at 31 March 2014	59,553

Provisions relating to Early Departure Costs covers pre 1995 early retirement costs. Liabilities and the timing of liabilities are based on pensions provided to individual ex employees and projected life expectancies using government actuarial tables. The major uncertainties rest around life expectancies assumed for the cases.

Legal claims cover the Trust's potential liabilities for public and employer liability. Potential liabilities are calculated using professional assessment of individual cases by the Trust's insurers. The Trust's maximum liability for any individual case is £10,000 with the remainder being covered by insurers.

Restructuring provisions results from the Trust's ongoing restructuring scheme whereby staff have been redeployed at a lower pay grade whilst on pay protection as per Agenda for Change.

Other provisions cover Injury Benefits £1,992,000, employment tribunals and litigation claims £75,000, other contractual obligations £4,391,000 and £211,000 for carbon emission credits repayable.

Injury benefit provisions are calculated with reference to the NHS Pensions Agency and actuarial tables for life expectancy. Staff litigation claims represent potential liabilities to the Trust in respect of claims made by current or former employees.

Redundancy provisions covers staff who will be made redundant as part of the Trust's ongoing restructuring scheme.

The timing and amount of the cashflows is shown above but it must be pointed out that, in the case of provisions, there will always be a measure of uncertainty. However, the values listed are best estimates taking all the relevant information and professional advice into consideration.

34 Contingencies

	31 March 2015	31 March 2014
	£000's	£000's
Contingent liabilities		
NHS Litigation Authority legal claims	**(193)**	0
Pension & Injury Benefit	**(467)**	(620)
Net value of contingent liabilities	**(660)**	(620)

35 PFI and LIFT - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

	2014/15	2013/14
Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI	**£000's**	£000's
Service element of on SOFP PFI charged to operating expenses in year	**1,006**	973
Total	**1,006**	973
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**1,321**	1,244
Later than One Year, No Later than Five Years	**5,766**	5,415
Later than Five Years	**33,230**	34,764
Total	**40,317**	41,423

The estimated annual payments in future years are not expected to be materially different from those which the Trust is committed to make during the next year.

Imputed "finance lease" obligations for on SOFP PFI contracts due	**2014/15**	2013/14
	£000's	£000's
No Later than One Year	**4,407**	3,148
Later than One Year, No Later than Five Years	**18,760**	13,281
Later than Five Years	**53,769**	63,394
Subtotal	**76,936**	79,823
Less: Interest Element	**(49,021)**	(50,910)
Total	**27,915**	28,913

	2014/15	2013/14
Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**£000's**	£000's
No Later than One Year	**1,017**	3,148
Later than One Year, No Later than Five Years	**4,535**	12,469
Later than Five Years	**22,363**	41,222
Total	**27,915**	56,839
Number of on SOFP PFI Contracts		
Total Number of on PFI contracts	**1**	1
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**	0

36 Impact of IFRS treatment - current year

The information below is required by the Department of Heath for inclusion in national statutory accounts

	2014/15	2013/14
	£000's	£000's
The information below is required by the Department of Heath for budget reconciliation purposes		
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	**546**	518
Interest Expense	**2,146**	2,140
Impairment charge - AME	**0**	(1,108)
Impairment charge - DEL	**0**	0
Other Expenditure	**1,006**	973
Revenue Receivable from subleasing	**0**	0
Impact on PDC dividend payable	**(292)**	(419)
Total IFRS Expenditure (IFRIC12)	**3,406**	**2,104**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	**(3,952)**	(3,950)
Net IFRS change (IFRIC12)	**(546)**	**(1,846)**
Capital Consequences of IFRS: LIFT/PFI and other items under IFRIC12		
Capital expenditure 2014/15	**0**	0
UK GAAP capital expenditure 2014/15 (Reversionary Interest)	**199**	192

37 Financial Instruments

37.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the Finance Department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

37.2 Financial Assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	11,023	0	**11,023**
Receivables - non-NHS	0	2,199	0	**2,199**
Cash at bank and in hand	0	28,382	0	**28,382**
Total at 31 March 2015	**0**	**41,604**	**0**	**41,604**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	10,290	0	10,290
Receivables - non-NHS	0	6,241	0	6,241
Cash at bank and in hand	0	41,808	0	41,808
Other financial assets	0	0	0	0
Total at 31 March 2014	0	58,339	0	58,339

37.3 Financial Liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0	0	**0**
NHS payables	0	1,407	**1,407**
Non-NHS payables	0	36,871	**36,871**
PFI & finance lease obligations	0	27,915	**27,915**
Total at 31 March 2015	**0**	**66,193**	**66,193**
Embedded derivatives	0	0	0
NHS payables	0	6,636	6,636
Non-NHS payables	0	44,312	44,312
PFI & finance lease obligations	0	28,979	28,979
Total at 31 March 2014	0	79,927	79,927

PFI & finance lease obligations relate to amounts payable in respect of the Trust's PFI and finance lease funded assets over the remaining life of the arrangements.

38 Events after the end of the reporting period

There are no material events after the reporting period which may have a material impact on the Trust's reported financial performance.

39 Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Sandwell & West Birmingham Hospitals NHS Trust.

The Department of Health is regarded as a related party. During 2014/15, Sandwell And West Birmingham Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000s	£000s	£000s	£000s
NHS Sandwell & West Birmingham CCG	0	260,925	0	1,938
Birmingham and the Black Country	0	53,419	0	3,097
NHS Cross City CCG	47	44,056	47	98
Health Education England	0	18,936	0	238
NHS Birmingham South & Central CCG	0	13,419	0	265
NHS Walsall CCG	0	5,373	0	205
NHS Business Services Authority (NHS Pensions)	25,102	0	318	0
NHS Litigation Authority	6,676	0	0	0

There are a number of other Health Bodies with which the Trust has transacted during the normal course of its activities but these are not considered to be material.

The Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with the Department for Education and Skills in respect of university hospitals and Sandwell MBC and Birmingham City Council in respect of joint enterprises.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Trust Board.

The Trust has ongoing contractual relationships with all of the entities listed above.

40 Losses and special payments

The total number of losses cases in 2014/15 and their total value was as follows:

	Total Value of Cases £s	Total Number of cases
Losses	240,419	205
Special payments	269,749	91
Total losses and special payments	510,168	296

The total number of losses cases in 2013/14 and their total value was as follows:

	Total Value of Cases £s	Total Number of cases
Losses	284,559	222
Special payments	250,521	88
Total losses and special payments	535,080	310

There were no individual cases where the value of losses or special payments exceeded £300,000 in either 2014/15 or 2013/14.

41. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

41.1 Breakeven performance

Turnover	313,388	327,536	348,475	359,161	384,774	387,870	424,144	433,007	439,022	**446,590**
Retained surplus/(deficit) for the year	(5,726)	3,399	6,524	2,547	(28,646)	(6,885)	4,540	(3,441)	(2,505)	**4,585**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	**0**
2006/07 PPA (relating to 1997/98 to 2005/06)	0	0	0	0	0	0	0	0	0	0
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0	0	0	0	0
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	0	0	36,463	9,533	(2,395)	8,872	8,922	**(263)**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	358	1,092	334	**331**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	(557)	(455)	(640)	0	0	**0**
Absorption accounting adjustment	0	0	0	0	0	0	0	0	0	**0**
Other agreed adjustments	0	5,726	0	0	0	0	0	0	0	**0**
Break-even in-year position	**(5,726)**	**9,125**	**6,524**	**2,547**	**7,260**	**2,193**	**1,863**	**6,523**	**6,751**	**4,653**
Break-even cumulative position	**(13,527)**	**(4,402)**	**2,122**	**4,669**	**11,929**	**14,122**	**15,985**	**22,508**	**29,259**	**33,912**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS [organisation]'s financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013/14 %	2014/15 %
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	(1.83)	2.79	1.87	0.71	1.89	0.57	0.44	1.51	1.54	**1.04**
Break-even cumulative position as a percentage of turnover	(4.32)	(1.34)	0.61	1.30	3.10	3.64	3.77	5.20	6.66	**7.59**

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

41.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

41.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2014/15 £000s	2013/14 £000s
External financing limit (EFL)	**11,130**	3,015
Cash flow financing	**10,932**	(981)
Unwinding of Discount Adjustment	**0**	66
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**10,932**	(915)
Under spend against EFL	**198**	3,930

41.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2014/15 £000s	2013/14 £000s
Gross capital expenditure	**17,346**	21,630
Less: book value of assets disposed of	**0**	(193)
Less: donations towards the acquisition of non-current assets	**(51)**	(213)
Charge against the capital resource limit	**17,295**	21,224
Capital resource limit	**17,330**	21,815
Underspend against the capital resource limit	**35**	591

42 Third party assets

The Trust does hold small amounts of cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts. The balance at 31st March 2015 was £3k (31st March 2014 £1k).

43 Charitable Funds

The Board of Sandwell and West Birmingham Hospitals NHS Trust acts as Corporate Trustee for the Sandwell and West Birmingham Hospitals NHS Trust Charitable Funds. Within the specifications of IAS 1, these funds are not considered to be material to the overall financial performance or position of the Trust and are therefore not consolidated into the accounts of the Trust.

For the financial year ended 31st March 2015, key performance statistics for the Charitable Funds are as follows:

	31st March 2015 £000	31st March 2014 £000
Incoming Resources	1,683	1,547
Resources Expended	(869)	(1,047)
Other Movements	281	22
Net Movement in Funds	1,095	522
Total Value of Charitable Funds at Year End	6,924	5,829

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

We have audited the financial statements of Sandwell and West Birmingham Hospitals NHS Trust for the year ended 31 March 2015 on pages 1 to 45. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Board of Directors of Sandwell and West Birmingham Hospitals NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2015 and of the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and
- the information given in the Strategic Report and Director's Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with the NHS Trust Development Authority guidance;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditor

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

We planned and performed our work in accordance with the Code of Audit Practice 2010 for local NHS bodies. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all material respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that, in all material respects, Sandwell and West Birmingham Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate

We certify that we have completed the audit of the accounts of Sandwell and West Birmingham Hospitals NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Andrew Bostock for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

4 June 2015

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST ON THE NHS TRUST SUMMARISATION SCHEDULES

We have examined the summarisation schedules designated TRU01 to TRU22 and TRU25 of Sandwell and West Birmingham Hospitals NHS Trust for the year ended 31 March 2015, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This report is made solely to the Board of Directors of Sandwell and West Birmingham Hospitals NHS Trust as a body, in accordance with Part II of the Audit Commission Act 1998[1]. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

For the purpose of this report, the agreement of figures between the statutory financial statements and the summarisation schedules extends only to those figures within the audited financial statements which are also published in the summarisation schedules. Auditors are required to report on any differences over £250,000 between the final audited statutory financial statements and the summarisation schedules.

Unqualified audit opinion on the financial statements; no differences identified:

In our opinion the figures reported in the final audited statutory financial statements, on which we have issued an unqualified opinion, agree to the figures reported in the summarisation schedules.

Andrew Bostock for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

4 June 2015

[1] References in this report to the Audit Commission Act 1998 are saved transitionally for the purposes of the 2014/15 audit of accounts.

Statement of Chief Executive's responsibilities

2014-15 Annual Accounts of Sandwell and West Birmingham Hospitals NHS Trust

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

Toby Lewis
(Chief Executive)

Date 4 June 2015

2014-15 Annual Accounts of Sandwell and West Birmingham Hospitals NHS Trust

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

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

- make judgements and estimates which are reasonable and prudent;

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

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

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Toby Lewis
(Chief Executive)

Date 4 June 2015

Antony M Waite
(Director of Finance)

Date 4 June 2015

Remuneration Report for the Financial Year Ending 31 March 2015

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. The Committee meets as required.

Membership of the Committee is comprised of the Trust's Chair and all Non-Executive Directors. At 31 March 2015, these were:

- Richard Samuda (Chair)
- Olwen Dutton (Vice Chair)
- Gianjeet Hunjan
- Sarindar Singh Sahota
- Harjinder Kang
- Paramit Gill
- Michael Hoare (Non-Executive Director designate)

During 2014/15, the composition of the Committee changed; Paramit Gill was appointed on 14 April 2014 while Clare Robinson resigned on 28 February 2015.

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 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. In 2014/15 no inflationary rises were approved.

It is not the Trust's policy to employ Executive Directors on 'rolling' or 'fixed term' contracts; all Executive 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.

During 2014/15, the composition of the Board members also changed; Executive Director Michael Sharon resigned on 02 April 2014 and Raffaela Goodby was appointed on 11 February 2015. Non-Executive Clare Robinson resigned 28 February 2015 and Paramjit Gill was appointed on 14 April 2014.

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								
	2014/15				2013/14			
Name and Tile	(a)	(b)	(c)	(d)	(a)	(b)	(c)	(d)
	Salary (bands of £5,000) £000	Expenses payments (taxable) to nearest £00	All pension related benefits (bands of £2,500) £000	Total all payments and benefits (bands of £5,000) £000	Salary (bands of £5000) £000	Expenses payments (taxable) to nearest £100 £00	All pension related benefits (bands of £2,500) £000	Total all payments and benefits (bands of £5,000) £000
Richard Samuda, Chair	20-25	47	0	25-30	20-25	39	0	25-30
Clare Robinson, Non-Executive Director and Vice Chair (to 28 February 2015)	5-10	0	0	5-10	5-10	4	0	5-10
Gianjeet Hunjan, Non-Executive Director	5-10	0	0	5-10	5-10	0	0	5-10
Sarindar Singh Sahota, Non-Executive Director	5-10	0	0	5-10	5-10	0	0	5-10
Olwen Dutton, Non-Executive Director (Vice Chair)	5-10	0	0	5-10	5-10	0	0	5-10
Richard Lilford, Non-Executive Director (to 31 January 2014)	0	0	0	0	5-10	0	0	5-10
Harjinder Kang, Non-Executive Director	5-10	0	0	5-10	5-10	1	0	5-10
Paramjit Gill Non-Executive Director (from 14 April 2014)	5-10	0	0	5-10	0	0	0	0
Michael Hoare, Non -Executive Director Designate	5-10	0	0	5-10	0-5	0	0	0-5
Toby Lewis, Chief Executive	180-185	0	40-42.5	220-225	180-185	0	27.5-30	205-210
Antony Waite, Director of Finance & Performance Management	140-145	0	0	140-145	30-35	0	5-7.5	35-40
Robert White, Director of Finance & Performance Management (to 16 February 2014)	0	0	0	0	110-115	0	0-2.5	110-115
Rachel Overfield, Chief Nurse (to 08 September 2013)	0	0	0	0	45-50	0	157.5-160	205-210
Linda Pascal, Acting Chief Nurse (09 September 2014 to 01 January 2014)	0	0	0	0	20-25	1	52.5-55	75-80
Colin Ovington, Chief Nurse (from 9 December 2013)	110-115	0	72.5-75	185-190	35-40	0	32.5-35	70-75
Roger Stedman, Medical Director	170-175	0	42.5-45	215-220	170-175	0	40-42.5	210-215
Rachel Barlow, Chief Operating Officer	110-115	0	12.5-15	120-125	110-115	3	2.5-5	110-115
Mike Sharon, Director of Strategy & Organisational Development (to 02 April 2014)	10-15	0	5-7.5	15-20	110-115	0	0	110-115
Kam Dhami, Director of Governance	95-100	0	7.5-10	105-110	95-100	0	0-2.5	95-100
Raffaela Goodby Director of Workforce & Organisational Development (from 11 February 2015)	10-15	0	0	10-15	0	0	0	0

Notes to Salaries and Allowances of Senior Managers

1. Non-Executive Directors - do not receive pensionable remuneration and therefore do not accrue any pension related benefits.
2. 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 below 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 (or other allowable beneficiary's) pensions payable from the scheme. 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 OF SENIOR MANAGERS								
Name and Title	Real increase in pension at age 60	Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31st March 2015	Lump sum at age 60 related to accrued pension at 31st March 2015	Cash Equivalent Transfer Value at 31st March 2015	Cash Equivalent Transfer Value at 31st March 2014	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 £000
Toby Lewis, Chief Executive	0- 2.5	5-7.5	35-40	115-120	639	518	108	0
Anthony Waite, Director of Finance & Performance Management	0	0	40-45	130-135	783	744	20	0
Colin Ovington, Chief Nurse	2.5-5	7.5-10	50-55	155-160	1043	927	91	0
Roger Stedman, Medical Director	0-2.5	5-7.5	40-45	120-125	663	599	48	0
Rachel Barlow, Chief Operating Officer	0-2.5	0-2.5	30-35	90-95	468	435	22	0
Mike Sharon, Director of Strategy & Organisational Development (to 02 April 14	0-2.5	0-2.5	35-40	115-120	851	800	3	0
Kam Dhami, Director of Governance	0-2.5	0-2.5	30-35	95-100	508	476	20	0
Raffaela Goodby, Director of Workforce & Organisational Development (from 11 February 2015) - not in a pension scheme at 31 March 2015	0	0	0	0	0	0	0	0

Pay Multiples

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 the Trust in the 2014/15 was £180,000 (2013/14, £180,000). This was 6.67 times (2013/14, 6.55) the median annualised remuneration of the workforce, which was £26,974 (2013/14, £28,568). Annualised remuneration may not reflect actual remuneration in year, for example where an individual was in post for only part of the year.

In 2014/15, 14 (2013/14, 11) employees received remuneration in excess of the highest-paid director. Annual remuneration on a whole time equivalent basis ranged from £12,675 to £355,935 (2013/14, £14,294 to £311,048). Total remuneration includes salary and any additional payments for overtime, additional activities and enhancements but excludes any severance pay, employer pension and national insurance contributions. Employees of the Trust do not receive performance related pay nor benefits in kind.

The Trust's average workforce numbers totalled 7,110 and the change in average number of WTE employed across year was a reduction of 68. The change in WTE employed from March 2014 to March 2015 was a reduction of 260. 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 2013/14 and 2014/15 by 14% (from £311,084 to £355,935). 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 a non-consolidated inflationary increase in pay in 2014/15 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 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as at 31 March 2015	9
Of which, the number that have existed:	
for less than 1 year at the time of reporting	1
for between 1 and 2 years at the time of reporting	0
for between 2 and 3 years at the time of reporting	6
for greater than 3 years	2

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 31 March 2015, for more than £220 per day and that last longer than six months, new engagements between 01 April 2014 and 31 March 2015.

	Number
Number of new engagements, or those that reached six months in duration, between 01 April 2014 and 31 March 2015	1
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	1
Number for whom assurance has been requested	1
Of which:	
assurance has been received	0
assurance has not been received	1
engagements terminated as a result of assurance not being received	0

There are no off payroll engagements of Board members or senior officials with significant financial responsibility between 01 April 2014 and 31 March 2015, however there is a Board member seconded from Birmingham City Council from 11 February 2015 for 18 months.

The Trust has made significant progress to reduce the number of non substantive (agency, bank and other off payroll engagements) staff it uses from 18 in 2013/14 to 9 in 2014/15, ie a reduction of 50%.

REGISTER OF INTERESTS AS AT APRIL 2015

Name	Interests Declared
Chairman	
Richard Samuda	• Director – Horton's Estates Ltd. • Director – 'Kissing It Better' • Non Executive Director – Warwick Racecourse
Non Executive Directors	
Olwen Dutton	• Partner – Bevan Brittan LLP • Fellow – Royal Society of Arts • Member – Lunar Society • Member – Birmingham Forward • Member – Council of the Birmingham Law Society • Member – Labour Party
Gianjeet Hunjan	• 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	• 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	• Managing Consultant – PA Consulting Group
Paramjit Gill	• 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 • General Practitioner
Voting Executive Directors	
Toby Lewis (Chief Executive)	• Board member – Sandwell University Technical College
Rachel Barlow (Chief Operating Officer)	• None
Colin Ovington (Chief Nurse)	• None
Roger Stedman (Medical Director)	• Partner – Excel Anaesthesia (private anaesthesia services)
Tony Waite (Director of Finance & Performance Mgt)	• None
Associate Members	
Kam Dhami (Director of Governance)	• None
Raffaela Goodby (Director of Workforce & OD)	• Board member in PPMA (public sector people manager's association) member's organisation • E4S Practitioner Board member (voluntary national body)
Michael Hoare (Non Executive)	• Director, Fujitsu UK
Trust Secretary	
Simon Grainger-Lloyd	• Director – Parkfields Management Ltd.

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 Birth Centre.

Sandwell General Hospital
Lyndon
West Bromwich
West Midlands
B71 4HJ

Rowley Regis Community Hospital
Moor Lane
Rowley Regis
West Midlands
B65 8DA

Leasowes Intermediate Care Centre
Oldbury Road
Smethwick
West Midlands
B66 1JE

Halcyon Birth Centre
Oldbury Road
Smethwick
West Midlands
B66 1JE

Car Parking

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.

Reduced car parking charges as a result of clinic delays

Where a patient is seen more than one hour late in clinic, they do not have to pay extra for car parking.

Ask for a form at the clinic reception area. Completed forms need to be taken to either the BTC Reception desk, at City, or the General Enquiries Desk in main reception at Sandwell. The patient has to pay the minimum charge of £2.60 and will then be given a ticket to leave the car park without further payment.

A retrospective postal claim can be made, but the form must still have been completed by the clinic staff. In this case a ticket would be provided for a free return visit.

Visitor Charges

The visitor charges are:

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

Concessions

One Shot Tickets	4 for £10
Season Tickets costs remain unchanged at:	
3 days	£9 (+ £5 refundable deposit)
7 days	£18 (+ £5 refundable deposit)
3 months	£42 (+ £5 refundable deposit)

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 4 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 four. 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

Security

Security officers are on duty at City and Sandwell Hospitals 24 hours per day, 365 days per year. Intercoms are linked directly to Security from entry/exit barriers and the pay on foot machines. All car parks at City and Sandwell Hospitals are illuminated at night, monitored by CCTV and patrolled regularly by security officers.

Patient Advice and Liaison Service (PALS)

By contacting PALS, you can talk to someone who is not involved in your care. You can ask questions, get advice or give your opinions.

Providing on-the-spot help and support with the power to negotiate solutions or speedy resolutions of problems, PALS also acts as a gateway to independent advice and aims to:

- Be identifiable and accessible;
- Provide help and support with the power to negotiate solutions to problems;
- Act as a gateway to independent advice;
- Provide accurate information to patients, carers and families;
- Provide advice and support to you, your family and carer(s).
- Listen to and act on your concerns, suggestions or comments.
- Help to resolve your concerns by liaising with the ward or department involved on your behalf.
- Pass on positive feedback to the relevant members of staff working in that area.

PALS can help to resolve your concerns informally but is not part of the formal complaints process.

How can I contact PALS?
You can: Phone: 0121 507 5836, 10am – 4pm, Monday – Friday. (Please leave a message if the line is engaged or if you are calling outside office hours.)

Email: swb-tr.pals@nhs.net.

If you would like to see someone, you can drop in at City Hospital between 10am and 4pm or phone the office to arrange an appointment. The team can be found at:

PALS
Birmingham Treatment Centre (ground floor)
City Hospital
Dudley Road
Birmingham
B18 7QH

Send your concern or question to us by completing the our feedback form and submitting it online or:

- Handing it to a member of staff.
- Posting it to the address above.
- Faxing it to 0121 507 5893.

Putting it in one of our red boxes. These are located: at Sandwell General Hospital outside the PALS office (near the main entrance) and near the Emergency Department; near the PALS office at City Hospital; and in the main reception at Rowley Regis Hospital.

How can I complain?
To make a complaint, you can:

Send it in writing to:

Complaints Department
Sandwell & West Birmingham Hospitals NHS Trust
City Hospital
Dudley Road
Birmingham
B18 7QH

Fill in the complaints form here and send it to the above address.

Phone: 0121 507 4346, 10am – 4pm, Monday – Friday. (Please leave a message if the line is engaged or if you are calling outside these times)

Email: swbh.complaints@nhs.net

Volunteers

In 2015 we are expanding our volunteer programme by managing our volunteers directly and introducing new ways for volunteers to get involved in the life of the Trust. There are a range of ways to become involved in volunteering, including Mi Way - covering way-finding which means helping direct people through the Trust's sites, buildings and facilities; helping them check-in for appointments and accompanying them to their relevant clinics. Mi Day is about enhancing the inpatient experience by providing recreational activities for patients whilst they are with us, listening and talking to patients, helping them contribute to patient surveys and use bedside equipment such as WiFi, and linking in with external support agencies when required to support the patient in their discharge.

MI Plate provides assistance to patients at mealtimes both in hospital or community. This includes encouraging them to drink fluids, helping them with their menu choices and helping them with their meals. Volunteers must be 16 or over, and can offer as much or little time as they have available. They can volunteer for any one or all of the available streams.

Our volunteers have told us they get a great deal out of volunteering, such as a sense of being part of the community, being able to 'give something back' and using and developing skills and confidence to make a real difference to others. Our Volunteers Service is run by our Patient Action Centred Team, and they can be contacted on 0121 507 4855 between 8am and 5pm, Monday to Friday.

Some of the many volunteers who support us

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Our promises to you...
- English

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

Our promises to you...
- Polish

Nasze obietnice wobec Ciebie...

1. Obiecuję, że... sprawię że poczujesz się mile w
2. Obiecuję, że... znajdę czas żeby Cię wysłuchać
3. Obiecuję, że... będę uprzejmy, grzeczny i okaż
4. Obiecuję, że... sprawię że będziesz poinformo
5. Obiecuję, że... przyznam się do błędów i zrobi żeby je naprawić
6. Obiecuję, że... uszanuję Twój punkt widzenia
7. Obiecuję, że... będę opiekuńczy i życzliwy
8. Obiecuję, że... będziesz stale brał(a) udział
9. Obiecuję, że... wykroczę ponad swoje obowiąz

Our promises to you...
- Urdu

ہمارا عہد ہے کہ : آپ سے

1- آپ کے یہاں آنے پر ہم آپ کو خوش آمدید کہتے ہیں ۔
2- آپ کی بات سننے کے لئے آپ کو وقت دیا جائے گا ۔
3- ہم آپ کے ساتھ نرمی، ادب و احترام اور تہذیب سے پیش آئیں گے۔
4- ہم آپ کو ہونے والی صورت حال سے باخبر رکھیں گے اور تفصیل بتائیں گے
5- اگر ہم سے کوئی غلطی ہوئی تو اسے مان لینے کے بعد اصلاح کی پوری پوری کوشش کریں گے ۔
6- ہم آپ کی رائے اور تجویز کو اہمیت دیں گے ۔
7- ہم آپ کی ہمدردانہ طور پر دیکھ بھال کریں گے ۔
8- آپ کو بھی مشورے اورکارکردگی میں شامل کریں گے ۔
9- ہم آپ کی خدمت کے لئے بہت کچھ کرسکتے ہیں ۔

ہمارے یہاں ہر شخص اہم ہے۔

Our promises to you...
- Punjabi

ਸਾਡੇ ਵਾਅਦੇ ਤੁਹਾਡੇ ਨਾਲ...

1. ਅਸੀਂ... ਤੁਹਾਡਾ ਆਦਰ-ਮਾਣ ਕਰਾਂਗੇ
2. ਅਸੀਂ... ਤੁਹਾਡੀ ਗੱਲ ਸੁਨਣ ਲਈ ਸਮਾਂ ਕੱਢਾਂਗੇ
3. ਅਸੀਂ... ਤੁਹਾਡੇ ਨਾਲ ਨਿਮਰਤਾ, ਸ਼ਰਾਫਤ ਅਤੇ ਸਤਿਕਾਰ ਨਾਲ ਪੇਸ਼ ਆਵਾਂਗੇ
4. ਅਸੀਂ... ਤੁਹਾਨੂੰ ਸੂਚਿਤ ਕਰਦੇ ਰਹਾਂਗੇ ਅਤੇ ਜੋ ਕੁੱਝ ਹੋ ਰਿਹਾ ਹੈ ਉਸ ਬਾਰੇ ਸਮਝਾਵਾਂਗੇ
5. ਅਸੀਂ... ਆਪਣੀਆਂ ਗਲਤੀਆਂ ਨੂੰ ਸਵੀਕਾਰਾਂਗੇ ਅਤੇ ਉਨ੍ਹਾਂ ਨੂੰ ਸਹੀ ਕਰਨ ਵਾਸਤੇ ਜੋ ਵੀ ਕਰਨਾ ਪਵੇ ਕਰਾਂਗੇ
6. ਅਸੀਂ... ਤੁਹਾਡੇ ਦ੍ਰਿਸ਼ਟੀਕੋਨ ਦਾ ਸਤਿਕਾਰ ਕਰਾਂਗੇ
7. ਅਸੀਂ... ਤੁਹਾਡੇ ਹਿਤਕਾਰੀ ਅਤੇ ਪ੍ਰਵਾਹ ਕਰਨ ਵਾਲੇ ਬਣਾਂਗੇ
8. ਅਸੀਂ... ਅਸੀਂ ਤੁਹਾਨੂੰ ਕਾਰਵਾਈ ਵਿਚ ਸ਼ਾਮਲ ਰੱਖਾਂਗੇ
9. ਅਸੀਂ... ਆਪਣੀ ਪੂਰੀ ਵਾਹ ਲਾਵਾਂਗੇ

ਜਿੱਥੇ
ਹਰ ਕੋਈ
ਮਾਅਨੇ ਰੱਖਦਾ ਹੈ

Where EVERYONE Matters

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