Sandwell and West Birmingham Hospitals NHS
NHS Trust

Listening and learning





Integrated Annual Report and Accounts 2015/16

Incorporating the Quality Account and the Trust Charity Annual Review

Where EVERYONE Matters

Contents

Front cover images

Pictured from top left to right are Gary Howse, from the Medical Engineering Department demonstrating a medical device to pupils from Aldridge School and the George Salter Academy, patient John Sparks, patient Amina Khalfey, Team leader for the children's therapy service in Oldbury and Smethwick, Una Peplow with young patient Faye Black and patient Vera Lewin.

1. Introduction

After over a decade of waiting, this year saw us start work in Smethwick building your new acute hospital: the Midland Metropolitan. It will open in October 2018. Less than 900 days away. We want to deliver brilliant emergency care to those who are most unwell. The new hospital will help us to do just that every day and night of the week. In this annual report, you can read about examples of us improving care now, in advance of that development. Our stroke services have changed for the better and are now among the best in the UK. This year we made changes and investments in cardiology and in emergency surgery, where we have ambitions to do the same.

The year just gone told us a lot about our community services. The Care Quality Commission rated every single one of those services as good or outstanding. Our community children's services secured the highest possible rating – a fitting tribute to our health visitors, therapists, and community children's nurses. One in six of our patients are under 18, so it is good news indeed that we have a beacon of hope and success from which to develop further. Community services grow in importance, year on year, as we work to keep people well at home, and to prevent avoidable admission to hospital. We are delighted to be awarded a five year contract for the care of people who are dying. We want, through that contract, to try and support more people to die where they would wish, and to provide outstanding support to them, their families, and their GP.

In November 2015 we launched our 2020 Vision. After 18 months engagement with patients and staff, this sets out our future aims. It is unambiguous that the new hospital in 2018, new IT systems in 2017, or changes in our workforce year on year, are important steps in a journey. But the purpose of that work is better care. In particular we want to be renowned for the way we integrate care around the outcomes our patients tell us matter. 2015 has seen us take major steps to change forever the relationship between professionals and patients. It is exciting to be winning awards for our innovations. It is important to be opening up our wards to visitors, and now to be inviting relatives to 'stay overnight' with those that they care about, as part of John's Campaign. We do not under-estimate the change or the challenges it creates for staff. As a Trust at the very heart of the communities we serve, it must be right to take bold and brave steps to alter traditional boundaries with our patients and through that to build trust.

We provide care to half a million people. Staff are rightly proud of specialist services that we offer. The regional eye hospital for the West Midlands and the regional cancer centre for women's health are part of our organisation. Increasingly we are developing further strengths in disease groups that are prevalent in our local population: Sickle cell services, rheumatological conditions like lupus, immunology care, foetal medicine and our specialist faecal incontinence team. Our research and development ambitions are part of that, helping us to recruit patients to ground-breaking studies, and to recruit clinicians to develop their careers with us. We are a key part of the 100,000 genome project in Birmingham, and we have seen significant growth in our research work in 2015. Working alongside the University of Birmingham Medical School, and as a founding partner in the Aston Medical School that opens in 2017/18, we look forward to developing complex care services further. The Black Country Alliance, through which we work together with Dudley Group and colleagues at the Manor in Walsall, will be central to making sure that specialist services are delivered locally wherever that is possible.

General practice, and primary care as a whole, is the centre of the local NHS. Our Trust plays an important role in supporting local teams. In 2014 we made great strides with diabetes care. This year, in 2015, we have improved transport of pathology samples to practices, and cut waits for imaging scans. GPs can now see in their practices the results of tests ordered in our Trust. And we have more than trebled the amount of advice we provide to GPs by email and other methods, to either avoid referral or improve the precision of those referrals. Our pilot work on respiratory medicine is promising and shows a good prospect of developing a shared care model in avoid admissions. It is a tremendous honour to be selected as one of four Royal College of Physicians' pilot sites for the work we are doing – very much creating here "the Future Hospital".

The Trust's Board are especially proud to be able to report on two important changes in the past year. After many years of effort, trial, and sometimes error, we have made definitive progress with how complaints are managed, responded to, and learnt from in our organisation. There will be no complacency. But times to receive responses have fallen sharply. In our Trust we have always had high rates of compliments for the work of staff. In 2016 we pledge to work even harder to make sure that through our extraordinarily successful learning model – quality improvement half days – we tackle the underlying issues from the complaints that we receive. 2015 saw our organisation become Birmingham's first NHS Living Wage employer. This is one part of a package of measures to alter the employment relationships that we have. We are the forefront of apprenticeships in our region, and we have invested more than ever before in education and learning for staff. Part of our contribution to health and wealth in our area is through these endeavours and we will work with local employers and with schools and colleges in coming months to build on those opportunities.

Richard Samuda
Chairman

Toby Lewis
Chief Executive

About Sandwell & West Birmingham Hospitals NHS Trust

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

Our teams are committed to providing compassionate, high quality care from City Hospital on Birmingham's Dudley Road, from Sandwell General Hospital in West Bromwich, and from our intermediate care hubs at Rowley Regis and at Leasowes in Smethwick (which is also our stand-alone Birth Centre's base). 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. Our new hospital – the Midland Met – is currently under construction and will be open in Autumn 2018. It is located on Grove Lane, on the Smethwick border with west Birmingham.

Over the last year:

- More than 6000 babies were born at our Trust
- There were 200,000 patient attendances at our emergency departments with over 40,000 people admitted for a hospital stay.
- 92.5% of patients who attended our emergency departments were seen within four hours
- Over 50,000 day case procedures were carried out
- Over 500,000 patients were seen in outpatient
- Over 40,000 patients were admitted to hospital
- Over 701,000 patients seen by community staff

We helped deliver over 6000 babies in 2015/16. Above is one of the 'home from home' rooms in our midwife-led birth centre Serenity at City Hospital.

This year we displayed a banner describing the future of services in Sandwell. The vast majority of care stays in West Bromwich when the Midland Metropolitan Hospital opens.

2. Performance Report

In 2015 we launched our 2020 vision following engagement with patients, carers, residents, stakeholders and colleagues from across our organisation. The vision sets out how care will look in 2020 for patients across each of our clinical groups – what will stay the same and what will be different. It also includes how our estate will be configured with the completion of the Midland Met Hospital in 2018 and the development of the Sandwell Treatment Centre, as well as how our workforce and technology will transform to meet our future needs.

Our 2020 vision				
Public health plan	Research and development plan	Education, learning and development plan	Safety plan	Quality plan
Our operating model				
Long-term financial plan	Estates plan	Digital plan	Workforce plan	

The 2020 vision is supported by five plans that are all in place. The safety and quality plans were completed in 2016. These plans are supported by our enabling strategies: our long-term financial model, our estates, digital and workforce plans. Our detailed plans will continue to evolve but the direction of travel is clear and consistent. We want to take a lead role in disease prevention. We aim to provide care for long-term conditions in different ways and in partnership with GPs. Acute hospital care will be specialised and centralised for excellence and long term rehabilitation and social care will be part of what we do, working alongside others to meet the changing needs of our population. Together, the delivery of these plans will enable us to achieve our vision – to be the best integrated care organisation in the NHS. We use the National Voices definition of integrated care where "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."

Performance Overview

This year the Trust has had some significant successes through the hard work of our teams and partners. Read about our top ten highlights of the year.

1. Complaints improvement

This year a major highlight is the transformation that we have delivered in improving how we listen and respond to complaints from patients and carers. The time taken to respond to complaints has dramatically improved from an average of 62 days at the end of 2014/15 to 26 days by the end of March 2016. This improvement was generated through changing the way we have managed complaints so that they are handled by people closest to the issue. We have a fast-track system depending on the severity of complaints and have become much more patient-focused, asking our patients whether they would like an initial meeting and what outcome they expect right at the start of the process. We have also improved the way we learn from complaints, embedding changes right across our organisation. Throughout this report you will see stories about how we have listened and learned from patient complaints and other feedback.

2. Community Care Quality Commission rating

In November 2015 we were given an 'outstanding' rating by the Care Quality Commission (CQC) for our Children, Young People and Families community services following their inspection in June 2015. The services they inspected included health visiting, community nursing and therapy teams who work across homes, schools, children's centres and hospital settings. Every part of the service achieved a rating of either good or outstanding with outstanding ratings for being caring and well-led.

3. A learning organisation

Starting last April we allocated one half day each month to organisation-wide learning stopping non-urgent services across the Trust. These Quality Improvement Half Days (QIHDs) ensure that the best of what we already do here, happens more consistently across our Trust. This means that every month around 1500 people have met together in their teams or directorates to learn from each other and from national best practice. Each QIHD has a shared learning topic creating a consistent focus on a different quality improvement initiative or standard every month.

4. Securing the new Midland Metropolitan Hospital

Opening in October 2018, the new Midland Met Hospital is one of several major developments across the Trust, planned to ensure we provide a truly integrated service. The Midland Met Hospital is being delivered through a Public Private Partnership under a 30-year concession contract using the UK Government's PF2 model. We appointed our preferred bidder, The Hospital Company – a Carillion Joint Venture – in August 2015. Planning consent from Sandwell Metropolitan Borough Council was secured in September and we signed the contract in December. On 22nd January 2016 we marked the first spade in the ground and began our 1000 day countdown

contract in December. On 22nd January 2016 we marked the first spade in the ground and began our 1000 day countdown until the opening date in October 2018.

5. Completing the redevelopment of Rowley Regis Hospital

We have continued to invest in our sites and this year have completed expansion of the Rowley Regis Hospital creating a vibrant healthcare facility for patients that is more convenient for nearby residents than having to travel to either City or Sandwell Hospitals. Better car parking, more clinics and drop-in diagnostic services are making a real difference to patient experience. This year we also confirmed our plans for the Sandwell Treatment Centre, assuring the public and our teams of the services that will be developed on the Sandwell Hospital site. We opened Trinity House, the refurbished maternity building at Sandwell, that is now home to our finance, informatics and organisation development teams, providing a long-term base with teams having relocated from sub-standard accommodation at the City site.

6. Tackling readmission rates

We have made progress during the year on tackling readmission rates so that patients who are discharged return home or to another healthcare facility at the right time and with the right support in place. This year we made sure all our teams involved in admitting and discharging patients are aware of and use the LACE tool that identifies people who are most at risk of readmissions. Using this tool consistently has enabled teams to pro-actively make care arrangements, reducing readmissions. We have more work to do to further reduce readmission rates by 2% during the year ahead.

7. Delivering our goals for public health

We believe we have a responsibility to help people live healthier lives, and have met several of the objectives in our three year public health plan. We introduced a pricing change for food served in our catering outlets where healthier "green" food is cheaper, and unhealthy "red" food is more expensive. The sale of chips has halved since the introduction of our Choose Green campaign. Vending machines have been stripped of high sugar, high fat items. In the year ahead we will introduce more healthy food options with meal deals and loyalty schemes. We launched our Making Every Contact Count programme with partners in November 2015 so that staff can quickly and easily refer patients to support services to help people make vital lifestyle changes. Staff have been trained in how to make very brief interventions. Our midwifery service has made great improvements in the numbers of pregnant women who receive carbon monoxide testing and referrals to stop smoking services.

8. Cancer standards

We maintain excellent standards of care in cancer services so that patients are seen and treated quickly. We met or exceeded all of the cancer waiting and treatment time targets during the year. We also provide additional support for our patients as recommended in the Cancer Strategy for England 2015-2020 which details a recovery package for patients who are living with and beyond cancer. The recovery package includes the delivery of holistic needs assessments, and treatment summaries.

We provide health and wellbeing events, held annually for patients and their carers. At the events patients are given information about diet, exercise, how to access financial support and advice on returning to work. Treatment plans, signs and symptoms of the recurrence of cancer and pampering therapies are also available all day throughout the events. A clinical nurse specialist is also present to offer support. The events to date have proved successful with patients saying they appreciate the opportunity to meet others in the same situation so they do not feel isolated in their diagnosis.

In addition, the team has been working with the cardiac rehabilitation team to deliver a pilot project called "Physical activity and wellness programme for cancer". By enrolling in this programme, patients complete an exercise programme that has been personally designed for them. This aim is to help patients feel fit and more confident about themselves.

9. End of life care

During 2015/16 there were a number of changes brought about within the palliative and End of life service which have built the foundations for further success in the future. The team moved over to the Community & Therapies group, joining the iCares directorate. This has enabled closer working with community colleagues such as district nursing, therapies and specialist teams, and aims to ensure an integrated service for patients so that they can die within their own homes with the full support of the right services at the right time.

The Macmillan therapy team have joined the palliative and end of life service creating a fully integrated, multi-disciplinary service which now includes specialist nurses, palliative medicine consultants, OTs, End of Life Care Facilitators and administrative staff. The team work across the community and acute hospital sites to support patients at the end of life with physical and psychological symptoms and social needs.

This year we have been awarded the new End of Life Care contract for Sandwell and West Birmingham starting in April 2016. This will see exciting advancements in end of life care which includes the implementation of a new coordination hub. The hub will provide a single point of access for patients,

relatives and professionals for advice, information and appropriate signposting or treatment where required. The hub will coordinate services from health, social care, the voluntary sector and local hospices to enable patients to receive improved care at the end of life and die in a place of their choosing. The hub will also be supported by a new urgent response team who will visit patients at home at a time of crisis to prevent the need for unnecessary hospital admissions.

10. Positive feedback on our medical training programme

We are proud of the standard of our medical training, but we don't just think it is good, our doctors tell us it is. Medical Training is the backbone of any teaching hospital and is a priority for us. Every Foundation Year 1 (FY1) and FY2 junior doctor receives ongoing medical training in our Trust, and over the last year we received 97% positive feedback from them, relating to the quality of training they received. For example, one comment was that 'the training was helpful, clear, practical and engaging'.

Our training focuses on practicality, such as what doctors should do within the 'golden hour', which is the first hour following diagnosis when action must be taken and treatment started. We were one of the first NHS Trusts in the country to undertake such training and have been doing it since 2012.

Medical students from University of Birmingham undertaking bedside training, led by Clinical Teaching Fellow Dr Aled Picton and patient Barbara Treen with students Megan Wright, Juno Stahl, Lois Crabtree, Radia Choudhry and Michail Tsakalidis.

Palliative Medicine Consultant Dr Anna Lock at the Trust's annual Consultant Conference.

How we performed against our priorities

Strategic Objective	2015/16 Priority	Delivered?
Safe, High Quality Care	Finalise and begin to implement our Right Care Right Here (RCRH) plan for the current Sheldon block, as an intermediate care and rehabilitation centre for Ladywood and Perry Barr	✓
	Implement our Rowley Regis expansion plans (Rowley Max), so that by March 2016 we have in place our RCRH model on the site	✓
	Expand our iCares and heart failure services to provide improved provision in West Birmingham, by agreement with local practices	✓
	Tackle caseload management in community teams	x
	Improve outpatients by implementing phase 2 of our Year of Outpatients programme	x
	Reduce readmissions by 2%	x
	Achieve the gains promised within our 10/10 programme	x
	Meet the improvement requirements agreed with the Care Quality Commission	x
	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	x
Accessible and Responsive	Complete the reconfiguration of interventional cardiology and acute surgery between Sandwell and City Hospitals	✓
	Meet national wait time standards, and deliver from October a guaranteed maximum six week outpatient wait	x
	Deliver material transfer of respiratory medicine into community settings	x

Strategic Objective	2015/16 Priority	Delivered?
 Care Closer to Home	Develop, agree and publicise our final location plans for services in the Sandwell Treatment Centre	✓
	Deliver our plans for significant improvements in our universal Health Visiting offer, so 0-5 age group residents receive high standards of professional support at home	✓
	Ensure that we improve the ability of patients to die in a location of their choosing, including their own home	x
 Good use of resources	Finalise our long term workforce plan, explaining how we will safely remove the paybill equivalent of 1000 posts between 2016 and 2019	✓
	Complete the second year of our leadership development programme, providing clinical leaders with the skills and expertise to lead the organisation forward	✓
	Agree and begin to implement our three year Education Plan	✓
	Reform how corporate services operate to create efficient transactional services by April 2016 that benchmark well against peers within the Black Country Alliance	x
	Reform how corporate services support frontline care, ensuring information is readily available to teams from ward to Board	x
	Create balanced financial plans for all directorates and deliver group level balance on a full year basis	x
	Cut sickness absence below 3.5% with a focus on reducing days lost to short-term sickness	x
	Work within our agreed capacity plan for the year	x
 21st Century Infastructure	Reach financial close on the Midland Metropolitan Hospital	✓
	Agree EPR Outline Business Case, and initiate procurement process, whilst completing infrastructure investment programme	✓
	Develop our capital plan, and execute spend in line with that plan on a quarter by quarter basis	✓
	Implement successfully and safely the new tariff regime (Enhanced Tariff Offer) as the Trust moves to a PBR system with all commissioners by 2017	x
 An engaged and effective organisation	Implement Advice and Guidance support for GPs in all specialties, and expand use of video technology to consult with patients	✓
	Support agreed projects with selected GP partners through the CCG's 'push sites' initiative, designed to fit care models to local populations	x
	Create time to talk within our Trust, so that engagement is improved. This will include implementing Quality Improvement Half Days, revamping Your Voice, Connect and Hot Topics, and committing more energy to First Fridays	x

The priorities that were not fully delivered during the year have all become a focus within our 2016/17 annual plan. We didn't fully achieve all of our priorities during the year. Read on for further explanations of our performance against some of our priorities.

Priorities we did not fully deliver

Reducing delayed discharges and discharge before lunch

Safely discharging patients is fundamental, and it needs every individual at our Trust to play their role in achieving this target. 'Urgent Care Challenge' is one of the successful campaigns that the Trust has been running. The campaign encourages staff at all levels to contribute their ideas in improving safe discharges and to share their lessons with other teams. We have seen more morning discharges and delayed transfers of care (DTOC) reduced by 50% during the year. Sandwell was cited as one of the most improved areas for DTOC in the country. There have been a lack of home care and care home facilities that has contributed to us not meeting our objective.

Meet national wait time standards, and deliver from October a guaranteed maximum six week outpatient wait.

We were not able to meet the emergency four hour wait standard although we remain in the top 30% of Trusts nationally. We have seen good performance in the cancer standards and significant improvements in imaging reporting waits during the year. Referral to treatment within 18 weeks was met in line with our plans.

Corporate services

We did not fully realise the potential service improvements in the way corporate services are delivered and support our clinical groups. This year we aim to work closer across the Black Country Alliance to demonstrate excellent standards of service. The move of many corporate teams to a shared location at Sandwell has supported the teams to work more closely together and better align our processes and systems.

Implement the new tariff regime

The new system is well underway, and we will make this a Trust-wide system that also covers mental health, community, and eye services.

Financial balance

Not all directorates have achieved financial balance and this year we will make sure that teams have greater visibility of their budgets and are supported in learning how to best use our financial resources.

Tackling sickness absence

Reducing time away due to sickness remains a key priority for us. Some groups have maintained consistently low levels and others have made significant improvements with robust application of our sickness policies.

Respiratory medicine

Progress has been slower than we would have liked however we are now part of the Future Hospital programme with support from the Royal College of Physicians. We expect our Respiratory Community Services to deliver an integrated whole care system that will see greater collaboration between primary and secondary care services.

Our 'capacity plan'

More emergency patients came to hospital than we planned for but the main factor that meant we did not achieve our capacity plan was that we treated far fewer people in clinic and theatre than we said we would. At the start of this year we will see weekly tracking of the right number of patients being booked.

Achieving the gains promised within our 10/10 programme

To date we are not achieving 100% in all categories of this important patient safety checklist. During the first quarter of 2016 we will embed these standards in our assessment units.

Tackling caseload management in community teams

We have made significant improvements within our Community and Therapies group with a 10% increase in patient contact time for district nurses, health visitors and community midwives. A caseload management tool is now used to provide real time capacity information by combining staff availability with patient dependency to easily see current and future workload across the teams. We have more to do to tackle the caseloads in children's services.

Community paediatric patient Sammy Ahmed. In 2016/17 we will tackle caseloads in our community children's teams.

Effective management of our risks

We report the Trust's risk register to the public Trust Board every month and the Audit and Risk Committee on a quarterly basis. The Board has discussed the pre-mitigated red risks to test whether mitigation plans are sufficiently robust to provide assurance. As of March 2016 the Trust Risk Register had 29 key risks which were reported against monthly. Three of these had red residual risk scores after mitigation that related to a lack of Tier Four bed facilities for children and young people with mental health conditions, a risk of further reduction or failure to recruit senior medical staff to Emergency Departments and reliance on non-recurrent measures to support the Trust's financial performance and future investment plans. This reporting has led to focused challenge by the Board around sickness absence, financial performance and service delivery quality.

This year, new risks were escalated to the Board included IT system failures and that reduced ability to provide interventional radiology services. The Board has discussed the management of sickness absence as a key risk as well as the impact on infants of a national BCG vaccine shortage. During the year, risks that have been removed include: One to one care on the High Dependency Unit as staffing levels have now increased and are monitored monthly; and risks of delays to trauma patients requiring traction which has been resolved since the fitting of new trauma tables.

The Trust continues to implement an electronic risk system. This enables clinical groups and corporate directorates to import their risk registers and update actions directly. This will become fully operational in the first 3 months of 2016/17.

Partnerships with a purpose

Forming the Black Country Alliance on Black Country Day

In July 2015, we launched the Black Country Alliance (BCA) – a partnership with The Dudley Group NHS Foundation Trust and Walsall Healthcare NHS Trust. The BCA together services over a million people with a turnover of in excess of £1billion and aims to improve health outcomes, improve health care experience for staff and patients and make the best use of the resources we hold. The BCA is enabling us to keep and develop high quality health services for our populations. During the year we have established several programmes of work that mean in 2016 we will begin a new seven day service of interventional radiology, supporting patients with urgent needs at weekends. Sandwell & West Birmingham Hospitals NHS Trust will become the lead provider in partnership with The Dudley Group NHS Foundation Trust for a new rheumatology service in Walsall. Together, we have secured use of a mobile clinical research bus. Currently at Sandwell, this facility is enabling us to undertake more clinical research together in areas where lack of facilities has limited research opportunity and participation. We have confirmed our priorities for collaboration for 2016-2018 including how we can best work together on back office functions to drive down costs and share expertise.

SWBH Chief Executive Toby Lewis, The Dudley Group Chief Executive Paula Clarke and Walsall Healthcare NHS Trust Chief Executive Richard Kirby launching the Black Country Alliance.

Voluntary Sector collaboration

Over the last year, the Trust has been working more closely with many voluntary sector organisations. We have an important partnership with Agewell, a charity that works alongside older people in order to provide whatever help they need. Edna Barker, Agewell Chair, is a familiar face at City Hospital's D47 Reablement Ward, where she and her team work to befriend patients, lift their spirits, and help them reintegrate into the community when they are discharged. Sometimes a friendly face and a chat is all that's needed, and Edna's Army is always keen to take on more volunteers in order to fulfil these needs. Agewell have opened a shop on the Sandwell Hospital site, with all proceeds going back into all the hard work they do.

GP partnerships

In 2015/16 we have had discussions with many of our practices about working together closely to provide more seamless care. This has included more consultants running clinics in primary care settings, our new advice and guidance service and the amount of information in patient letters. This year we will continue to work with GP practices across our area strengthening our commitment to deliver integrated care through more formal partnership arrangements with primary care provider organisations.

Local authority partnerships

Through the ADaPT project, we have strengthened our working relationships with local authority partners. This has led to greater collaboration between health and social care professionals, resulting in a reduction in the number of patients delayed in our acute hospitals – Sandwell being one of the most improved areas across the country. In June 2015, Birmingham City Council staff played a key role in helping us understand our patients' journey through City Hospital as part of our second Urgent Care Challenge Week. We have also seen the benefits to patient care gained through a joint venture with Sandwell Metropolitan Borough Council opening McCarthy Ward at Rowley Regis Hospital to alleviate the pressures over winter.

Right Care Right Here

A multi-agency collaboration to reshape how local services are delivered, Right Care Right Here has been in place for over ten years. During the year it has been renewed with a new independent chair and a clear vision for partners to work together for a better future for the people of Sandwell and West Birmingham. The Trust remains a key part of this partnership which works with the 110 GP practices, patient representatives, voluntary organisations and health and social care teams to provide high quality care, closer to home with first class specialist facilities.

Carter's Green Medical Practice in West Bromwich. We work closely with GPs across Sandwell and West Birmingham.

Terry Cordrey, ADaPT Project Lead, ADaPT aims to reduce delayed transfers of care.

Our commissioners

We work in partnership with our commissioners, mainly Sandwell and West Birmingham Clinical Commissioning Group and Birmingham Cross City Clinical Commissioning Group, who commission the majority of our services for patients within the areas that we serve. As well as delivering on our contractual and quality requirements, this year we have collaborated over patient and public engagement activity on changes to emergency surgical assessment and interventional and inpatient cardiac care, and supported public listening exercises on urgent care and patient transport. Through their engagement activity, the CCGs listened to hundreds of patients' views that have contributed to how service changes are implemented.

How our groups performed

Our organisation is structured into seven clinical and one corporate group. Our clinical groups deliver care in a range of different ways to our patients and are a way for us to group services and directorates together. Our corporate group includes the services that are needed to support clinical care.

Community & Therapies Group

Budget: £48million
Headcount: 935 staff

The Community & Therapies Clinical Group continues to thrive and develop. The group of therapy and nursing teams deliver over 30 different clinical services across inpatients, outpatient clinics, in patients' homes and a diverse range of community locations. The Clinical Group Director and the Group's HR Business Partner work in close partnership to maintain a focus on sickness absence introducing a standardised approach across all teams by way of a 'sick phone', regular confirm and challenge meetings and line managers held to account for maintaining accurate records.

Key Achievements

- SWBH Staff Awards – Nine finalists in the 2015 shortlist and three winners (Jo Peasley – Employee of the Year, Terry Cordrey – Leader of the Year and Leasowes – Local Primary Care award). Therapists were also significant members in the FrailSafe Team winners of the Best Innovation award.
- Our Palliative Care teams were awarded the End of Life Care contract for at least the next five years for patients in the last year of their life. The specialist teams have developed a single point of access hub, a 24/7 telephone service for patients, relatives and professionals offering advice, clinical triage and signposting. This is in partnership with John Taylor Hospice, St Mary's Hospice, Age Concern and Crossroads.
- Development of an enhanced, equitable musculoskeletal service (MSK) to Occupational Health working with managers to reduce long term sickness due to MSK conditions and support return to work with proactive case management.
- Future Hospital Development Site – the Trust has been selected to be one of four sites nationally by the Royal College of Physicians. Community and acute physiotherapists within Community & Therapies are fully involved in the integrated working for those patients with long term respiratory conditions. The programme launched in March 2016 and aims to work with GPs, reduce admissions, deliver and education and training across seven days.
- We now have four Independent Prescribers – three in Physiotherapy and one in Foot Health.
- We have continued positive relationships with Universities – Birmingham, Keele and Coventry, both in undergraduate education and PhD and research posts.

Helen Cartwright changes Alma Bennett's dressing in her home.

Listening and learning

Used for centuries to control pain, acupuncture is a fairly new treatment provided by our community physiotherapists to provide pain relief for patients in conjunction with other treatment. It is for some very effective. However, when a patient went home following their acupuncture session they discovered one needle had been left in situ. The patient was not in danger, however we have taken action to ensure this will not happen again by introducing a 'count in, count out policy,' so all needles will be taken out before the patient leaves the treatment room.

Future plans

- Foot Health is to be a pilot site for prevention of foot ulcer recurrence in diabetic patients using plantar pressure feedback.
- We will build relationships with the Black Country Alliance partners particularly in relation to therapies and stroke services.
- We will enhance of the OPAT service (Outpatient Parenteral Microbial Treatment – IV Therapy) to reduce acute length of stay.
- We have a new ward to open in Sheldon block in Nov/Dec 2016 to accommodate social care patients.

Our plan is to provide a comprehensive, seamless range of nursing, therapy and medical services to meet the needs of our local population to help them live well. We will continue improving our three main services: ICares, Ibeds and Ambulatory Care. ICares will ensure that patients will receive support to stay out of hospital and receive appropriate rehabilitation, whether that is in their own or care homes. Ibeds will focus on inpatients at the hospital, ensuring that multidisciplinary teams work together to deliver person-centred care so patients recover quickly and enjoy a good quality of life. Ambulatory Care will provide specialist interventions in an outpatient setting, making sure that chronic conditions are monitored carefully. These three main services will ensure that patients receive the best and most appropriate care whether they are staying at the hospital or at home. Our plans include using advanced technology to further support self-care at home and ensure that all referrals come through a single point of access meaning patients only need to use one number to access the services that they require.

Imaging Group

Budget: £17.1million
Headcount: 297 staff

We provide a wide range of Imaging services to inpatients and outpatients, as well as providing a direct access service for GPs. The plan for the group is to continue providing a wide range of services including X-ray, Interventional Radiology, CT & MRI scans, Dexa, Ultrasound, Nuclear Medicine and Breast Screening. The quality of the services will be improved through offering more services at weekends and in the evenings. We aim to have more equipment so waiting times can be shorter. Consequently, our patients will have more choices of where and when they want to have their scans. We want to make sure that our future plans will place the patient experience in the centre of what we do and by improving the quality of the services through intensive training and investment in equipment, we will able to support our colleagues in providing the best treatment to our patients.

During the year we completed:

- 32950 CT scans
- 24194 MRI Scans
- 188261 Plain Film X-rays
- 7086 Breast Screening Mamograms
- 50931 Ultrasound Scans
- 38850 Obstetric Ultrasound Scans

Key Achievements

- Scoping of the Black Country Alliance partnership programme to deliver Interventional Radiology out of hours: The BCA have launched a pilot to offer a seven-day Interventional Radiology nephrostomy service. Sandwell and West Birmingham Hospitals NHS Trust, Walsall Healthcare NHS Trust and Royal Wolverhampton Hospital Trust are joined together to offer weekend nephrostomies, which relieve kidney blockages, to patients who are unable to wait 36 hours for treatment.
- Reduction in waiting times for diagnostic scans from over 42 days to 35 days. Waiting times have been reduced across the Imaging group to help identify patients' health issues faster.
- A CQC (Care Quality Commission) review regarding our improved documentation of IRMER competency records as well as our new systems to ensure our records remain up to date (for both permanent and temporary staff), had inspectors calling parts of Imaging 'exemplary'.
- Our medical illustration department had a top-of-the-range printer installed to bring essential printing of forms and leaflets in-house and create a new revenue stream by offering print capability to other trusts and external companies.
- We have continued positive relationships with Universities and recruit newly qualified radiographers. Student sonographer Leah Marsden said: "The Trust and Ultrasound Department is really supportive of its trainees, it's one of the things which makes this such a great place to train."
- Radiopharmacy trainee clinical scientist Shazmeen Hansrod was awarded the student prize for her Abstract and was able to present her work at the British Nuclear Medicine Society Conference. At this conference, a record breaking number of works from SWBH were accepted.
- Dr Claire Keaney was a finalist for SWBH employee of the year for her work with Paediatrics. Dr Keaney is the only radiologist with a paediatric interest and therefore her skills are always in demand. Despite how busy she is, consultant colleagues say she is approachable and keen to discuss cases. She holds monthly radiology meetings, which are highly valued, for paediatrics and neonates to discuss interesting cases and teaches both the paediatric and radiology juniors during these sessions.

Listening and learning

Ultrasound scans are an invaluable examination enabling us to look beneath skin to see what's happening inside. However when one of our patients felt their dignity was compromised on being asked to undress and change into a gown before their scan, we changed our procedure to enable all patients to remain in their own clothing where possible. The reason for changing into a gown had been to ensure the ultrasound gel did not get onto patients clothes, but by explaining to the patient what the examination involved before the appointment, patients are now able to dress accordingly and feel more comfortable in their own clothes.

Philip Bonehill, Imaging Support Worker, by the old CT scanner at City Hospital. We agreed a new Managed Equipment Service (MES) so that our patients benefit from the most up to date diagnostic care.

Future plans

- We will deliver a guaranteed maximum wait of six weeks from referral to reporting for all forms of imaging.
- We will launch ISAS accreditation process for the department - ISAS (Imaging Services Accreditation Scheme) is a patient-focused assessment and accreditation programme, created with the intention of guaranteeing patients get high-quality treatment from trained members of staff when they undergo diagnostic imaging services.
- We will continue building relationships with BCA – Our exciting and ever-expanding work with The Dudley Group of Hospitals NHS Foundation Trust and Walsall Healthcare NHS Trust continues to help us pave the way to a future that sees new opportunities and high quality patient care brought to the forefront.
- We will have new equipment through our Managed Equipment Services (MES) programme – A ten-year long MES contract agreed with Siemens will entitle us to the latest technology and equipment, allowing us to keep up to speed and provide the best care for our patients.
- Obstetric Ultrasound will offer in-depth cardiac screening for expectant women can chat more readily seek out foetal anomalies.
- Breast Screening team will provide tomosynthesis scanning - a new breast screening process that allows us to seek cancers more accurately.

Pathology Group

Budget: £19.4million
Headcount: 328 staff

Pathology at SWBH covers a whole range of services that allow us to study diseases, working on diagnosing, treating, and monitoring conditions from the bedside or in labs. We have facilities across our sites that allow speedy results, as well as an anticoagulation service that runs locally and site-wide. Our 2020 vision sees several changes that will be incredibly beneficial to the service, providing a faster and a more localised service for patients across the Trust and with a single main base we can introduce the analysis of samples seven days a week (Our main lab will move site in 2018.) We will also offer a booked Phlebotomy services, as well as a walk-in clinic. Alongside this, as we move towards a paper-free NHS, we will start offering electronic tests, and results can now be texted securely rather than posted. As a national specialist centre, we endeavour to continue our research into multiple conditions, and we will always work diligently to improve patient care however we can.

The last year has seen a number of new initiatives in our Pathology Department with the aim of ensuring that clinical science improves patient care and experience.

Key achievements

- This year we have improved the transport of pathology samples from GP practices into our centralised laboratories to ensure that samples arrive in a timely manner reducing the risk of samples changing as they age. We have increased phlebotomy time and introduced the use of centrifuges to stabilise samples in certain community sites as well as changing the transport runs. Work continues with an emphasis on training staff in how to store samples and for much greater auditing of how samples are transported and processed.
- Our Microbiology department has continued to focus on early identification and and treatment of sepsis. We have been involved with the UK sepsis trust in the national campaign and locally have been working with resuscitation and emergency departments to both recognise and then treat at the earliest possible stage this life threatening condition, ensuring that blood cultures are taken from patients in a timely manner.
- In a bid to reach out to the many communities we serve, we involved staff in a project to record hand hygiene messages in many different languages. Working towards improving hand hygiene across the Trust, for staff, patients and visitors, the Infection Prevention and Control team wanted to get the message out to communities where English is not their first language. The videos were recorded by staff speaking in their native languages of Punjabi, Bengali, Slovak, Urdu, Jamaican Patois, Vietnamese and Twi among others. With approximately 80% of known germs able to be transmitted by touch, effective hand hygiene remains the single most effective way of reducing the risk of transmission to our patients and others.

Listening and learning

Blood tests are usually very quickly done, and as they don't take long it is great for patients to be able to pop in to somewhere local to them. So when one of our patients complained that they had to go to City hospital to have their blood sample taken, we acted to install a new phlebotomy area in Sandwell Hospital. We haven't forgotten Rowley Regis Hospital either, as the phlebotomy department there has recently been substantially renovated, widening the choice of locations for patients who need to have a simple blood test taken.

Biomedical Scientist Nisha Gomez in the lab at Sandwell Hospital.

Future plans

The national drive for pathology is to take forward innovative science. We are known for this in our own pathology organisation where we have put an emphasis on developing new tests and services that are of direct benefits to patients. From improvements in IT systems with direct electronic ordering of tests, right through to Blood spot technology offered to our mental health trust and even direct to the public for Vitamin D, through to initiatives looking at introducing DNA technology into our laboratories….All have their place in our service.

There is considerable work to do in conjunction with our Capital Projects team in planning the move of microbiology, histopathology and specialist biochemistry laboratories from the City site to Sandwell. Plans are now advancing to use the lower ground floor at Sandwell for these laboratories. During 2016/17 we will see detailed plans drawn up and enabling works proceeding. Then, in 2017/18 a substantial building programme will take place in a phased way to see our laboratories moving over to the Sandwell site. This will bring our Pathology department together for the first time and will give many advantages in efficiency and effectiveness that are difficult to achieve when our laboratories are split four miles apart. We continue to develop our education and training programmes and in the year ahead will publish a number of short online film clips which will look at specific topic areas of interest to both our staff and to those who are in laboratories around the country.

Surgery A Group

Budget: £61.7million
Headcount: 1,039 staff

The 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 there are critical care wards at both main acute sites. We treat patients who present to our A&E departments with acute surgical or orthopaedic emergencies, besides performing a large number of elective operations. Over the last year we've seen 43,892 new attendances and 45,391 reviews.

Key achievements

- In August 2015 our Critical Care Outreach Service was expanded to cover 24 hours, seven days a week across City and Sandwell hospitals. This investment has meant faster decisions about the care of patients whose condition deteriorates during the night. The expanded provision has reduced hospital mortality rates, as well as improved patient flow and reduced the length of stay on Critical Care. The service is called when a patient's condition on the ward deteriorates, and its specialist nurses put a management plan in place to nurse the patient on the ward or if appropriate move them in a timely way to a critical care area.

Senior Staff Nurse in the new surgical assessment unit at Sandwell, Janice Jackson.

- In November 2015 we saw the culmination of months of planning and development with the much awaited launch of the Trust's brand new Surgical Assessment Unit (SAU) at Sandwell Hospital. The new Surgical Assessment Unit (SAU), which is based on Newton 2, boasts increased capacity ensuring patients are able to be assessed for emergency and urgent surgical procedures by a round the clock team of on-site specialists. With these new facilities in place, the Trust also decided to implement a reconfiguration in the management of patients with surgical care needs, closing down the SAU at City and introducing patient pathways that bring patients either to the new SAU at Sandwell or Emergency Gynae Unit on D17 at City depending on their condition.

Listening and learning

Sometimes we get it wrong because we don't communicate effectively within wider teams, which is especially important when procedures change. This was clearly seen when one of our patients underwent treatment in urology of botox injections, and was advised before their operation that they would be able to use a catheter at home to empty their bladder. However, after the operation, the staff did not show the patient how to use a catheter, which meant the patient returned to hospital to have their bladder emptied. At the time of this patient's procedure it was not standard practice to teach patients how to self-catheterise. But, as a result of the complainant's concerns, our standard practice has changed to ensure that all patients undergoing this procedure will be instructed in self-catheterisation. Now patients will not be at risk of having a readmission and will be able to manage their post-operative recovery more effectively themselves. This demonstrates how we learn from complaints, and ensure our service is improved for everyone.

Future plans

- We are currently developing minimally invasive approaches in vascular surgery using radiofrequency ablation, and this will be the standard over the coming year.
- Simple hand surgery will be provided in an outpatient setting rather than in a theatre, making it more accessible to a wider patient group.
- We're planning to roll out patient initiated follow ups to other specialities, since they were successfully trialled in breast surgery
- We're going to focus on 'one stop shop' outpatient appointments meaning that occasions where pre-operative screening is required will be reduced.

Surgery B Group

Budget: £28.3million
Headcount: 395 staff

The Birmingham and Midland Eye Centre (BMEC) is the largest facility of its kind in Europe offering rapid eye services (both emergency and non-emergency), and hires specialists from many different fields of Ophthalmology. General Ophthalmology services are also accessible at three of our sites. Our Audiology team offer a range of services, from general checks to specialist hearing aid fittings at both our Sandwell and City sites. Our ENT team work across the Trust to deliver essential emergency and routine treatments. Our Oral Surgery can be found at City Hospital, where it works in partnership with other dental services to provide general oral surgery as well as cancer services.

Key achievements

- In BMEC theatres we are now in our second year of supporting apprentices through the year long Clinical Health Care level 2 programme. Our two students in 2015/16 have felt part of the team and believe their confidence has increased with dealing with other people. Due to complete in August 2016 – one apprentice wants to carry on with Operating Department Practice
- Safety is paramount within Surgery B and BMEC Theatres were delighted be recognised at the annual SWBH Awards, winning the Patient Safety Award. The culture within theatres has developed so that all staff consistently follow correct processes for ensuring the right patient is operated on each and every time. All staff feel empowered to raise concerns and call a 'hard stop' in the knowledge that they will always be supported.
- As part of a review of our service provision, it was identified that the Intravitreal Injection Service (where anti VGF treatments are injected into the back of the eye to help reverse the progress of macular degeneration) could move from a doctor-led to a nurse led service. With support from Ziad Abdel Karim (Advanced Nurse Specialist) and Ms Bushra Mushtaq (CD for Ophthalmology) five staff have been assessed as competent and are administering up to 650 injections a month. New models of working, with nurses and allied health professionals utilising their skills, is seen as being integral to the success of our services.
- The Trust has developed a new online web-based tool, designed to enable patients to be managed in a community setting with quicker implementation of altered clinical management plans. Previously, optometrists and dentists were unable to use the NHS e-Referral Service as GPs did, in order to receive timely responses from speciality consultants about clinical

Bushra Mushtaq was appointed Clinical Director for Opthalmology.

queries regarding their patients. Timely guidance (received within one working day) means safer care for patients and reduces demand on specialist clinic appointments.

- A pioneering treatment for a blinding eye disease developed at BMEC has been awarded a £560,000 research grant. A project to develop software to monitor patients with blinding inflammatory eye disease uveitis has been given a Health Improvement Challenge Grant by the Wellcome Trust.
- The Trust has become the first in the UK to use 3D technology in eye surgery, by trialling a £60,000 system. Traditionally, eye surgeons use a surgical microscope to perform eye surgery, which requires the surgeon to hold the same posture for many hours, depending on the complexity of the surgery. With this new 3D technology, surgeons can look at the large monitor and see the different layers of the eye in higher definition. By using this technique, surgeons can perform intricate surgery much more precisely, thus improving the outcomes for patients.

Listening and learning

It was a great use of modern technology for us to introduce a new electronic booking-in system, giving our patients the opportunity to check in quickly without having to queue for a receptionist. However when a patient complained that they felt their privacy was being compromised by the person behind them seeing their details, we acted to create a physical space between the person using the check in machine and the next person waiting. This has now been in place for some time and is a much improved process, ensuring no check in details can be seen by other patients.

Future plans

Some of our ENT services will operate in partnership with other centres to maintain specialist services locally, We are working to ensure waits are shorter and many more visits will be on a one-stop basis. By transforming our links to primary care practitioners we will be able to offer truly seamless integrated care.

As we approach 2020 we intend to remain the lead for specialist eye care with some substantial changes to the service. The move towards our new hospital means that some services will relocate, but we will begin to partner with other centres in order to provide ENT care locally for those who cannot access the hospital. we are striving to do a lot more in the way of research, education and training, and developing new innovative techniques across the field.

Medicine and Emergency Care Group

Budget: £107.5million
Headcount: 1,575 staff

The medicine and emergency care group includes over 300 medical staff, over 1000 nursing staff, a range of administration and allied health professionals working across the three directorates - emergency care, admitted care and scheduled care). We have recruited over 300 people during the past year The directorate of emergency care covers emergency medicine, acute medicine, the mental health service, RAID and toxicology. The directorate of admitted care covers elderly care, stroke, neurology, neurophysiology, cardiology and all ward clinical teams. The directorate of scheduled care covers gastroenterology, respiratory, dermatology, diabetes and renal, rheumatology and immunology and haematology/oncology.

Key achievements

- The performance of our stroke services is currently within the top 8% in the country meaning patients can access the best treatment quickly with excellent rehabilitation and recovery outcomes.

Fatima Said, Senior radiographer in the cardiac catheter lab at City.

- In August 2015 Sandwell & West Birmingham Hospitals NHS Trust centralised its cardiology in-patient and interventional services at Sandwell and City Hospitals into one bespoke location at City Hospital with two new cath labs. This change followed extensive engagement with patients and the public and has significantly increased patient safety by ensuring that our expert teams are on one site to provide the best care to patients.
- Respiratory services have been chosen by the Royal College of Physicians (RCP) to be one of only four services in the country to take part in the national Future Hospital programme. The RCP will support the team by giving them the access to quality improvement expertise, helping to implement new ways of working and providing support to evaluate the impact of the projects. The project is expected to deliver an integrated care and 'whole system' approach to respiratory care at Sandwell and West Birmingham.
- Supportively with GP partners on improved patient management in the Primary Care setting: The CATS (Consultant Assisted Triage Service) is a project that addresses the challenging and increasing demand for specialist opinions. CATS is a comprehensive approach to triage, with increased time spent reviewing the referral, searching previous history and test results before making a clinical decision as to whether this patient can be managed in the community with additional support/modifications to the care plan, or whether they may need immediate diagnostic testing. This approach has now been badged 'Enhanced Triage' by consultants – it takes longer, but offers whole system solutions to referral management which includes both GP/Patient in the decision making.
- Following the establishment of CATS, we saw a reduction in waiting times for a first specialist out-patient appointment. In a 6 month period we have reduced Gastroenterology waits from over 3 months to the current situation whereby patients can consistently book their own appointment within 7 weeks. This enables the urgent patients in real need of specialist care to be seen.
- We have introduced seven day nursing services within our respiratory, acute oncology and SCAT Sickle Cell and Malossaemia service.
- We have changed the way we work in emergency care with successful implementation of an escalation tool and a clear protocol of roles and responsibilities, improved working relationships and better rota management.

Listening and learning

When one of our paraplegic patients did not get the regular bowel support they needed during their stay on one of our wards, we investigated why not. We found that there was no procedure for our FINCH team (specialist faecal/bowel management team) to provide their specialist care on nonsurgical wards, as they predominantly treat surgical patients. Hence our patient did not receive the bowel care support needed during an inpatient stay. The complaint centred around the lack of provision for this type of bowel care, and the lack of training that was apparent on the ward. During the investigation the General Manager established a new pathway for this service on nonsurgical wards, ensuring all patients in need of this service will receive it regardless of which ward they are being cared for in.

Future plans

The Fixing our Future project is reviewing our care model to help us meet the future demands of our patients. The general objective of this project is to make sure that we can provide outpatients clinics that will be as close as possible to where patients are or where they want to be seen. This will play a vital role in helping us deliver the Trust's visionto have the right care in the right place at the right time. We have also set up a centralised medical infusion unit which is delivering constant and appropriate care for patients requiring intravenous and subcutaneous treatment by nursing staff of appropriate skill set.

The medical infusion suite (MIS) is based in a central location on the main spine of City hospital previously known as the surgical assessment unit. It is proposed that a single infusion unit will operate at Midland Metropolitan Hospital which will open in October 2018. Establishing the medical infusion units (MIS) at City hospital will facilitate a simple change of location in 2018.

In the year ahead we are focusing on training, clinical research and staff support to improve the performance of our acute teams. At the same time, we will work more closely with our local GPs by continuing to offer Advice and Guidance to Primary Care clinicians thus reducing unnecessary hospital visits for patients. Also, we aim to develop plans that can offer more services 7 day a week and improve the waiting times for patients to see our speciality teams. The Group remains committed to maintaining an outstanding reputation for teaching and education and embedding innovation and research. With the Midland Metropolitan Hospital opening in 2018, we are working to ensure that transition plans are in place, so when the new hospital opens, staff will be ready to move seamlessly and continue to provide excellent acute services to our patients. We aim to transfer patients to rehab facilities as soon as the acute phase of their admission is complete – this will release beds in Midland Met for further acute admissions and allow patients to be managed by dedicated therapists in the community, often nearer their own home.

Women's and Child Health Group

Budget: £48million
Headcount: 935 staff

The Women's and Child Health Clinical Group encompasses gynaecology services (including our widely acclaimed gynaecology oncology services), sexual health, genito urinary medicine, maternity and neonatal services, health visiting, family nurse partnership services and acute and community paediatric services.

Key achievements

- During the year we successfully achieved Stage 3 UNICEF Baby-friendly initiative status demonstrating our commitment to supporting and increasing breastfeeding
- Following an inspection in June 2015 we were rated by the Care Quality Commission (CQC) as being 'outstanding' for our community and young people's services.
- Our maternity services were finalists in the national British Journal of Midwifery Awards for Innovation in practice
- We reconfigured our directorates so that health visiting and maternity are more closely aligned. This has enabled our teams to work better together providing seamless care for women and families.
- We have continued our partnership collaborations with one of our senior consultants being employed part time by Aston University to establish the undergraduate curriculum for their new medical school.
- Professor David Luesley, our professor of gynaecological oncology, received the lifetime achievement award in the SWBH 2015 Awards scheme and our therapies team were awarded Clinical Team of the Year.
- Women's maternity records are now available to women electronically following the launch of our electronic patient portal.
- Our paediatric services won an award for outstanding Diabetic Services, led by Dr Chizo Agwu.
- During the year we successfully relocated our Emergency Gynaecology Assessment Unit to a bespoke unit which is co-located with our female surgical unit.
- We increased the services we provide to local primary schools in the area so the young children who need support can access our specialist teams.

Listening and learning

When one of our youngest patients was admitted only days after birth in another hospital, we treated their feeding problem, which was the reason they were admitted. However after successful treatment via a nasal gastric tube they were discharged and subsequently diagnosed with a cleft palette. Since the baby had recently been born at a different hospital we did not repeat the routine checks made at birth. We have now changed our policy to ensure any baby admitted within seven days of birth will undergo a repeat of the new born screening and tests. The policy will provide a safety net for any issues that are not apparent, or are missed at birth and provide reassurance to parents when their new born babies are readmitted to hospital at such a young age.

Future plans

In the coming year, our genito urinary medicine (GUM) and contraception and sexual health (CASH) services will be combined, with one service meeting all the needs of our users across a range of venues and, although we already provide a 7 days a week service, our patients will be able to access more services through the use of technology and alternative forms of contact such as Skype.

We are pleased that our maternity service has been chosen as an early adopter site for the roll out of a series of quality initiatives supported by the Department of Health. This will allow us to further improve the quality of our service

provision. Investigations such as scans will be more widely available in community venues as we look to be a beacon of excellence in maternity care which continues to receive positive feedback from women. We will do all of this while continuing to work with the community who use our services to achieve outcomes that are important to them as well as promoting healthy outcomes to all.

Our next year's goal is to work on appointing an Academic Professor of Obstetrics in partnership with Aston University, and improve joint working between our Midwifery and Health Visiting teams.

Our paediatric team plan to expand the development of our multidisciplinary allergy services, and we are working closely with the local authority to improve co-operative working arrangements with our health visiting teams.

Zoe Challenor with her new baby Seren, born at Serenity midwife-led unit.

Corporate Group

Budget: £82.3million
Headcount: 1,702 staff

The corporate function covers our workforce, estates, strategy, governance and communications, operations, nursing and facilities, finance and the medical director's office.

Key achievements

- Over the last year we have substantially reorganised our catering service within facilities to provide a better service for patients and staff. One initiative is the introduction of a range of dementia friendly crockery in contrasting colours and deeper more user-friendly bowls to help avoid spillage. We've also introduced out of hours hot food vending machines at Sandwell and City Hospitals, which provide healthier options of favourite dishes such as beef stew, Chinese chicken and spaghetti bolognese, for anyone who would like a tasty hot meal overnight. We've also opened another Costa Coffee outlet on City Hospital site, to reduce queues at peak mealtimes.
- As the financial year drew to a close in March this year, around 500 support staff opened the next chapter in their working lives with a move to new office accommodation in 'Trinity House', formerly the maternity building at Sandwell Hospital. Teams in information, finance, HR, communications and IT are among some that have made the move – many from offices on the City Hospital site, and others from buildings located across the Sandwell Hospital site. The move is part of the long term plan to base our support function on our Sandwell site, in time for the opening of the new Midland Met hospital on Grove Lane in Smethwick. Staff have already found benefit in the move, with many welcoming the opportunity to be in a central location, in close proximity to other support teams they work alongside.
- We have invested significantly in information technology with a major infrastructure upgrade to improve the resilience, capacity and capability of our systems. We began our procurement process for a new Electronic Patient Record and will confirm our agreed supplier within the year ahead.
- A team of researchers from the Trust and the University of Birmingham are among those in receipt of a prestigious award of almost £2 million from Arthritis Research UK to investigate the role of the microbiome in arthritis. It has long been suggested that the bacteria

which live in our gut, mouth, and elsewhere on our bodies may affect the immune system and lead to the development of certain diseases, including rheumatoid arthritis, however exactly how changes to the microbiome lead to disease remains to be established. This award brings together an international multi-disciplinary team of researchers with partners from Birmingham, Oxford and UCL, as well as collaborators in the US at Harvard University, New York University and Mount Sinai Hospital, New York. The contribution of our Trust will be to recruit patients via our dedicated early inflammatory arthritis clinic, which has been running since 2000. This is one of several large grants awarded to staff at the Trust over the last 12 months and represents an important contribution towards the delivery of our research and development plan.

- The Trust has an open culture and actively encourages its staff and patients to raise concerns so that we can quickly resolve them, acting in the best interests of patients. Our Whistleblowing Policy ia designed to enable all staff to 'blow the whistle' safely so that issues of concern are raised early and in the right way. Staff can use our dedicated telephone line to raise concerns and can raise any concern early rather than wait for proof. Employees who raise a concern through the whistleblowing process are protected against victimisation by legislation. The Trust also undertakes to not take reprisal against people who raise genuine concerns, and also guarantees, where possible, anonymity. We have promoted the importance of, and the routes for raising concerns to staff and patients throughout the year.

Future plans

Our Corporate teams support the entire Trust in order to help clinical services deliver the best care for patients. As we work towards becoming a paper-free Trust, our invest ment in computer programmes that are easy to work with, accessible, and that meet the needs of the teams, become increasingly important.

Our Finance team has worked to develop a plan that sees us achieve a surplus so we can reinvest in our services, and they intend to work hard to make sure that surplus is achieved. As we move towards Midland Met, some of our estates team will leave us to join the building provider, so we know we have an excellent team of staff maintaining it. Within R&D we will take on more clinical trials and significantly increase our research scale. Perhaps most important of all, however, is our desire for corporate support around patient safety, risk management, quality improvement and change management to be outstanding. In doing so, we can demonstrate the best possible quality work, and in turn help our organisation flourish.

We are currently working as an Alliance inside the Black Country Alliance (BCA) to reform how corporate services operate. We expect to create efficient transactional services that benchmark well against peers within the BCA. The move of our corporate teams to a new central location at Sandwell Hospital is providing a more integrated service to our clinical groups.

Associate Director of Finance, Tim Reardon talking through future plans to run a more efficient finance function.

Quality and Performance Analysis

Incorporating our Quality Account 2015/16

This section details our performance and includes our Quality Account which is our annual report to the public about the quality of our services. In this section you can find:

- How we performed in 2015/16 in the eyes of our patients.
- How we performed for 2015/16 against our standards.
- How well we performed against external measures.
- How well we performed when compared to other Trusts.
- Our priorities for 2016/17.

Jasbir Hayer, on Priory 3 ward at Sandwell Hospital.

William Ricketts, Community Respiratory patient.

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.

Signature

Richard Samuda

Chairman

Signature

Toby Lewis

Chief Executive

How we measure quality

We review our performance against external frameworks (primarily the NHS TDA Accountability framework 2014/15, CQC and Monitor's published Quality Governance Framework) as well as internal targets on a broad range of indicators published in our Integrated Quality & Performance Report (IPR). The IPR is published monthly to a number of senior committees as well as the Trust Board. Performance is managed through our Groups through our group performance review programme.

Data quality improvements

We have implemented a performance indicator assessment process, the data quality kitemark which provides assurance on underlying data quality. Each indicator is assessed against seven data quality domains to provide an overall data quality assurance rating which is included in the IPR. Data Quality remained an on-going area for development during 2015/16. We have a data quality improvement plan in place to ensure that the quality of our performance information continues to improve. During the year we have improved data quality as reported in the IPR. Our audit plan is a rolling programme covering all performance and quality indicators. We are establishing a Data Quality Group whose scope will be to identify and implement data quality improvements and address data quality issues.

The Trust's SUS (Secondary Users System) data quality is benchmarked monthly against others via the HSCIC SUS Data Quality Dashboards which are used to monitor compliance with mandatory fields and commissioning sets.

During 2015/16 we provided data to secondary users for inclusion in Hospital Episode Statistics (HES) as follows:

	Percentage with valid NHS number	Percentage with valid GP practice
Inpatients	98.8%	100%
Outpatients	99.7%	100%
Emergency patients	96.7%	99.2%

Peer Group

The peer group we have used for benchmarking 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.

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

Sandwell and West Birmingham Hospitals NHS Trust is registered with the Care Quality Commission and has no conditions attached to that registration.

Services provided / subcontracted

During 2015/16 we provided and/or subcontracted 44 NHS services. We have reviewed all the data available on the quality of the care in these services. Where we have subcontracted any activity, it would only be to a provider, who like us was registered with the CQC but has no conditions attached to that registration. 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 2015/16 represents 100% of the total income generated from the provision of NHS services by Trust.

How we performed in 2015/16: In the eyes of our patients

During the year we have actively encouraged concerns, complaints and feedback from patients and carers that has enabled us to make improvements in the care we provide.

Family and Friends Test

The Family and Friends Test (FFT) - would recommend scores give us important feedback from people who use our services. During 2015/16, the Trust expanded the FFT survey to other parts of the organisation including Outpatients, Day Surgery areas and Children's services. We use a blended methods approach comprising of electronic tablet PCs, mobile phone SMS and paper/card surveys to seek feedback from patients. This survey has helped us to identify both good and some not so good areas of our services. The Clinical Groups and Directorates use 'near real time' FFT data to make improvements in their areas. Making FFT inclusive for all and increasing response rates continues to be a challenge for the organisation.

Some of the improvements that we made during the last year include the introduction of 'open visiting' to ward areas, a breakfast club for stroke rehab patients, launch of a 'snacks n papers' trolley service for ward-bound patients, a 'What makes you sad and What makes you glad' feedback board in the neonatal unit, introduction of volunteer breastfeeding helpers in the maternity unit and rolling out an innovative series of training workshops called 'Towards Service Excellence' for all patient facing staff members.

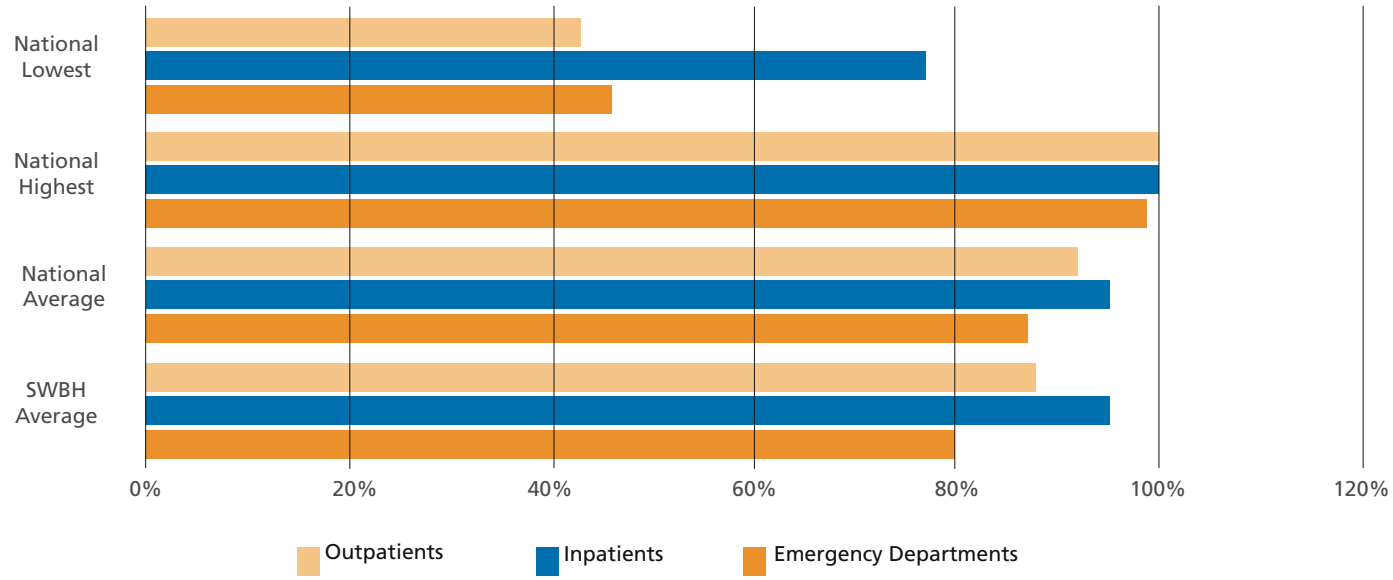
Family and Friends Test (FFT) - would recommend scores

SWBH Inpatient score	National Average	National lowest	National Highest
95%	95%	77%	100%

SWBH ED score	National Average	National lowest	National Highest
80%	87%	46%	99%

ED: Emergency Departments

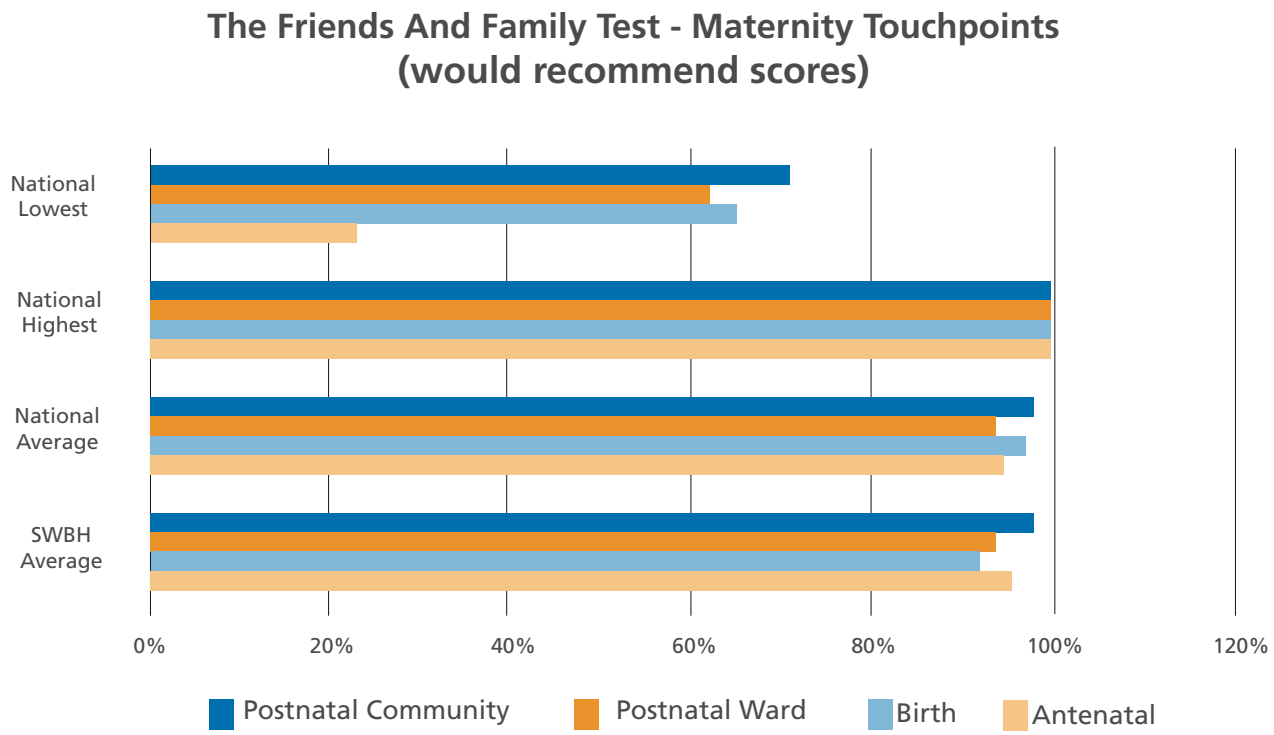
The Friends And Family Test (would recommend scores)



Members of Agewell, Pauline Withey and Deb Harrold launch a new trolley service at Sandwell Hospital.

The new 'what makes you sad, what makes you glad?' feedback board in our neonatal unit.

THE FRIENDS AND FAMILY TEST: MATERNITY (Would Recommend Scores)				
Areas	SWBH Average	National Average	National Highest	National Highest
Antenatal	96%	95%	100%	23%
Birth	92%	97%	100%	65%
Postnatal Ward	94%	94%	100%	62%
Postnatal Community	98%	98%	100%	71%



National Patient Surveys

The national survey programme is used to measure patient experience and perceptions across the NHS and this Trust.

We are continually striving to ensure that the quality of care provided meets expectation and we respond to the needs of service users, including the listening to patients, the need for privacy, information and involving patients in decisions about their care.

Eileen Keeble performs a 24 week scan on Habiba Sultana at Rookery Children's Centre.

Women's Experience of Maternity Services - 2015 Section Headings	SWBH 2013	SWBH 2015	Lowest Trust score achieved (National)	Highest Trust score achieved (National)
Start of care in pregnancy	*	4.9	3.6	7.3
Antenatal check-ups	*	7.0	6.0	7.9
During pregnancy	*	8.6	7.8	9.3
Labour and Birth	8.6	8.8	7.3	9.4
Staff	8.1	8.1	7.4	9.4
Care in hospital after birth	7.6	7.1	6.7	8.9
Feeding	*	8.4	7.1	8.5
Care at home after the birth	*	8.1	7.4	8.9

Scores out of ten, higher is better.
* Comparative data not available

Midwife Dominika Korsten with 28-weeks pregnant Emma Ingram.

Noel and Ryan Bradbury in the Maternity Special Care Ward at City Hospital

Patient Stories to the Trust Board

During 2015/16, patient stories have continued to form a key part of every SWBH NHS Trust Board meeting. The introduction of video patient stories has widened the reach of these stories so more teams and services are now able to learn from the themes that are raised and apply them to improvements in their own areas.

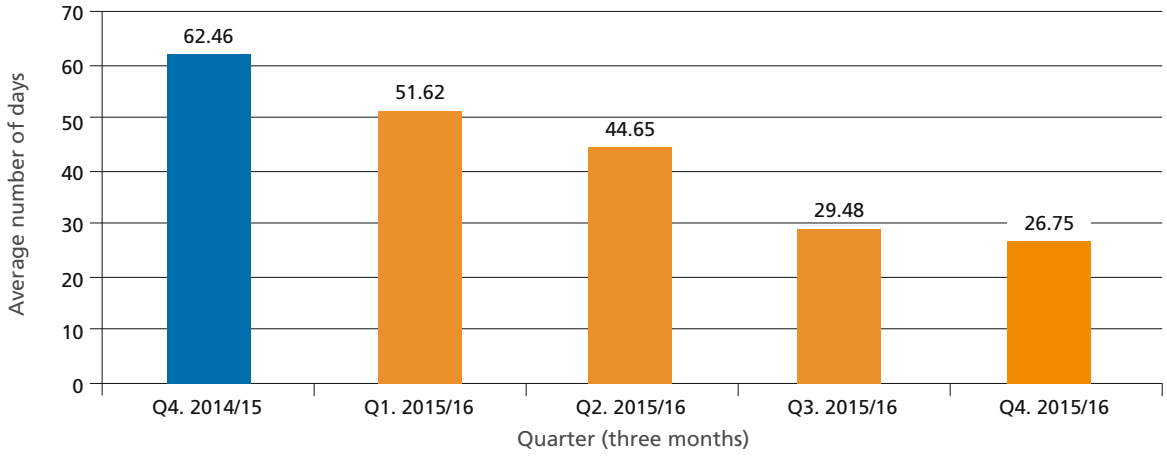
Complaints

The time taken to respond to complaints has improved dramatically as we have worked with patients to understand the outcomes that are important to them. This year we have changed the way that complaints are handled making sure that patients and families are able to have their complaints heard and resolved by people who are close to the situation. In many instances we have offered meetings as a first route to resolving a complaint and many patients and families have been pleased to take these meetings up. All complaints are taken seriously and handled sensitively. We have fast-tracked severe complaints to enabled speedier resolution where possible.

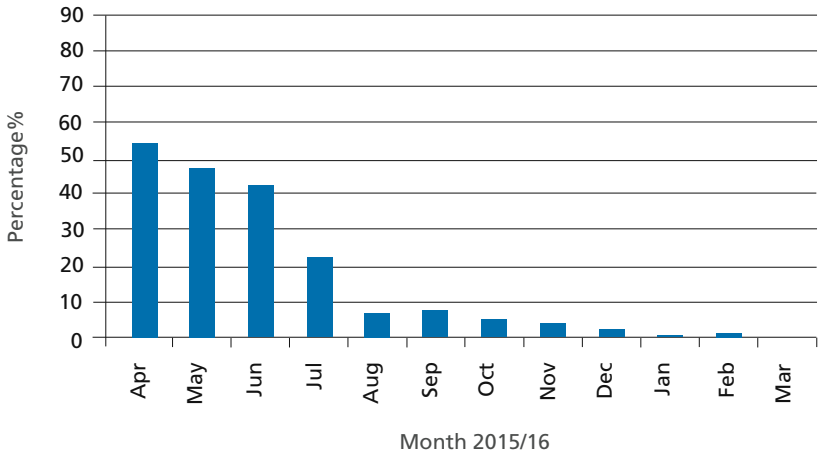
Lessons learned from complaints investigated are reported upon and shared to improve the care we provide. Ensuring that complaints are responded to in a timely manner means that these lessons, remedies, or changes in practice are implemented straight away.

	2014/15	2015/16
Formal complaints received	837	929

Average number of days to respond to complaints by quarter



Percentage of complaint responses where the time taken to respond has exceeded the original agreed response date



The most common themes of complaints

Theme	2014/15 %	2015/16 %
All aspects of clinical treatment	55	53
Appointment delay/cancellation (outpatient)	13	16
Attitude of staff	12	12
Communication/information for the patient	4	6
Personal Records	1	3
Appointment delay/cancellation (inpatient)	2	2
Admissions/ discharges, transfers	3	1
Transport services	2	1

We have embedded learning from complaints throughout our organisation. Some examples of changes we have put in place include:

- Making the self-check-in kiosks more user friendly for people with visual impairments.
- Ensuring that our rehabilitation wards are as focused on risks of developing pressure sores as our medical and surgical wards.
- Sharing clear information with patients on how to self-catheterise after a certain urology procedure so that patients can recover better at home.
- Implementing a pathway for patients who need bowel support but are admitted to hospital for other conditions, so that they can receive specialist support from our Faecal Incontinence Team.
- Ensuring that newborn babies transferred from other Trusts are given the same newborn screening and tests.

Patient Advice and Liaison Service

We encourage local resolution as much as possible, on the basis that clinical teams are well placed to deal with issues that arise on a day to day basis. Where this cannot be achieved, and where a formal complaint is not necessary, our Patient Advice and Liaison Service (PALS) provides an essential liaison service between the patient and organisation, clinician or team providing care. PALS also support patients who need clarification, additional information about our services or where they are concerned about an aspect of care, but not yet sure if a complaint is warranted.

The most common themes of PALS enquiries

Theme	2014/15 %	2015/16 %
Appointment issues	19	25
Clinical Issues	18	25
Complaints advice or referral	12	5

Kelly Stackhouse, Lead nurse FINCH service who won the Patient's Choice Award at the national RCNi Nurse Awards 2016.

Patient Roger Bowen was pleased with his care on Newton 4.

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 national PROMs data every month with additional organisation-level data made available each quarter. Data is provisional until a final annual publication is released each year. The tables below shows the percentage of patients reporting an improvement in their health status following the procedure and the average adjusted health gain achieved compared against the average for England.

Percentage reporting improvement

	Health Status Questionnaire - Percentage improving			
	Finalised data for April 13 – March 14 (Published August 15)		Provisional data for April 14 – March 15 (Published February 16)	
	SWBH	National	SWBH	National
Hernia repairs	50.5%	42.9%	50.7 %	43.7%
Hip replacement	89.4%	86.1%	89.6%	89.3%
Knee replacement	81.4%	74.1%	81.0%	78.0%
Varicose vein surgery	51.9%	46.5%	51.1%	46.7%

	Health Status Questionnaire - Average adjusted health gain							
	National	SWBH	Highest National	Lowest National	National	SWBH	Highest National	Lowest National
Hernia repairs	0.085	0.085	0.107	0.041	0.084	0.058	0.154	0.000
Hip replacement	0.436	0.417	0.495	0.348	0.437	0.414	0.493	0.347
Knee replacement	0.323	0.261	0.373	0.229	0.315	0.286	0.384	0.226
Varicose vein surgery	0.093	0.077	0.161	-0.021	0.095	0.087	0.154	0.040

The finalised data for 2013/14 and the provisional data for 2014/15 shows that there are areas where the reported outcome is below the average for England.

In response, the Trust has taken the following action:

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.
Groin hernia repair	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. We will revise and reintroduce post operative expectations and further guidance information and literature to the patients. We will also introduce a PROMS lead within General Surgery.

How we performed in 2015/16: Against our standards

KPI (Key Performance Indicators) 2015/16

KPIs	Measure	2015/16	Standard	Achieved
Access metrics				
Cancer – 2 week GP referral to first out patient	%	94.0	=> 93	✓
Cancer – 2 week GP referral to first outpatient (breast symptoms)	%	96.3	=> 93	✓
Cancer – 31 day diagnosis to treatment all cancers	%	98.3	=> 96	✓
Emergency Care – 4 hour waits	%	92.54	=> 95	x
Referral to treatment time – incomplete pathway < 18 weeks	%	92.0	=> 92	✓
Acute Diagnostic waits < 6 weeks	%	0.55	< 1	✓
Cancelled operations	%	0.9	=< 0.8	x
Cancelled operations (breach of 28 day guarantee)	%	1	0	x
Delayed transfers of care	%	2%	=< 3.5	✓
Outcome metrics				
MRSA Bacteraemia	No.	3	0	x
C Diff	No.	29	<30	✓
Mortality reviews	%	75	=> 90	x
Risk adjusted mortality index (RAMI)	RAMI	90	<100	✓
Summary hospital level mortality index (SHMI)	SHMI	97	<100	✓
Caesarean Section rate	%	25.2	=< 25	x
Patient safety thermometer – harm free care	%	93.8	=> 95	x
Never Events	No.	4	0	x
VTE risk assessment (adult IP)	%	95.1	=> 95	✓
WHO Safer Surgery Checklist (completion of all sections)	%	100	=> 98	✓
Quality governance metrics				
Mixed sex accommodation breaches	No.	2	0	x
FFT would recommend score - inpatient	%	95	95	✓
FFT would recommend score - emergency care	%	80	95	x
Staff sickness absence	%	4.9	=< 3.5	x
Staff Appraisal	%	85.8	=> 90	x
Medical Staff Appraisal and Revalidation	%	85.6	=> 90	x
Mandatory Training Compliance	%	97.4	=> 90	✓
Clinical quality and outcomes				
Stroke Care – patients who spend more than 90% stay on Stroke Unit	%	92.0	=> 90	✓
Stroke Care – Patients admitted to an Acute Stroke Unit within 4 hours	%	80.6	=> 80	✓
Stroke Care – patients receiving a CT scan within 1 hour of presentation	%	72.9	=> 50	✓
Stroke Care – Admission to Thrombolysis Time (% within 60 minutes)	%	83.9	=> 85	x
TIA (High Risk) Treatment within 24 hours of presentation	%	97.4	=> 70	✓
TIA (Low Risk) Treatment within 7 days of presentation	%	97.7	=> 75	✓
MRSA screening elective	%	93.6	=> 80	✓
MRSA screening non elective	%	93.1	=> 80	✓
Inpatient falls reduction – Acute	No.	599	< 660	✓
Inpatient falls reduction – Community	No.	345	< 144	x
Hip Fractures – Operation within 36 hours	%	71.4	=> 85	x
Patient experience				
Complaints received – Formal	No	929	N/A	
Patient average length of stay	Days	3.32	=< 4.3	✓
Coronary Heart Disease - Primary Angioplasty (<150 mins)	%	92.2	=> 80	✓
Coronary Heart Disease – Rapid Access Chest Pain (<2weeks)	%	95.1	=> 98	x

Children's Safeguarding

We continue to work closely with Sandwell and Birmingham Multi-agency Safeguarding Hubs (MASH) and frontline practitioners to improve the quality of inter-agency referrals so that children and families receive the most appropriate intervention and support at the right time in order to safeguard children.

We have developed a Safeguarding Children Training Strategy to ensure our staff are appropriately trained and skilled to respond to safeguarding children concerns. 70% of staff have received face to face training on how to recognise and refer safeguarding issues and 68% of key staff such as midwives, paediatric staff, ED practitioners and health visitors have received more in depth training. We have delivered specific training on Domestic Abuse Risk Assessment and Child Sexual Exploitation (CSE) to key groups so that they can recognise the risk factors/triggers and make appropriate referrals.

Following joint work with Sandwell's CSE Team we are now flagging the electronic patient records of children and young people who are assessed to be at medium/high risk of CSE in order to support staff in their risk assessment and response when these vulnerable children access our services.

We have updated a number of policies and protocols in response to the increasing agenda around CSE, Domestic Abuse, Female Genital Mutilation and the Savile report recommendations.

Priorities for 2016/17 will include the full implementation of the Child Protection Information Sharing Project across unscheduled care settings and to continue to meet the requirements of the two Local Safeguarding Children Boards. We will extend the IDVA Project into City ED in September 2016.

Jayne Clarke, Trust Child Safeguarding Lead.

Jacqui Ennis - Learning Disability Nurse Specialist.

Safeguarding Adults

During the year we have seen developments in how we implement the Care Act 2015. This has included a focus on raising awareness regarding domestic abuse, neglect, coercion and radicalisation. We have a Prevent policy in place with a referral form and information to support staff in understanding how and when a referral should be made.

Two new postholders to support safeguarding will begin work within the Trust in 2016. We are working closely with voluntary organisations who are supporting the Trust to carry out an audit on our transition and access to services for people with a learning disability. We are also appointing a second learning disability nurse specialist, thanks to investment from Sandwell and West Birmingham Clinical Commissioning Group.

The Trust charity funded a new Independent Domestic Violence Advocate (IDVA) Project that launched in the Sandwell Emergency Department (ED) in November 2015. The project is proving positive in increasing staff awareness, identification and onward referral into support services for domestic abuse victims. Since November – January 2016 there have been 50 referrals from ED.

Readmissions

Tackling readmissions remains a focus for the Trust as we strive to ensure we are in a position to provide good quality care and that means ensuring patients are cared for in an appropriate setting. We will reduce readmissions by a further 2% this year. This year we have trialled telephone calls to patients following discharge to give follow-up advice or link with appropriate community teams. Our intensive focussed week that we held this year brought together multi-disciplinary teams and different organisations to focus on how we work together better to reduce readmissions. We have continued with our frailty assessments at the front door to support our planned care pathways and better inform the support systems that patients will need to have in place that could avoid a readmission.

Outpatient Care

Outpatient care has continued to improve during the year to provide better, more efficient care for patients and to better support our primary care colleagues. In November 2015 we introduced partial booking for follow up appointments. Patients who need to be seen within six weeks are booked for their next appointment date before they leave the clinic. Patients who need an appointment further ahead are asked to contact the Trust nearer the time to agree a convenient date and time. Partial booking will be in all specialties in May 2016.

Our Consultant Assisted Triage Service (CATS) began this year where referrals are assessed and advice can be given to GPs where appropriate. This began in the vascular service and has been extended over a range of surgical and medical specialties throughout the year. We have further embedded e-Outcome which means that an electronic outcome for each patient is recorded at clinic or within the month. This gives assurance that each patient's care needs are being delivered and tracked. In the year ahead all our referrals will come in electronically and this year we will ensure that all first outpatient appointments are within six weeks of referral.

Community caseloads

Smarter scheduling is key for all community services to optimise the time available for face to face clinical care by reducing administration and travel. Currently this is largely done at practitioner level through both paper and electronic means so we are working hard to standardise our approach by accessing appropriate scheduling tools via mobile devices. A caseload management tool has been procured in adult community services to provide real time capacity information by combining staff availability with patient dependency to facilitate visualisation of current and future workload projection across the teams. Specifically the tool provides valuable information regarding dependency gaps, team and individual caseload. Children's services also plan to review how they can use the tool. We continue to investigate how we can access mobile, lightweight devices to allow us access to electronic patient records in patient homes and facilitate opportunities for telemedicine and virtual consultations. All community services are working with GP practices, children's centres, leisure centres and other community locations to streamline and increase clinic capacity.

Focused care

The Trust has spent the past year improving care in a number of ways, but our work in focused care is arguably one of the most exciting. As part of our Safety plan we have highlighted the importance of providing the best possible dementia care in our healthcare settings. We initiated a programme of work around focused care to increase quality, to reduce costs and reduce harm. We have adopted the principles of John's Campaign to promote partnership working with relatives and carers for patients with cognitive disorders to enable the carer to support patients whilst in hospital day or night. We have purchased fold away beds to enable relatives and carers to sleep next to patients with dementia to offer vital support when they need it most. The beds will be introduced in 2016. Four of our wards were part of our focused care programme where we tested new ways of working including personalised folders for each patient. These folders contain the patient's information and what the staff should expect from them, risk and monitoring charts and a process measurement activity. Focused Care and John's Campaign best practice will be implemented on all wards by the end of 2016. Staff and carer's surveys will help us evaluate the impact of our work and investment.

Ten out of ten (10 out of 10)

10/10 is our patient safety standards checklist completed on admission to prompt immediate action from members of the ward team (doctors, nurses and therapists) to put in place measures to reduce the risk of harm for all our patients. During 2016 we will see a focused initiative in our medical and surgical assessment units to integrate 10/10 into practice so that staff and patients are empowered to identify and reduce risks. A rapid improvement model will be used to assist the change and help with sustainability.

Quality Improvement Half Days

Last April, the Trust launched Quality Improvement Half Days (QIHDs) to provide dedicated time every month for teams to meet to consider how best to improve the quality of care or services provided to patients and staff. The four hour afternoon sessions were a big change for the Trust involving all non-emergency activity being paused to give whole multi-disciplinary teams the chance to get together. They offer staff a chance to take time out to learn and develop

They offer staff a chance to take time out to learn and develop new ideas. They also help to tackle the cross-organisational learning that we want to improve. With nearly 50 meetings taking place across the Trust at the same time, one of the challenges was to find sufficient space. Because there is no non-emergency activity, it gives an opportunity to use spaces which would normally be used for patient care. For example, nearly 50 staff from Outpatients, Medical Records and the Elective Access teams met in the patient waiting area of the fracture clinic at Sandwell. One of the largest sessions in April was held in the iBeds directorate, with 97 people meeting in the Physiotherapy Department at City. QIHDs have been going strong since it launched and continues to motivate and inspire staff across the Trust.

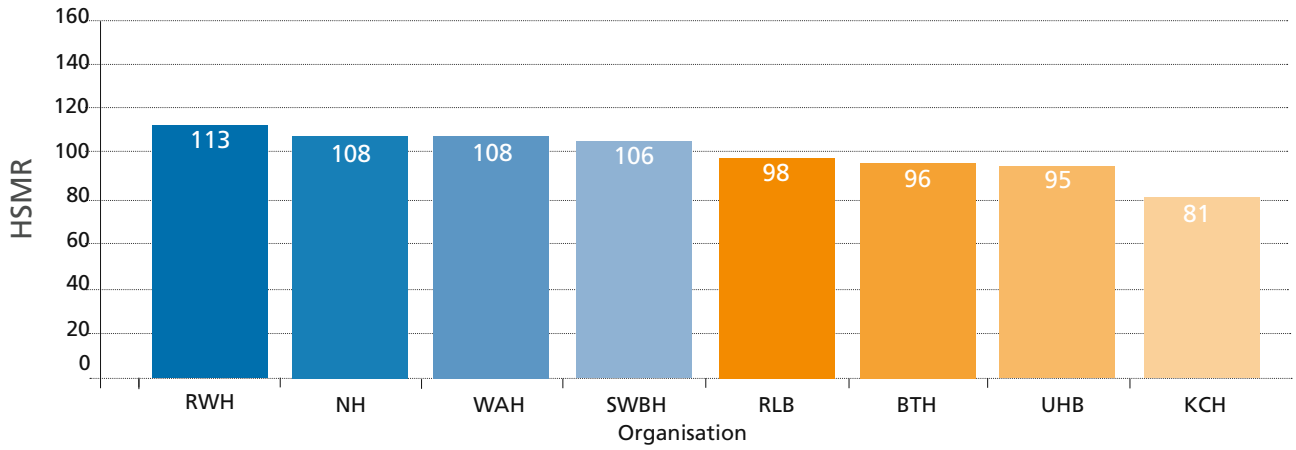
Mortality

Mortality data is now extracted from the CHKS system, which reports the Risk Adjusted Mortality Index (RAMI) as the principle measure of our organisation's mortality, and the HED system which reports the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI).

HSMR (Hospital Standardised Mortality Ratio)

The HSMR is a method of comparing mortality levels in different years, or for different sub-populations in the same year, while taking account of differences in population structure. The ratio is of (observed) to (expected) deaths, multiplied conventionally by 100. Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100. Our HSMR is currently (February 2016) 106 for SWBH. This information is derived from the HED system, which is rebased monthly to provide the most up to date data.

HSMR in comparison with our peers



Key
RWH - Royal Wolverhampton NHS Trust
NH - Northumbria Healthcare NHS Foundation Trust
WAH - Worcestershire Acute Hospitals NHS Trust
SWBH - Sandwell and West Birmingham Hospitals NHS Trust
RLB - Royal Liverpool and Broadgreen University Hospitals NHS Trust
BTH - Bradford Teaching Hospitals NHS Foundation Trust
UHB - University Hospitals Bristol NHS Foundation Trust
KCH - Kings College Hospital NHS Foundation Trust

RAMI (Risk Adjusted Mortality Index)

This is a methodology developed by Caspe Healthcare Knowledge Systems (CHKS) to compute the risk of death for hospital patients on the basis of clinical and hospital characteristic data. It is a ratio of the observed number of deaths to the expected number of deaths that occur within a hospital. The Trust's RAMI for the most recent 12 month cumulative period (December 2015) is 90 and flagging marginally outside of statistical confidence limits which is above the National HES peer RAMI of 82. The aggregate RAMI for the City site is within statistical confidence limits with a RAMI of 82, and the Sandwell site with a RAMI of 96, which is outside of statistical confidence limits. 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).

SHMI (Summary Hospital-level Mortality Indicator)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge. Our SHMI score is currently 97 for the Trust.

Mortality comparisons against national data

	Lowest	Highest	SWBH
Observed	526	4672	2229
Expected	796.3	4555.0	2293.8
Score (SHMI)	0.66	1.02	0.97

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.

Trust Mortality Review System

For the year 2015/16 we set ourselves a target of reviewing 90% of all hospital deaths within 42 days and 100% of all hospital deaths within 60 days. By reviewing the care provided we can identify areas where learning can take place to improve outcomes for our patients. Although there has been an improvement in the number of deaths reviewed within 42 days we have not achieved our target and will keep this as a priority for 16/17.

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD
Death	146	120	105	371	119	97	114	330	127	116	133	376	163	137	152	452	1529
Reviewed	132	105	98	335	104	88	98	290	100	54	62	216	122	94	92	308	1149
% Reviewed	90	87	93	90	87	90	85	87	78	46	46	57	74	68	60	68	75
% Cumulative Reviewed	90	89	90	90	89	89	89	89	87	82	78	78	77	76	75	75	75

November and December review rates were adversely affected by loss of electronic documentation relating to failure in our IT system.

Reducing avoidable deaths

We continue to focus on reducing avoidable deaths and during this year we will:

- Review 90% of deaths within 42 days and 100% of deaths within 60 days
- Ensure that we improve learning in three main areas which are improved sepsis management, management of acute kidney injury and end of life care.
- Streamline our mortality review system and reward reviews who complete 100% of their mortality reviews within our agreed timeframes.
- Participate in the National Retrospective Case Record Review (NRCRR) commissioned by HQUIP from Royal College of Physicians
- Participate in the National Learning Disability Mortality Review Programme (LeDeR) managed by the University of Bristol

End of life (palliative) care

In April 2016 we begin the Connected Palliative Care service which is a new service for patients in the last year of life. Sandwell & West Birmingham Hospitals NHS Trust is the lead provider for this new service and we are working with different partners to provide seamless care including Birmingham St Mary's Hospice, John Taylor Hospice, Age Concern and Crossroads. Our clinical staff will be leading the service development working closely with patients, carers and colleagues to join up services and support improvements in care.

Deaths of patients with involvement from specialist palliative care services

Diagnostic care coding= Z5.15. 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	%
2229	471	21.13

Anita Chew from Birmingham Age Concern, Tammy Davis the End of Life Service Lead at SWBH, Sundip Gill from Birmingham St Mary's Hospice, Penny Venables from John Taylor Hospice, and Chris Christie from Sandwell Crossroads.

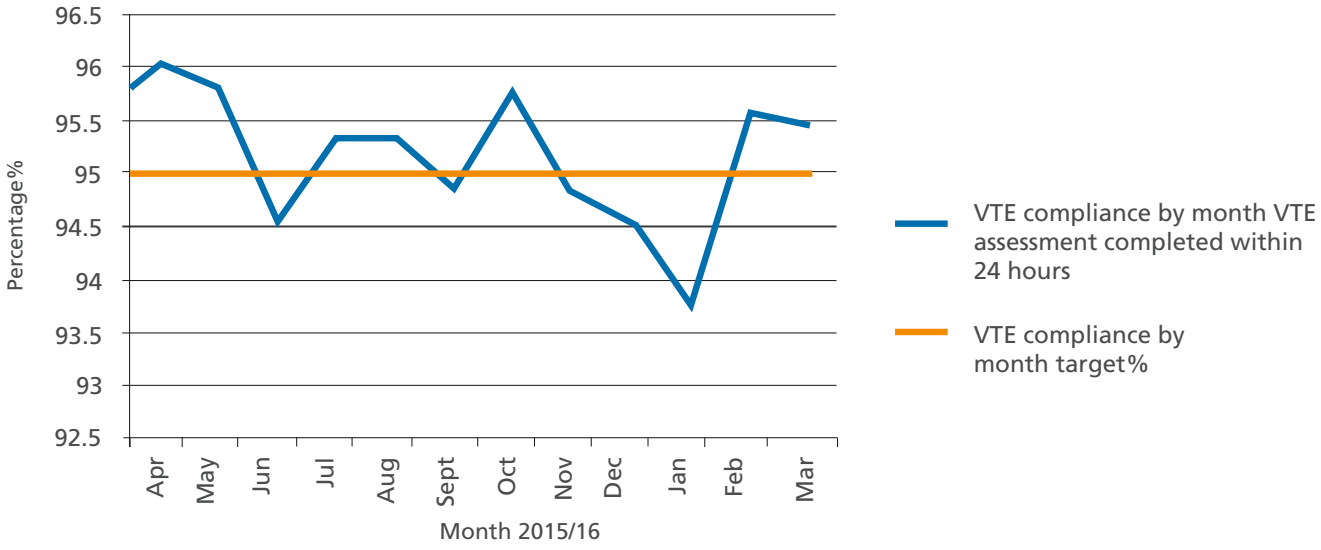
Venous thrombo-embolism (VTE)

A Venous thrombo-embolism (VTE) is a blood clot that forms in a vein. A calf vein is the most common site for this to occur but occasionally pieces of the clot can break away and flow towards the lungs and become a pulmonary embolism (PE). The Department of Health requires all Trusts to assess patients who are admitted for their risk of having a VTE. This is to try and reduce some of preventable deaths that occur following a VTE while in hospital.

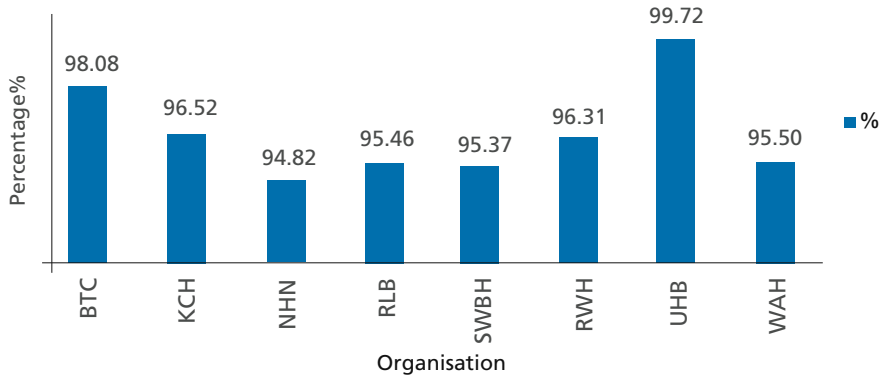
We report our achievements for VTE against the national target (95%) and report this as a percentage. The calculation is based on the number of adults admitted to hospital as an inpatient and of that number, how many had a VTE assessment within 24 hours. Following an audit of our VTE assessments last year we confirm that we are now reporting within the 24 hour period. Our year end position is 95.1%

Rachel Clarke, Deputy Manager of Anticoagulation and Joanne Malpass, Anticoagulant Services Manager.

VTE assessments completed within 24 hours 2015/16



VTE assessments compared to peers (higher is better)



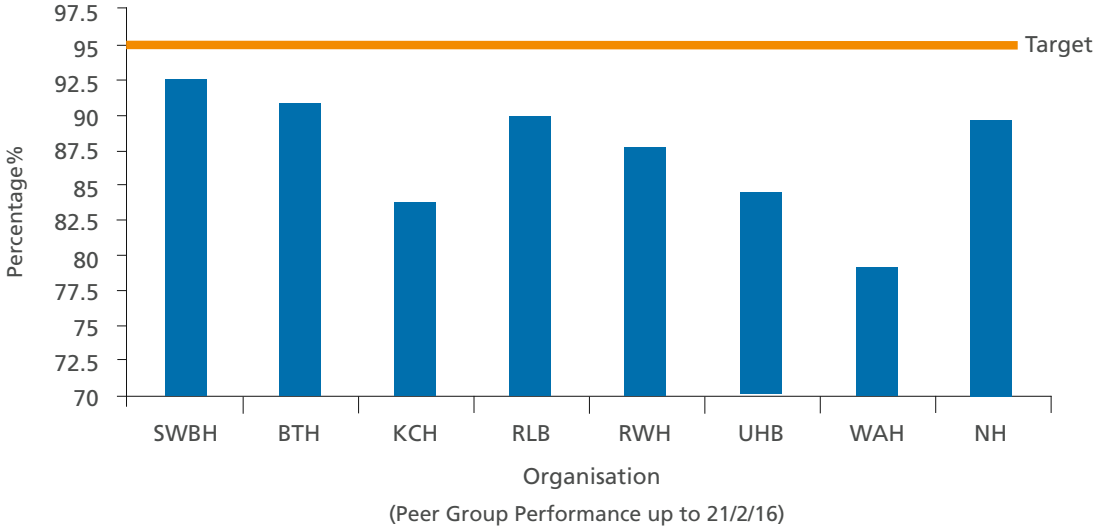
Data from NHS England – reporting period April 2015 – December 2015

Lowest	Highest	Average	SWBH
88.5%	100%	96.3%	95.1%

Emergency four hour waits

In line with the national standard we aim to ensure that 95% of patients will wait for no more than four hours within our Emergency Departments (ED). Although the majority of patients were seen within four hours on average we achieved 92.5%. Long waits for patients are now very rare and we have been able to reduce ambulance turnaround times meaning that ambulance crews can get back on the road more quickly. We remain committed to improving our performance and we are joining up work with community teams to improve our integrated care pathways.

Percentage of patients waiting 4 hours or less in Emergency Departments 2015/16 (Higher is better – target 95%)

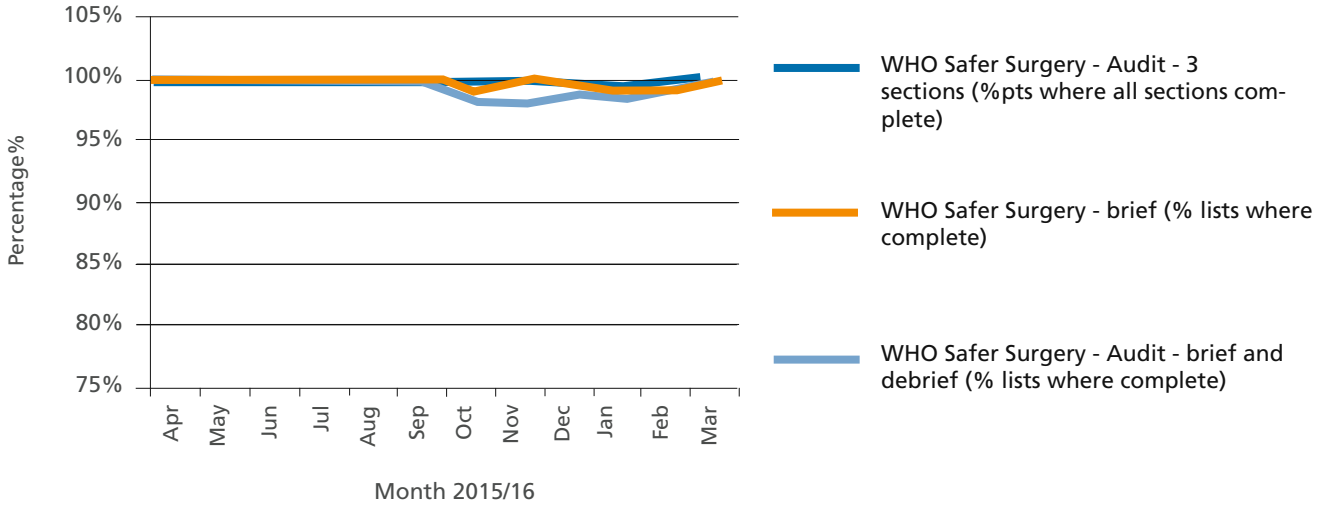


(Peer Group Performance up to 21/2/16)

WHO Safer Surgery Checklist

Compliance with the WHO safer surgery checklist is monitored through our monthly Theatre Management Board. Clinical directors are core members of the group. Surgery A have a monthly governance meeting where they discuss the audits on the WHO checklists. At the meetings they identify actions that will improve compliance.

Compliance with WHO Safer Surgery checklist 2015/16



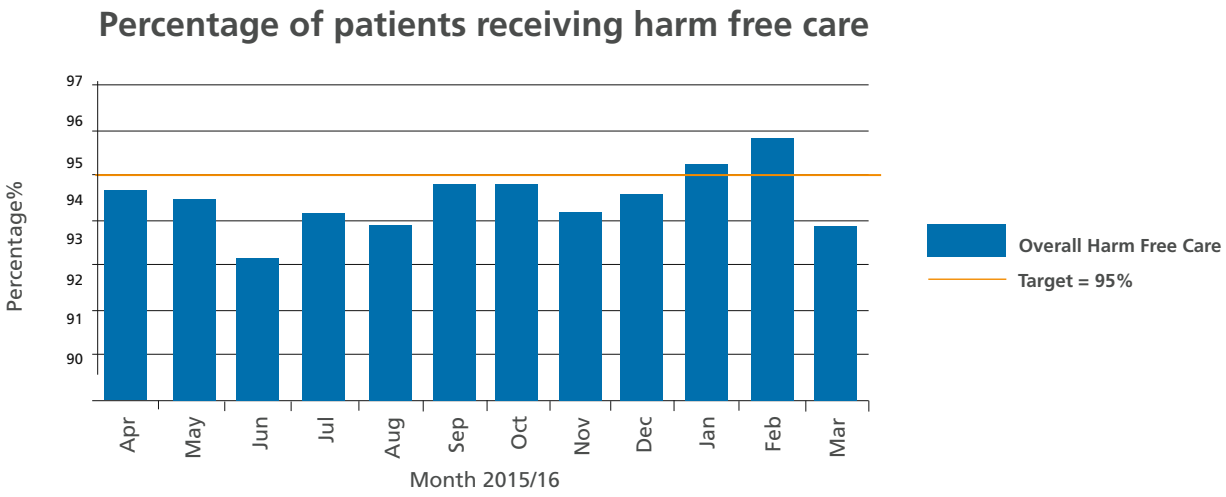
Harm free care

The Trust continues to undertake monthly prevalence audits looking at four harms – pressure ulcers, falls, catheter related UTIs and DVT. Results show that 94% of our patients suffer no harm whilst in our care. During the last 3 months of the year we have reached the national target of 95%. All harms are reviewed via the incident reporting framework with local and cross - Trust learning. For example, we are implementing a 'blue pillow' approach to heel elevation – an idea commenced by Newton 4 ward.

Patient Audrey Branwood on one of the new pressure relieving mattresses at City Hospital.

Harm free care by peer with national average

National Average	Sandwell & West Birmingham Hospitals NHS Trust	Bradford Teaching Hospitals NHS FT	Kings College Hospital NHS FT	Royal Liverpool & Broadgree University Hospitals NHS Trust	University Hospitals Bristol NHS FT	Worcester-shire Acute Hospitals NHS Trust	Northumbria Healthcare NHS FT
94%	94%	92%	95%	94%	93%	94%	97%



Pressure ulcers

Pressure ulcer prevention remains one of the key priorities 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.

In line with the Trust's vision to provide patients with the safest care possible the Trust promotes being open with the reporting of pressure damage incidences in order to learn from mistakes and improve future care for patients. Through ongoing monitoring and review of grade three pressure ulcers the Trust strives to keep our safety promises by learning from incidents, changing care when required and reducing harm to our patients.

During 2015 there was investment in new mattresses at City site which has meant patients have no delays in receiving pressure relief and do not need to be disturbed when they may be at a critical time in their illness. Traditional pressure relieving air mattresses remain available when clinically indicated. Benefits of the new mattresses also include improved patient comfort, mobility and reduced manual handling for our staff.

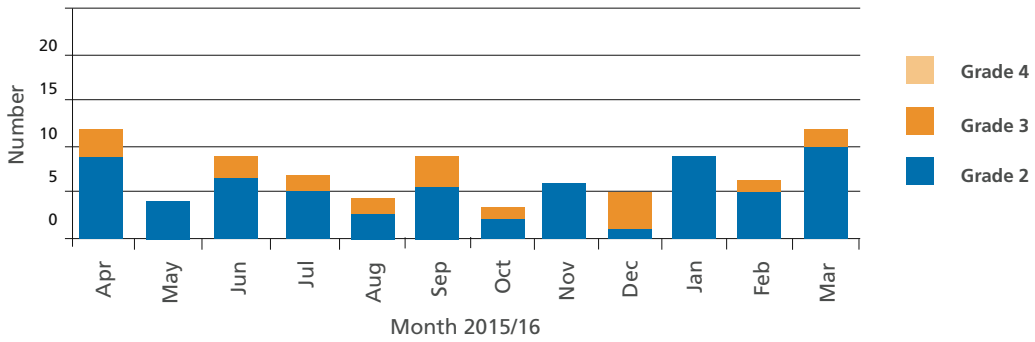
During the year the Tissue Viability team have had a focus of working with the Community nurses to promote the message of pressure ulcer prevention. This included a pressure ulcer awareness event and attending local resident meetings to talk about pressure ulcers and how to prevent them. This activity was welcomed by Agewell and gave an opportunity

for the public to ask advice on prevention within a social setting. The Tissue Viability team has also been working with Sandwell & West Birmingham Clinical Commissioning Group and have extended our training provision to include training for local practice nurses and nursing home nurses. These days provided a platform to raise awareness of pressure ulcer prevention as practice nurses are often the first health care professionals patients will have contact with.

More work is planned within the Sandwell community to reach out to the wider population, raising awareness of pressure damage and how to reduce the risk of pressure ulcers developing.

HCA Annette Reeves and Ward Manager Amanda Green celebrating 821 days pressure ulcer free on ward D21.

Avoidable Pressure Sores 2015/16

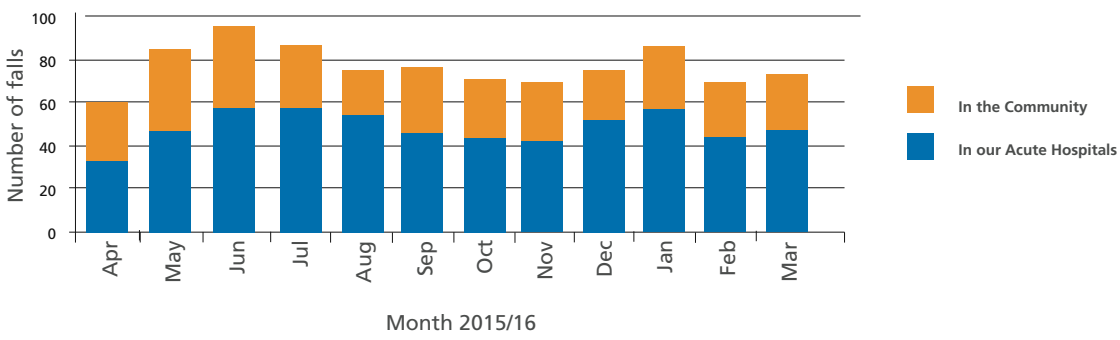


Falls

The number of falls in 2015/16 was 944 of which 21 resulted in serious harm.

We investigate and review each fall 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. We are currently undertaking a project to review the medication of those patients that are at high risk of falling. Our newly appointed Dementia Lead will also have a focus on falls prevention and will be working closely with clinical teams to identify themes around falls, for example, a high proportion of our falls are patients with dementia /delirium. We are also working with the risk team to design a questionnaire for clinical staff to complete at the time of the fall to help us investigate why the fall happened, whether it could have been avoided, whether we care for the patient appropriately post fall, and whether there are any lessons to learn for the organisation. This will be launched with clinical staff in Spring 2016.

Falls In 2015/16



Infection Prevention and Control

We are committed to a zero tolerance goal to eliminate all avoidable health care acquired infections (HCAIs) and we are proactive in the identification, management and monitoring of infections. We have an infection prevention and control service (IPCS) who provide education and training, surveillance of infections, monitoring of our practices to ensure that we are in line with national standards such as National Institute for Health and Care Excellence (NICE) guidance, recommendations from professional bodies and the Infection Prevention Society [IPS] audit tools. We facilitate Patient Lead Assessment in the Clinical Environment (PLACE) audits. We work in partnership with the Clinical Commissioning Groups (CCGs), Trust Development Agency (TDA), Health Protection Unit (HPU) and Public Health England (PHE).

Marie Williams, Infection Prevention and Control Nurse Advisor raises hand hygiene awareness among staff and patients.

Target	Agreed target/rate [Year end]	Trust rate [End Mar 2016]	Compliant	Comments	
MRSA bacteraemia	0	3	No	**Pre 48hrs** 0	**Post 48hrs** 2 = Sandwell Site 1 = City Site
C.difficile acquisition toxin positive	30	29	Yes	19 = Sandwell Site 10 =City site	
	• During this reporting period, SWBH introduced a more sensitive method of testing for C.difficile, enabling earlier detection of the organism in comparison to other tests. This has benefited our patients as early detection of C.difficile enables treatment to be commenced sooner, resulting in a better outcome. The introduction of the new method of testing was supported by SWB CCG. • As part of ongoing monitoring for C.difficile, a period of increased incidence [PII] was identified on one ward at Sandwell during February 2016, involving 3 patients [2 samples were identified with the same ribotype]. In line with Trust protocol the PII was escalated to an outbreak and a table top review was undertaken, resulting in the clinical group putting an action plan in place.				
MRSA Screening - Elective	85% (locally agreed)	93.6%	Yes		
MRSA Screening - Non Elective	85% (locally agreed)	93.1%	Yes		
Post 48hrs MSSA Bacteraemia (rate per 100,000 bed days)	N/A	5.73	N/A	All Post 48 hrs bacteraemia have a post infection review to identify issues and lesson learnt.	
Post 48hr E Coli Bacteraemia (rate per 100,000 bed days)	N/A	18.52	N/A	All Post 48 hrs bacteraemia – urinary catheter related have a post infection review to identify issues and lesson learnt.	

Blood culture contamination rates

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Blood culture contamination rates by site **(Target = 3%)**	**City**	2.4%	2.9%	1.7%	2.5%	3.2%	2.9%	2.9%	2.0%	1.7%	2.6%	3.7%	3.2%
	S.Well	3.5%	3.3%	3.9%	3.1%	4.1%	4.0%	1.5%	4.8%	4.1%	3.1%	6.0%	3.4%
	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 Aug 2014 the IPCS have introduced a training programme for all new doctors to the Trust.												

We monitor any periods of increase incident [PII] and outbreaks. During the period April 2015 – March 2016 there were a total of four wards closed on the Sandwell site due to symptoms of diarrhoea and/or vomiting: one ward in April 2015, one ward in February 2016 and one ward in March 2016 due to norovirus. One ward in January 2016 was closed as a precautionary measure with no organism identified. During the reporting period there were a total of three bay closures across the Trust, two of which were confirmed as norovirus but did not result in ward closure.

In addition to outbreaks of diarrhoea and/or vomiting, due to the emergence of multi resistant organisms, national guidance, increased surveillance and microbiological screening of patients, we identified more periods of increased incidence and outbreak attributed to a variety of micro-organisms including: - Clostridium difficile [CDI], Extended Spectrum ßeta lactamase organisms [ESBL], Carbapenamase resistant organisms [CRO] and Vancomycin resistant enterococci [VRE].

In all cases post infection reviews have been undertaken and multi-disciplinary and agency meetings held to identify lessons learnt and outcomes of lessons learnt.

Key to maintaining standards is continued commitment and compliance with infection prevention and control policies by all staff. Audit and training continues to be prioritised as a means of monitoring and delivering continuous improvements.

Information Governance Toolkit (IGT) attainment levels

The Trust is compliant across the Information Governance Toolkit requirements for 2015/16. We successfully achieved 86%, which is a "Satisfactory" (GREEN) level, according to the HSCIC IG Toolkit grading scheme and a minimum Level 2 achieved for all requirements. The Trust will continue to build on this to strengthen our IG practices and processes and work towards attaining Level 3 compliance.

Staff Nurses Nicola Hawthorne and Joanne McGugan at the sharps safety training session for community nurses.

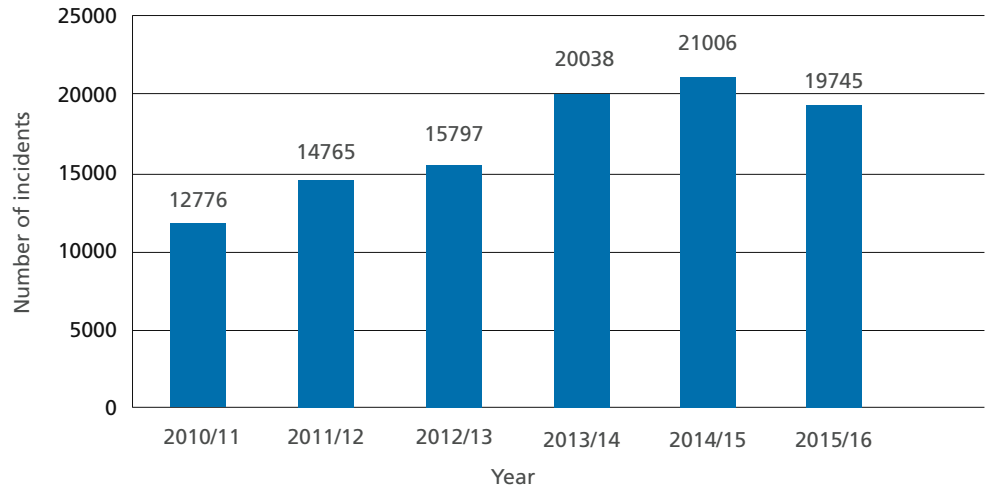
Date	Average rate of reporting per 100 admissions	Best reporter/ 100 admissions	Worst reporter/ 100 admissions	Number of incidents resulting in severe harm	Percentage of incidents resulting in severe harm	Number of incidents resulting in death	Percentage of incidents resulting in death
2011/12	6.29	9.82	2.34	86	1.15	14	0.2
2012/13	9.58	12.65	2.49	32	0.32	19	0.15
2013/14	11.67	12.46	1.72	24	0.2	16	0.1
	Average rate of reporting per 1000 bed days	Best reporter/ 1000 bed days	Worst reporter/ 1000 bed days	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
2014/15	56.19 per 1000 bed days	84 per 1000 bed days	7 per 1000 bed days	28	0.32	7	0.1
2015/16	54.86	74.67	18.07	18	0.3	2	0.03

The data shows an overall position of reduced incidents resulting in severe harm or death.

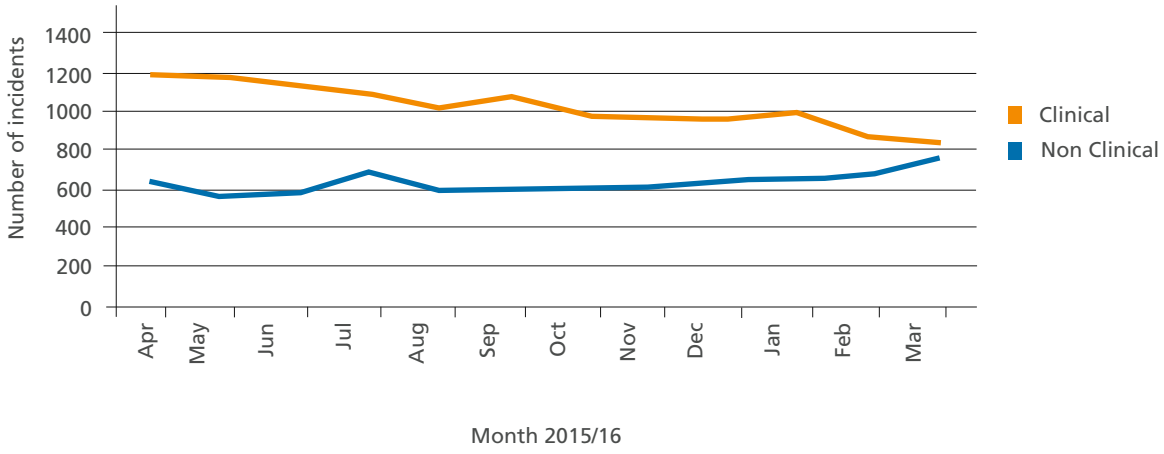
Incident reporting

A positive safety culture remains essential for the delivery of high quality care. The Trust continues to submit its incident data to the National Reporting & Learning System (NRLS) which is publically available and provides comparative data with like-sized Trusts. This data shows that as at the April 2016 report we remain in the highest 25% of Trusts with a reporting rate of 54.86 per 1000 bed days.

Total incidents reported by financial year



Incidents reported during 2015/16 (clinical and non clinical)



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. Patient safety incidents resulting in moderate harm or above that do not meet external reporting criteria are investigated at clinical group or corporate directorate level. The number of serious incidents reported in 2015/16 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, personal data or health and safety incidents.

2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of SIs	4	1	3	1	1	4	0	2	2	6	4	0

Never Events

During 2015/16 four never events were reported. 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.

Never events reported in 2015/16

Incident	What Happened	Where it happened	What we learned
Wrong side lithotripsy **(April 2015)**	Identified that lithotripsy was being performed on the right instead of left side.	This incident occurred at the Adult Surgical Unit (BTC) at City Hospital in Urology.	The investigation identified a number of safety controls that were not in place or not adhered to. Safety controls and changes to working practices were implemented (eg WHO checklist changes, sedation policy updated, adherence to site marking and Sign In / Time Out procedure).
Wrong side anaesthetic block **(May 2015)**	The patient was listed for a left intermedullary femoral nail on the trauma list. A fascia iliaca block was performed on the right side.	This incident occurred at Sandwell Hospital Theatres under the care of Anaesthetics and T&O.	The investigation identified a number of issues that contributed to this incident including safety controls that were not adhered to, distractions within the anaesthetic room and overlap of cases which meant that the anaesthetist who did the Sign In did not perform the procedure. A combination of procedure changes and training to reinforce good practice and adherence to safety controls was implemented.
Retained swab **(June 2015)**	A maternity patient attended at 30+6 weeks and an intra-uterine death was confirmed by ultrasound scan. The patient had a semi elective c-section with a total abdominal hysterectomy performed. The patient remained unwell post operatively and was returned to theatre following an estimated blood loss of between 1500 and 2000mls. The patient was transferred to ITU with a pelvic pack in place (as planned) and was taken back to theatre for the removal of the pack. The patient remained unwell with abdominal distention and vomiting. An abdominal xray was taken which identified a retained swab. The patient returned to theatre for removal of the swab.	This incident occurred at City Hospital under the care of Maternity services.	The management and recording of swabs was not robust and the inability of staff to give or receive respectful challenge both contributed to this incident. Actions implemented included changes to policy and procedures in addition to learning events to promote effective team working as well as introduction of a recepticle for individual swabs to improve visibility and counts.

Incident	What Happened	Where it happened	What we learned
Wrong site surgery **(Feb 2016)**	The patient attended day surgery for removal of K-Wire right distal ulna, under general anaesthetic. The surgeon opened the radial side of the pateint's hand and realised the error. The radial side (thumb) was closed and the operation then proceeded on the ulna side (little finger).	This incident occurred at Sandwell Hospital Theatres under the care of T&O.	Although safety documentation was completed it was found that there was a lack of precise anatomical position (side (L or R) or top, middle, bottom) as a requirement of the documentation. These aspects are being addressed.

How we performed against external measures

Our Care Quality Commission improvement plan

In March 2015 we published our improvement plan as the Care Quality Commission published their inspection report following their visit to the Trust in October 2014.The Trust was overall rated as "requires improvement". Our improvement plan identified five key themes of improvement:

1. Improve how we learn 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.
In 2015 we introduced our quality improvement half days (QIHDs) that offer protected time for teams to learn, cancelling all non-emergency services.

2. Ensure that we consistently deliver the basics 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.
Our "ok to ask" campaign enabled everyone in the Trust to feel comfortable questioning and challenging each other in our basic standards of care.

3. 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 have not achieved our ambitions on cutting absence due to sickness this year although some teams have sustained low levels and others have dramatically improved. We have changed many of our recruitment processes to fill vacancies with the right people more quickly including open days where recruitment checks and job offers can be made within a day, and guaranteed jobs for our student nurses who have passed their relevant competencies and assessments.

4. 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 have continued the second year of investment in our leadership programme supporting the top leaders in the Trust to be able to successfully lead and deliver our 2020 vision. Our monthly Your Voice survey engages every employee in feedback that is acted on by directorate and group leaders.

5. 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.
We have published all of our risk registers on our intranet site so that they are readily available to all staff. Anyone can view anyone's risk register. This has helped to facilitate greater understanding among groups of staff.

The majority of actions within our improvement plan have been completed successfully. During the first half of 2015/16 we will complete all of our actions and in the later part of the year we will seek assurance that our actions have achieved the desired outcome to improve the quality of care for our patients.

Despite clear and evidenced progress having been made against the majority of recommendations there remain eight areas where further work or a different approach may be required to succeed. These include embedding the Ten out of Ten (10/10) safety checklist, improving mandatory training compliance, and further strengthening discharge processes to meet the patient's preferred place of care / death.

In November 2015 the CQC published their report into our community services for children and young people. These services received an "outstanding" rating.

Service area	Plans delivered	Outstanding actions
Accident and Emergency	11 out of 12	• Complete roll-out of secure drug storage
Medicine and Emergency care	1 out of 5	• Further embed 10/10 • Improve mandatory training compliance • Ensure patient/carer agreement with their treatment plan is always obtained • Introduce new patient-centred care plans
Surgery	7 out of 8	• Update our electronic theatre management system
Children and Young People	5 out of 5	
Maternity	11 out of 12	• Complete roll-out of secure drug storage
End of Life care	2 out of 4	• Improve discharge processes to meet patient's preferred place of death • Further improvements required to achieve 100% completion of DNA CPR forms by doctors
Outpatients and diagnostic imaging	8 out of 11	• Resolve perception and communication issues • Improve outpatient experience for people with dementia and learning disabilities • Improve privacy of patients in the Sandwell eye clinic through relocation
Community	9 out of 10	• Complete roll-out of secure drug storage

CQUINs (Commissioning for Quality and Innovation)

The Trust is contracted to deliver a total of 20 CQUIN schemes during 2015/16. Seven schemes are nationally mandated, a further five have been agreed locally, five identified by the West Midlands Specialised Commissioners and three by Public Health. Out of a maximum £8.8m available we received £8.7m based on our achievements. Sandwell and West Birmingham CCG have declared that we have achieved to their satisfaction against the principal CQUIN objectives for 2015/16.

We agree, although we were unable to demonstrate achievement in a secondary objective in the following: Acute Kidney Injury - due to delays in the implementation of a new electronic discharge letter we were unable to demonstrate an improvement in informing GPs of patients with AKI. Similarly in Sepsis we demonstrated improvement through intermittent audit - however IT delays again hampered our ambition to capture every case of sepsis in A&E electronically.

CQUINs for 2015/16			
1	National	Acute Kidney Injury	x
2	National	Sepsis Screening	x
3	National	Sepsis Antibiotic Administration	✓
4	National	Dementia - Find, Assess, Investigate, Refer & Inform	✓
5	National	Dementia - Staff Training	✓
6	National	Dementia - Supporting Carers	✓
7	National	Improvement in diagnosis recording in HES Data Set of Mental Health presentations	✓
8	Local	Community Therapies - Dietetics Community Communication with GPs	✓
9	Local	Reduce Number of Ward Transfers experienced by patients with Dementia	✓
10	Local	Reduce Number of Out Of Hours Patient Transfers	✓
11	Local	Safeguarding	✓
12	Local	Falls Medication	✓
13	Spec.	Reduce Number of Consultant-Led Follow Up OP Attendances	x
14	Spec.	HIV - Reducing Unnecessary CD4 Monitoring	✓
15	Spec.	Haemoglobinopathy Networks - develop partnership working, define pathways and protocol	✓
16	Spec.	Breast Cancer - help patients make more informed choices regarding treatment	✓
17	Spec.	Bechet's Disease (Highly Specialised Service) - set up clinical outcome collaborative workshop	✓
18	Public Health	Breast Screening - improvement in uptake	✓
19	Public Health	Bowel Screening - improvement in uptake	✓
20	Public Health	Maternity and Health Visiting Services - Integrated working	✓

External Visits

Care Quality Commission inspection of community children's services

In June 2015 the Care Quality Commission sent a team of inspectors to our community children's services. The inspection was as a result of the CQC being unable to determine a rating for these services following the inspection of the Trust in October 2014. The CQC rated the services overall as being "outstanding", the highest possible rating. Every part of the service provided achieved a rating of either good or outstanding. The Trust achieved an outstanding rating for both caring and for leadership.

Overall Rating	Outstanding
Domain	Rating
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Outstanding

The CQC highlighted several areas of good practice:
"Staff were made aware of trust wide incidents in various forms, for example, through weekly team meetings, monthly governance meetings and emails from line managers to share lessons learned."

"All CYP teams had infection control champions who attended infection control meetings. The champions shared any actions to local teams to improve infection control practices"

"There was a multi-disciplinary approach to care and treatment and a proactive engagement with other health and social care providers to achieve best outcomes."

"We saw the transition of children moving from infant to junior and secondary school was seamless, however staff told us the transition for young adults when leaving education needed to be improved."

"Staff demonstrated determination and creativity to overcome obstacles to delivering care. Children/young person's individual preferences and needs were always reflected in how care was planned and delivered.

Staff were proactive about seeking the views of people who used services and to ensure children and their parents were fully involved in their care."

"The service was responsive to the diverse community and difficult to reach groups. Staff worked with other health professionals to provide an integrated and seamless service in a timely manner."

"We attended home visits with the children's nurse service and saw care delivery was individualised to meet the complex needs of children and support for the parents. For example, one parent told us the nurse looked at the needs of their child and planned care to support the family as a whole."

Children's Therapy Team Leaders Una Peplow, Kay Baker, Heather Bennett, Joanna Hall, Petrina Marsh, Jackie Williams, Jane Mills, and Harminder Bahia. The CQC rated our community and young peaple's service as outstanding.

"Local and senior leaders had an inspiring shared purpose, strive to deliver and motivated staff to succeed. Staff felt supported and nurtured by local and senior leaders with comprehensive and successful leadership strategies in place to ensure delivery and to develop the desired culture."

"Staff from all disciplines spoke with passion about their work and conveyed how happy they were within their respective teams, staff were self-motivated and energised to continually improve."

Inspection by the Human Tissue Authority

Mortuaries operate under the Human Tissue Act 2004 Licence and are inspected by the Human Tissue Authority (HTA) every three years. The mortuaries on both the Sandwell and City sites were visited on 30 September - 1 October 2015 as part of a routine inspection to assess whether the facility continues to meet the HTA's standards. It included a visual inspection of the mortuary, Post Mortem (PM) suite, body store and viewing room at the hub site (Sandwell) and a visual inspection of the body store, viewing room and storage of tissue, blocks and slides in Histology at the satellite site (City). Interviews with members of staff and a review of documentation were undertaken.

SWBH Mortuary services are licensed under the Human Tissue Act 2004 for the:

Making of a post mortem examination;

1. Removal from the body of a deceased person (otherwise than in the course of an anatomical examination or post-mortem examination) of relevant material of which the body consists or which it contains, for use for a scheduled purpose other than transplantation; and storage of the body of a deceased person or relevant material which has come from a human body for use for a scheduled purpose. Storage of the body of a deceased person or relevant material which has come from a human body for use for a scheduled purpose

The HTA found that:

- the Designated Individual and the Licence Holder were suitable in accordance with the requirements of the legislation the premises and all practices were suitable in accordance with the requirements of the legislation. All applicable HTA standards were assessed as "all fully met".

Many areas of strengths and good practice were observed throughout the inspection including:

- Detailed and comprehensive standard operating procedures covering all areas of activity in the mortuary;
- Inclusion of the mortuary in end of life care training for nurses and junior doctors, to give them a better understanding of mortuary work;
- A clear visual system to track any cases that have gone elsewhere for PM examination ensuring that the rotating staff can see at a glance in the current status of each case;
- The use of markers on fridge doors to alert staff when bodies need to be handled with care due to irregular body shape; and efficient and prompt traceability of tissues.

The HTA assessed the establishment as suitable to be licensed for the activities specified and there were no non-compliances.

The mortuary at Sandwell, where many areas of good practice were found by the Human Tissue Authority when they inspected it last autumn.

Participation in clinical audits

During 2015/16 we participated in 37 national clinical audits and three national confidential enquiries covering NHS services which the Trust provides. SWBH has reviewed all the data available to them on the quality of care in all of these services. During that period Sandwell and West Birmingham 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 NHS Trust participated in and for which data collection was completed during 2015/16, are listed 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
Women's & Child Health		
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Vital signs in children (Care in Emergency Departments)	Yes	100%
Diabetes (National Paediatric Diabetes Audit)	Yes	100%
Paediatric Asthma (British Thoracic Society Audit)	Yes	99%
National Pregnancy in Diabetes Audit	Yes	97%
Cystic Fibrosis Registry	Yes	100%
Acute care		
Emergency use of oxygen(British Thoracic Society Audit)	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Yes	98%
Severe trauma (Trauma Audit & Research Network)	Yes	60%
Adult Critical Care (Case Mix Programme)	Yes	100%
National COPD Audit (Secondary Care)	Yes	100%
National Complicated Diverticulitis Audit	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	67%
Procedural sedation in adults (Care in the Emergency Department)	Yes	100%
VTE in lower limb immobilization	Yes	100%
Long term conditions		
Diabetes (National Diabetes Audit) Adult	Yes	100%
Diabetes (National Foot care Audit)	Yes	100%
Inflammatory Bowel Disease (IBD)	No	NA
Rheumatoid and early inflammatory arthritis	Yes	Ongoing
National COPD Audit (Pulmonary Rehabilitation)	Yes	100%
UK Parkinson's Disease Audit	Yes	75%
Heart		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	93%
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	100%
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%
National Prostate Cancer Audit	Yes	100%
Oesophago- gastric Cancer (National O-G Cancer Audit)	Yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion (Audit of patient blood management in scheduled surgery)	Yes	100%
National Comparative Audit of Blood Transfusion (Use of blood in haematology)	Yes	100%
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database	Yes	100%
FFFAP- Inpatient falls	Yes	100%
FFFAP- Fracture Liaison Service Database	Yes	0ngoing

National Audits	Participated Yes /No	Percentage of eligible cases submitted
Other		
Elective Surgery (National PROMs Programme)	Yes	78%
National Ophthalmology Audit	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 studies in 2015/16: Acute pancreatitis Physical and mental health patient in acute hospital Non invasive ventilation	Yes Yes Yes	92% Ongoing Ongoing
Maternal, infant and newborn clinical outcome review programme	Yes	100%
Child Health Clinical Outcome Review Programme - Chronic neurodisability - Young people's mental health.	Yes	 Ongoing Ongoing

The team who carried out mock CQC inspections across all areas of the Trust in January 2016.

Karen Blackford, Sarah Potter, Antony Lynch, Claire Phillips, Anne Rutland and Rohima Khatun are all part of the Research & Development team.

Karim Raza, Director of Research and Development.

Participation in clinical research

In 2015/16 we recruited 2450 patients from our Trust to participate in research studies adopted onto the National Institute for Health Research (NIHR) Portfolio. This was the largest number of new research patients recruited by our Trust in any single year. In addition, a further 500 patients were recruited for non- NIHR Portfolio studies. Participation in clinical research demonstrates our ongoing commitment to improving the quality of care offered to patients and to making a contribution to wider health improvement. Furthermore, it ensures that clinical staff stay abreast of the latest treatment possibilities. Research is undertaken across a wide range of disciplines including Cancer (Breast, Lung, Colorectal, and Haematological, Gynaecological, and Urological malignancies), Cardiovascular disease, Dermatology, Diabetes, Gastroenterology, Neurology, Ophthalmology, Rheumatology, Stroke, Surgery 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. Examples of excellence in the last year include:

- The award of major research grants to clinicians at the Trust. Prof Karim Raza (Rheumatology) is a co-investigator on the Arthritis Research UK Strategic Programme Award 'The microbiome as a therapeutic target in inflammatory arthritis' (£2 million) and Miss Si Rauz (Ophthalmology) is a co-investigator on a Direct Pathway Finding Scheme MRC Major Award to develop a sight-saving synthetic, optically-transparent, patient-delivered, biologically-smart dressing for the prevention of corneal scarring during acute microbial keratitis (£2.36 million).
- Continued excellence in publishing research in the highest impact factor journals.
- Increasing the breadth of our research to areas with historically limited research activity, for example Clinical Immunology and Respiratory medicine.
- Increasing the number of Allied Health Professionals delivering clinical research, in particular with important contributions from Physiotherapy.
- Integrating patient representation into the Trust's Research & Development (R&D) committee allowing the patient voice to influence the Trust's R&D programme.

Strategic Objective	Priorities for 2016-17	How will we achieve it?
 Safe, High Quality Care	Reducing readmissions.	Continue to identify patients at risk. Outcomes will be a 2% fall in re-admission rates at Sandwell compared to the 2014/15 baseline.
	Improving the experience of outpatients	Improve care so that patients experience a maximum wait of six weeks, elimination of clinic rescheduling and 98% patient satisfaction rate. We expect to reduce did not attend (DNA) rates by 2%.
	Achieving the gains promised within our 10/10 programme.	We will focus on a 100-day roll out in our assessment units during the first quarter of the year and invest in ward managers to support delivery.
	Meeting the improvement requirements agreed with the Care Quality Commission.	In the first half of the year we will ensure we complete the remaining outstanding tasks in the Improvement Plan and in quarter three we need to ensure benefits have been gained from that work.
	Tackling caseload management in community teams.	We will make sure that nursing caseloads at team level are reduced to the median in the Black Country. Patient contact time will be increased by 10% among district nurses, health visitors and midwives.
 Accessible and Responsive	Meet national wait time standards, and deliver from a guaranteed maximum six week outpatient wait.	Achieve 93% or better for four hour waits in our emergency departments from Q2. Achieve the 18 week referral to treatment standard consistently. Eliminate open pathway referral issues seen in prior years. Deliver the 62-day standard in specific tumour groups.
	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.	Have fewer than 15 delayed transfers of care in Trust bed base with 40% of discharges taking place before midday.
	Deliver our plans for significant improvements in our universal Health Visiting offer, so 0-5 age group residents receive high standards of professional support at home.	Deliver our contractual standards and establish our new partnership model with Sandwell Metropolitan Borough Council so that it delivers effective health visiting care for families.
	Work within our agreed capacity plan for the year ahead, thereby cutting did not attend (DNA) rates, cancelled clinic and operation numbers, largely eliminate use of premium rate expenditure, and accommodating patients declined NHS care elsewhere.	Cut did not attend (DNA) rates by 2%. Ensure all specialties by October 2016 achieve a recurrent balance between demand and capacity.
 Care Closer to Home	Ensure that we improve the ability of patients to die in a location of their choosing, including their own home.	Make sure there is an increase in the proportion of patients identified as being on the planned pathway >72 hours before passing and Increase the proportion of patients able to die in place of their choosing.
	Respiratory medicine service sees material transfer into community setting, in support of GPs.	Establish the community respiratory service so that we see a reduction in unplanned readmissions for respiratory patients at Sandwell.

Strategic Objective	Priorities for 2016-17	How will we achieve it?
 Good use of resources	Create balanced financial plans for all directorates, and deliver Group level I&E balance on a full year basis.	Demonstrate group level balance for income and expenditure for the full year.
	Reform how corporate services support frontline care, ensuring information is readily available to teams from ward to Board.	Establish a reporting tool at frontline service level with clearly visible monthly reports on standards to support the performance improvement cycle.
	Reform how corporate services operate to create efficient transactional services that benchmark well against peers within the Black Country Alliance.	Conclude benchmarking work across the alliance and report to the programme board, with a rationalisation plan. Meet the KPIs for each corporate service.
 21st Century Infastructure	Get NHSI approval for EPR full business case, award contract and begin implementation, whilst completing infrastructure investment programme.	Approve the preferred bidder and put capability in place for effective implementation next year.
	Develop, agree and publicise our final location plans for services in the Sandwell Treatment Centre.	Ensure that all departments relocating from City site know their future location at Sandwell and agree the investment trajectory as part of the 2016-2019 capital plan.
	Finalise and begin to implement our RCRH plan for the current Sheldon block, as an intermediate care and rehabilitation centre for Ladywood and Perry Barr.	Establish the West Birmingham intermediate care facility under the Better Care Fund.
 An engaged and effective organisation	Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness.	The overall Trust sickness aim is 2.5%, comprising a fall from 2% to 1% in short term sickness and a fall of 100 people in long term sickness at any one time.
	Finalise our long term workforce plan, explaining how we will safely remove the pay-bill equivalent of 1000 posts between 2016 and 2019.	Make sure that the 2017/18 pay and whole time equivalent start point and proposed change plans reflect the Trust's long term workforce model.
	Create time to talk within our Trust, so that engagement is improved. This will include implementing Quality Improvement Half Days, revamping Your Voice, Connect and Hot Topics, and committing more energy to First Fridays	Make sure that we see an improvement on employee engagement score by at least 5%, with Your Voice response rates of at least 25% and understanding of actions being over 50%. We will have at least 100 senior leaders at our monthly team briefing system with high visibility of senior leaders and improved feedback on organisation communications.

During the year we agreed 10 goals for our Quality Plan and 10 safety commitments for our three year Safety Plan. Both of these plans are published in 2016.

Our Quality Plan Goals

Our health outcomes will be among the best in the NHS.

1. We will reduce deaths in hospital that could be avoided so that we are among the top 20% of comparable NHS Trusts in the UK. We will take action to cut avoidable deaths from Sepsis, Hospital Acquired Venous Thromboembolism, Stroke, Acute Myocardial Infarction (Heart Attack), Fractured Neck of Femur and High Risk Abdominal Surgery.
2. Cancer patients that we treat will have some of the best health outcomes in the UK, with SWBH being among the top 20% of comparable NHS Trusts.
3. We will coordinate care well across different services so that patients who are discharged are cared for safely at home and don't need to come back for an unplanned further hospital stay.
4. We will deliver outstanding quality of outcomes in our work to save people's eye-sight, with results among the top 20% of comparable NHS Trusts in the UK.
5. More Sandwell and West Birmingham residents will take up the health screening services that we provide than in other parts of the West Midlands.
6. We will reduce the number of stillbirths and deaths in the first week of life so that we are providing a better service than others in the West Midlands.
7. Patients at the end of their lives will die in the place they choose, receiving compassionate end of life care.
8. Children we care for will have convenient appointment times and those who need to stay in hospital will be treated quickly so that they are not missing out on valuable time at school.
9. Patients will report that their health is better following treatment with us than elsewhere in England, ranking SWBH in the top 20% of NHS Trusts for patient-reported outcomes.
10. We will work in close partnership with mental health care partners to ensure that our children's, young people's, adult and older people's crisis and ongoing care services are among the best in the West Midlands.

Our Safety Plan Commitments

We will keep our promises to provide safe and compassionate care.

1. Because we complete our Ten out of Ten safety checklist for every patient within 24 hours, all patients will receive expert care.
2. Because we assess and monitor every patient, and learn from every incident, we will protect patients from harm so that they do not experience pressure ulcers or falls that could be avoided
3. Because we have outstanding infection control practices, we will prevent avoidable infections in our care
4. Because we always monitor patients' Vital Signs at the right time we can and will quickly take action if their condition worsens.
5. Because we involve patients in their care plans, and sign personalised plans, our patients and their carers will be best placed to understand their condition and have an agreed care plan.
6. Because we are committed to providing dementia care in the best possible manner, we will work with carers to meet always meet the commitments in our Focused Care plan and John's Campaign
7. Because we review all patients with antibiotics every 72 hours, patients will only be given antibiotics when they are needed.
8. Because we always give patients their medication at the right time, no patient will miss out on a dose medication.
9. Because we give patients clear information about any invasive procedures, patients are able to give informed consent that we will always record.
10. Because we involve patients in their discharge planning, we will usually deliver the expected date of discharge and will always make sure we follow up home care packages to make sure they are in place

Stroke Alert Nurse Priscilla Javillo. Our quality plan aims to cut avoidable deaths due to stroke even futher.

CQUINs (Commissioning for Quality and Innovation) 2016/17

The following CQUIN (commissioning for quality innovation) targets are agreed with our NHS commissioners. We publish data on how we are doing on each target every month within our intergrated performance report, which is dicussed in our public board meetings.

	Goal Name	Description of Goal
Goal Number	Staff Health and Well Being	OPTION B: Introduction of Health and Well Being Initiatives.
	Staff Health and Well Being	Healthy food for NHS Staff, visitors and patients.
	Staff Health and Well Being	Improving Uptake of Flu Vaccination.
	Sepsis	A&E screening and treatment.
	Sepsis	Inpatient screening and treatment.
	Antimicrobial Resistance and Antimicrobial Stewardship	Reduction of Antibiotic consumption.
	Antimicrobial Resistance and Antimicrobial Stewardship	Review of Antibiotic prescribing.
Local	Cancer	Audit of 2 week wait cancellations.
	Cancer	Cancer Treatment Summary record in discharge care plans.
	Cancer	Cancer VTE Advice.
	Safeguarding - CSE	Production of a child sexual explotation awareness video that is used in staff training sessions.
	Mortality	Achieve an improvement in the % of avoidable and un-avoidable death reviews within 42 days.
	Discharges	Implementation of Transfer of Care Plans.
	Discharges	Reduction in readmission rate.
Specialised Services	Materninty	Local QIPP scheme Preventing Term Admissions to neo-natal intesive care.
	Blood and Infection	Haemoglobinopathy Improving pathways.
	Trauma	Activation system for patients with long term conditions – GE2.
Public Heath and Dental	Improving access and uptake through patient and public engagement	Breast Cancer Screening.
	Improving access and uptake through patient and public engagement	Bowel Cancer.
	Secondary Care Dental	Sugar Free Medicines Audit.

Partner statements

Healthwatch Sandwell

"In general this is an impressive report with good evidence of the Trust using information from audits and complaints to improve the service.

The handling of complaints with an emphasis on resolution by staff in the area involved has speeded up resolution and probably improved quality. The Trust has aimed to learn from complaints and gives valuable examples of this. Table top reviews following incidents are a process which has been used as a benchmark for other health and social care organisations and the ability to tackle such delicate issues as the giving and receiving of respectful challenge shows their value.

The use of Patient Reported Outcome Measures places the patients' perspective at the centre of evaluation of the service. The resultant improvement of information packs and guidelines to make expectations more realistic and pre-operative assessment more thorough shows their value. The development of the Ten out of Ten tool shows an appreciation of the importance of close attention to details of care in improving safety.

The Trust has taken part in a large number of national and local audits and following these has developed achievable action plans for improvement. A good example is increasing Consultant review of patients where emergency laparotomy is being considered and early plans for a General Surgeon/Elderly Physician appointment for patients over 70 years. There has been a significant increase in the participation of patients in clinical research, which tends to improve the quality of care as a result of more successful staff recruitment.

Other improvements include the provision of folding beds to allow carers of patients suffering from dementia to remain with them.

Inevitably, some problems persist. Staff sickness rates remain high but deeper analysis of this has shown improvements in some areas. The audit of the use of the Trauma Team shows a problem which is unlikely to be resolved merely by appointment of a scribe and re-auditing may lead to a more radical solution. Falls while under care in the community are much higher than the target. Friends and Family test scores at the start of care in pregnancy are low. Breastfeeding rates at the time of discharge are extremely low, this being a big social and medical issue.

The Trust appreciates that their biggest problem is the rising readmission rate of over 7%, which cannot be simply regarded as a product of an "efficient" reduced length of stay. It is gratifying that this is regarded as a high priority for the future and we suspect that considerable analysis of the causes of this have already been undertaken, even if not reported on."

Lyndon 2 patient Elsie Williams celebrating her 100th Birthday with a card from HM The Queen.

Jenny Simpson, a patient on D16, happy to be discharged after successful treatment

Healthwatch Birmingham

"At Healthwatch Birmingham we are passionate about putting patients, public, service users and carers (PPSuC) at the heart of service improvement in health and social care in the City of Birmingham. In line with our new strategy, we are focused on helping drive continuous improvement in patient and public involvement (PPI) and patient experience. We also seek to champion health equity so that PPSuC consistently receive care that meets their individual and collective needs. We have therefore focused our comments on aspects of the Quality Account which are particularly relevant to these issues.

We are pleased to see details of the Trust's Friends and Family Test (FFT) performance included within the Quality Account. We note the Trust has achieved a 95 per cent 'would recommend' FFT score for the Inpatients Department (in line with the national average), and that the Trust has achieved on or above the national average in three out of its four 'maternity touchpoints' (based on month 11 data). However, we are disappointed that the Emergency Department and Outpatients Department FFT scores are below the national average. We would value more detail on whether the Trust has identified the reasons why performance is relatively low in these areas, and whether it has any plans for improvements.

We appreciate the inclusion of the results from the National Women's Experience of Maternity in the Quality Account. However, there are no national averages or comparisons with previous years provided. This makes it difficult for us to comment on the Trusts performance, and we would therefore ask for these data to be provided in the Quality Account (if available).

As mentioned previously, one of Healthwatch Birmingham's focuses is on promoting health equity in the City. We note that the draft provided to us states that making FFT inclusive for all remains a challenge for the Trust, and we would appreciate more information on how the Trust will seek to address this challenge. We would also value any additional information on how the Trust has monitored and improved the experience of 'hard to reach groups' (e.g. people with learning disabilities, people with mental health problems, minority ethnic groups etc.). If this is not available, we would ask for this to be considered for next year's Quality Account.

It is positive that the Trust has changed the way complaints are handled this year to make sure patients and families are able to have their complaints heard and resolved by people who are close to the situation. We are happy to see the Trust has significantly improved its response times to complaints, from an average of 62.46 days in Q4 2014/15 to 26.75 days in Q4 2015/16. It is also excellent to see that the percentage of responses exceeding the original agreed response date have decreased markedly over the year. In addition to this, we value the information provided on the learning that has been taken from complaints.

We note that appointment issues are a prominent theme in both complaints and PALS enquiries. This corresponds with some of the feedback we have received this year about SWBH. Several patients and carers have commented on issues they have had with appointments via our feedback centre. These issues have included: poor communication around appointment cancellation and rearrangement, long waiting times in clinic, and comments on the disorganisation of the appointment system. Given these issues, we are encouraged to see that the priorities for 2016/17 include a commitment to improve the outpatient experience and cut cancelled clinic and operation numbers. We request clear evidence to be provided of progress against these priorities in next year's Quality Account. We also note that 12 per cent of all complaints received by the Trust in 2015/16 have been about the attitude of staff. This year we have received mixed feedback about staff at SWBH. We have had several positive comments about the care patients have received from staff at the Trust. However, we have also received a significant number of negative comments about staff, particularly around attitude and communication. We would therefore appreciate information on whether there are any initiatives planned to improve in this area.

We would like to congratulate the Trust on achieving an 'outstanding' rating for its community children's services following a CQC inspection. It is particularly heartening that staff were assessed as being proactive about seeking the views of people who used services, and as always reflecting individual preferences in how care is planned and delivered. It is also excellent that the CQC commented on the service's responsiveness to difficult to reach groups.

Whilst the draft Quality Account provided to us provides detail on how patient feedback is gathered at the Trust, there is limited information on how the Trust engages and involves PPSuC when developing or redesigning services. We would therefore value more detail on this in the Quality Account.

It is concerning that there have been four Never Events at the Trust in 2015/16, and that the Trust did not attain the 95 per cent standard set for harm free care during this time (averaging 93.5 per cent for the year). It is also concerning that the Trust was not compliant with its MRSA bacteraemia target. We hope to see improvements in these areas in next year's Quality Account."

Sandwell and West Birmingham Clinical Commissioning Group

"Overall Sandwell and West Birmingham CCG believe this to be a well put together report, that is clear, concise and easy to read, and well structured. In addition to this, we would also like to make the following points:

In terms of Quality, the CCG has been involved in the development of quality measures through the Chief Officer for Quality and the Trust has continued to develop throughout the year.

Regarding Complaints, there has been a significant improvement during 2015/16 in the Trust's complaint response times and its ability to identify lessons to improve the quality of the service.

In terms of Harm Free Care, the CCG Governing Body has kept aware that the Harm Free Care score of 94% is just below the 95% target and target will continue to be monitored. It is encouraging however to note that the Trust are continuing to the reduce the number of serious pressure ulcer incidents, with zero being reported in Q4.
Regarding External Visits, the CCG recognises the excellent achievement of the Trust in receiving an 'Outstanding' rating for Community Childrens services by the CQC.

In terms of Never Events, there were four never events reported by the Trust this year. Although these are events that should never happen, the CCG was fully informed and involved in the investigative process and acknowledge the actions taken by the Trust to help prevent these incidents happening again in future."

Trust response

We thank our partners for their supportive comments on our Quality Account. We have included benchmark data on the National Women's Experience of Maternity Care Survey as requested by Healthwatch Birmingham.

Alesha McIntosh, one of our Sickle Cell and Thalassaemia Centre (SCAT) patients at City Hospital.

Community patient Wesley Thompson attending our pain management clinic at the Lyng.

making **everyone** matter

The Trust Charity

The year has been one of change for the Trust Charity as it works to become ever more relevant to the needs of staff and patients across the area of Sandwell and West Birmingham that the Trust serves. Our vision is to enhance the experience of all people accessing our services including staff, patients and their families. The Trust Charity does this by providing additional facilities or equipment and supporting innovative projects that create a comfortable and secure environment. In order to operate effectively, there has been a need to review and rationalise the more than 300 individual funds that made up the "Sandwell and West Birmingham Hospitals NHS Trust Charities". This has seen the beginnings of a rework of the Trust Deed. This is an ongoing process and one that should be completed by the middle of 2016. Whilst this governance and structural adjustment work has been carried out, the strategic priorities remain as:

The raising of income to support;

Infrastructure

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

Education

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

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.

Community resilience

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

Grant Programme

The 2014 / 2015 grant programme saw 17 small schemes, and 14 large schemes, including specialist equipment, funded. The works proposed within each scheme are now being implemented and the Trust Charity staff team are monitoring and evaluating the progress of each activity. This to evidence actual activity over that planned and the number of beneficiaries impacted upon.

Heads of terms for a 2016/2017 grant programme are currently being assembled and these will be published in the planned Trust Charity Yearbook. This new document will also feature a detailed Impact Report.

Domestic Abuse Tackled in Partnership with Sandwell Women's Aid Partnership

The Trust Charity's signature investment of £250,000 to address domestic abuse in Sandwell demonstrates its progressive approach to partnership and the challenge of gender based violence. With an estimated 10,000 victims of domestic abuse across Sandwell, this is an issue that cannot be ignored and one that the Trust Charity has to work to address. The partnership with Sandwell Women's Aid does just that offering domestic abuse crisis support within A&E with the deployment of three Independent Domestic Violence Advisers (IDVAs) who work to identify and respond to the needs of victims of violence. These IDVAs conduct comprehensive risk assessments, provide on the spot advice and support, facilitate safety planning and make referrals to agencies such as the Police and Children's Social Care. In addition, they liaise with a part-time Information Officer to ensure crucial information flow minimises the risks faced by victims and survivors. All of this informs future programme planning and intervention such as specialist training on domestic abuse across the Trust. Skilling up the wider Trust workforce on the intricacies of abuse is a key part of this work, developing an integrated healthcare response which is both person centred and sustainable.

Small grants

The trust charity also supports the little things that can make such a difference to the care experience of patients and their carers and the capability of staff to enhance that experience. During the year the trust charity support included:

- New blinds for the conservatory at Rowley Regis Hospital to make a more comfortable environment for patients and visitors
- Comfortable furniture in some clinic spaces, waiting areas and outside environments Paying for an event to recognise the contribution of organ donors
- Education and support material for patients with long-term conditions
- Supporting the trust choir who bring joy to patients and staff through their singing on the wards and at events.Toys and gadgets for use in our children's services.

All of this informs future programme planning and intervention such as specialist training on domestic abuse across the Trust. Skilling up the wider Trust workforce on the intricacies of abuse is a key part of this work, developing an integrated healthcare response which is both person centred and sustainable.

Fundraising

Individuals, companies, community groups, charitable trusts and more continue to fundraise and donate to the Trust Charity. Tesco, New Square West Bromwich, donated gifts to be raffled in support of the charity and are working with the fundraising team to explore new opportunities and generate more revenue. The relationship with New Square, Centre Management, West Bromwich continues to develop and a highly successful Christmas Grotto saw more than £1500 raised. A school football competition and gala dinner saw more than £6000 raised for paediatric and child health care. Organised by Sport Plus, a children's sports and activity provider, the competition took place at West Bromwich Albion and brought together children from across the region, their teachers and coaches.

Enterprising fundraiser Peter Hill enrolled his friends into the pub crawl to end them all – it lasted for 28 years and saw more than 16,000 pubs visited. At each stop, the landlord was asked to donate £1.00 to charity. The 'Black Country Ale Tairsters', as Peter and his friends call themselves, generously donated £3000 to the Trust Charity. The West Bromwich Building Society has both raised valuable funds for the Charity and provided much needed volunteers. Following a donation of £500, a number of West Bromwich Building Society volunteers worked to decorate the children's ward at Sandwell, making the environment pleasant and fun for those children remaining in hospital over the festive period.

The Midland Metropolitan Hospital

The Trust Charity is to mount a fundraising appeal in support of the Midland Metropolitan Hospital. This will see a charitable funding element added to the capital investment and spend. To this end, the Trust Charity Board is looking to establish a dedicated Midland Metropolitan Appeal Committee and to identify a suitable appeal committee patron and committee chair. In addition, initial work is being undertaken to confirm the appeal case for support and the fundraising target. This is likely to see funds raised in favour of arts, research, education and heritage activity.

Looking ahead

In the year ahead we will:

- Confirm the Trust charity as a single entity, dissolving linked and associated charities to ensure clarity.
- Continue to refine and develop the Trust Charity's brand, profile and agency; confirming the Charity as one of the region's leading investors in healthcare provision.
- Develop an integrated fundraising portfolio comprising individual, membership and community fundraising activity conducted through the 'Membership Academy'. This will include legacy and in memoriam fundraising.
- Invest in dedicated major grants fundraising aimed at securing signature funding from institutional, government, corporate, large scale trust and foundation donors.
- Conduct a further grant programme with a Trust wide call for submissions and disbursing around £1m in small and large grants.
- Launch the Midland Metropolitan fundraising appeal
- Use the platform of the Midland Metropolitan Appeal to develop a hi-net worth fundraising programme.
- Ensure fundraising sustainability through investment in experienced and proven fundraising staff.

You can read about the trust charity's finances on p126.

Sport Plus Football for Kids raised £6000 for the Trust's Charity.

West Bromwich Building Society helped decorate the children's ward at Sandwell in time for Christmas.

3. Accountability Report

Corporate Governance Report

Directors' Report

The Trust Board meets monthly. The chair is Richard Samuda and Vice-chair is Olwen Dutton. During the year two non-executives directors completed their term of office and were replaced by two new non-executive directors: Robin Russell and Waseem Zaffar.

Non-Executive Directors: Board and committee attendance

	Trust Board	Audit and Risk Management	Quality and Safety	Finance and Investment	Charitable Funds	Workforce & Organisational Development	Configuration Committee	Public Health, Equality and Community	Remuneration Committee
Richard Samuda, Chair	12/12		8/10	8/8	4/5	5/6	5/5	4/4	2/2
Olwen Dutton, Vice Chair	11/12	2/6	8/10						2/2
Dr Paramjit Gill, Non Exec Director	11/12					6/6		4/4	2/2
Mike Hoare, Non Exec Director	10/12		1/3	1/3			2/2		2/2
Harjinder Kang, Non Exec Director	11/12	2/6		7/8		6/6			2/2
Robin Russell**, Non Exec Director	8/10	4/5		2/5					2/2
Waseem Zaffar**, Non Exec Director	9/10				4/4			3/3	1/2
Dr Sarindar Sahota OBE*, Non Exec Director	4/4	3/3	4/4		2/2			1/1	
Gianjeet Hunjan*, Non Exec Director	4/4	3/3	4/4				1/1	1/1	

Executive Directors: Board and committee attendance

	Trust Board	Quality and Safety	Finance and Investment	Charitable Funds	Workforce & Organisational Development	Configuration Committee	Public Health, Equality and Community
Toby Lewis, Chief Executive	12/12			3/5	4/6	4/5	3/4
Rachel Barlow, Chief Operating Officer	11/12	5/10	4/8		6/6		
Kam Dhami, Director of Governance	11/12	7/10					
Raffaela Goodby, Director of Organisation Development	12/12		1/1		6/6		2/4
Colin Ovington, Chief Nurse	12/12	9/10		2/5	4/6		3/4
Dr Roger Stedman, Medical Director	12/12	8/10				2/5	
Tony Waite, Director of Finance and Performance	12/12	3/10	8/8	3/5		2/5	2/4

Key	
a/ b	a= the number of meetings attended b= the total number of meetings with apologies submitted for the meetings not attended
*	Stepped down from their position as Non-Executive Director in July 2015
**	Appointed as full NEDs from 1 June 2015
^	Became a member of different committees part way through the year

The Trust Executive Group is:

- Toby Lewis, Chief Executive Officer (board member)
- Rachel Barlow, Chief Operating Officer (board member)
- Roger Stedman, Medical Director (board member)
- Colin Ovington, Chief Nurse (board member)
- Tony Waite, Director of Finance and Performance (board member)
- Kam Dhami, Director of Governance (board member)
- Raffaela Goodby, Director of Organisational Development (board member)
- Ruth Wilkin, Director of Communications
- Alan Kenny, Director of Estates and New Hospital Project
- Mark Reynolds, Chief Informatics Officer

Rachel Barlow, Chief Operating Officer who is the member of the Trust Board with responsibility for clinical services.

The members of the Audit and Risk Management Committee at 31 March 2016 were Robin Russell (Chair) and Olwen Dutton.

Committee	Purpose
Trust Board	The Trust is led strategically by the Board with Non-Executive Directors and the Executive Team working collectively to drive the strategic direction of the Trust and ensure high quality patient care, safe services and sustainable financial management over the medium/ long term. The Board meets monthly.
Audit and Risk Management	The committee provides oversight and assurance in respect of all aspects of governance, risk management, information governance and internal controls across Trust activities. The committee meets 5 times a year.
Quality and Safety	The committee provides oversight and assurance in respect of all aspects of quality and safety relating to the provision of care and services to patients, staff and visitors. During this year the committee has contributed to the development of the Trust's Quality and Safety Plans which form core pillars of the Trust's strategic direction. The committee meets monthly.
Finance and Investment	The committee provides oversight and assurance around the Trust's financial plans, investment policy and the robustness of major investment decisions. The committee has retained a sharp focus on the Trust's delivery against its Long Term Financial Model. The committee has met monthly since July 2015.
Charitable Funds	The committee provides oversight and assurance in respect of how the Trust's Charitable Funds are invested to the benefit of patients in in accordance with the wishes of donors. Over recent months the committee has been focussed on the work to consolidate the charitable funds and re launch the charity. The committee meets quarterly.
Workforce and Organisational Development	The committee provides oversight and assurance of delivery against the Trust's workforce and OD strategies including the programme of workforce transformation, recruitment and retention and sickness absence management. A lot of the committee's time has been spent on testing the workforce transformation proposals the Trust will be implementing during 2016. The committee meets quarterly.
Configuration Committee	The committee provides oversight and assurance in respect of the Midland Metropolitan Hospital project and the reconfiguration of the wider Trust estate in line with the new hospital. The committee has retained oversight of the project through to financial close and the beginning of the build phase. The committee meets on alternate months.
Public Health, Equality and Community Development	The committee provides oversight and assurance regarding plans to drive holistic public health interventions and the Trust's equality ambitions. The committee meets quarterly.
Remuneration Committee	The committee advises on the terms and conditions of employment and remuneration packages for the Chief Executive and Executive Directors. The committee meets as and when required.

Name	Interests Declared
Chairman	
Richard Samuda	• 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 – Council of the Birmingham Law Society • Member – Labour Party
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 • Academic Lead, NIHR Clinical Research Network: West Midlands • General Practitioner
Michael Hoare	• Director-Metech Consulting • Director CCL Group
Harjinder Kang	• Managing Consultant – PA Consulting Group
Robin Russell	• School Governor – Birchfield Community School
Waseem Zaffar	• Elected Councillor – Lozells & East Handsworth Ward (Birmingham City Council) • School Governor at Heathfield Primary School. • Member of Unite the Union and the Labour Party. • Director at Simmer Down CIC.
Sarindar Singh Sahota OBE (ceased to be a NED in July 2015)	• Trustee – Acorns Hospice • Member – Court of University of Birmingham • Trustee – Nishkam Schools Trust • Director – Asian Business Forum • Member – Smethwick Delivery Board • Chair – Birmingham City Council Citizen-Led Quality Board for Assessment and Support Planning
Gianjeet Hunjan (ceased to be a NED in August 2015)	• 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
Executive Directors	
Toby Lewis (Chief Executive)	• Board member – Sandwell University Technical College • Independent member - Council of Aston University
Rachel Barlow (Chief Operating Officer)	• None
Kam Dhami (Director of Governance)	• None
Raffaela Goodby (Director of Organisation Development)	• Board member in PPMA (public sector people manager's association) member's association • E4S Practitioner Board member (voluntary national body)
Colin Ovington (Chief Nurse)	• None
Roger Stedman (Medical Director)	• Partner – Excel Anaesthesia (private anaesthesia services)
Tony Waite (Director of Finance & Performance Management)	• None

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 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)
2/6/2016

ANNUAL GOVERNANCE STATEMENT 2015/16

SCOPE OF RESPONSIBILITY

As Accounting Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives. I must do this within the context of safeguarding public funds, ensuring long term financial sustainability and the delivery of quality standards. I am personally responsible for these as set out in the Accounting Officer Memorandum.

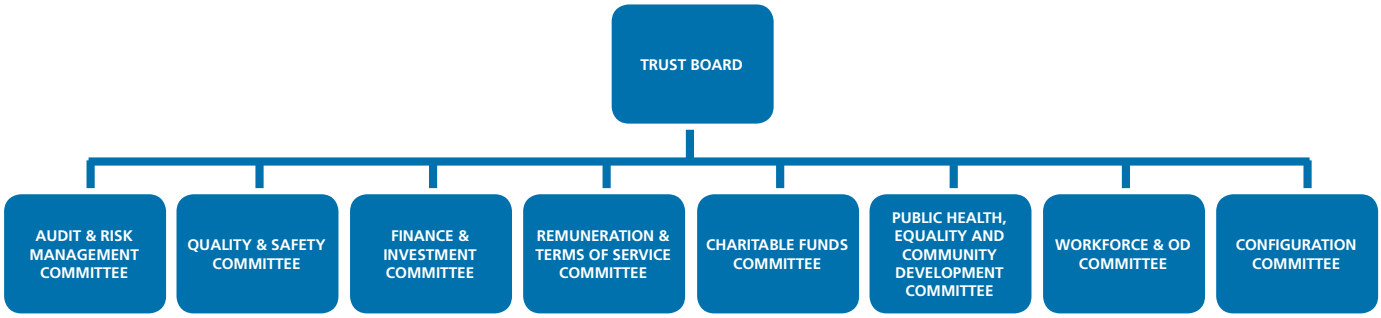
Our internal controls continue to reflect a commitment to work in partnership and in doing so having effective mechanisms in place to manage risks and interdependencies. 2015/16 saw the creation of the Black Country Alliance in which we work ever more closely with counterparts in Dudley and Walsall. There is a real momentum building around this work and in my next Annual Governance Statement I will be able to draw broader attention to the governance model for the work that we have started this year. I am satisfied that we have in place sound arrangements for the work to date, overseen by a joint Board, and agreed information sharing protocols.

We continue to play an important role in the Right Care Right Here Executive and Board with our ongoing commitment to ensuring Sandwell and West Birmingham is not only a healthier place to live but also a better place to live and work. This will change in 2016-17 with the development of the Black Country (and West Birmingham) STP. I continue to meet on a regular basis with the CCG Accountable Officer and representatives of the two local authorities to drive forward joint working through which health and social care services are more closely integrated to ensure timely and effective care pathways that meet the collective needs of the users of our services and their families and carers.

THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

The Trust is led strategically by the Trust Board. The Board sets the strategic direction of the Trust. Below the Board there are 8 Board committees (figure 1) which serve as an overview function against our key priorities and work streams. This structure is designed to ensure open and frank challenge from across the Board on progress against our agreed ambitions as a Trust.

Figure 1



2015 saw the departure of two longstanding Board members Dr Sarinder Singh Sahota OBE and Gianjeet Hunjan. They have been replaced by Councillor Waseem Zaffar and Robin Russell who chairs the Trust's Audit and Risk Committee. The membership and attendances at Trust Board and its committees for the year are outlined in appendix 1.

The Board's governance model continues to evolve in a planned and structured way to ensure focus and delivery against the Trust's key priorities. Five committees remain unchanged from their effective use in 2014/15.

- The **Quality and Safety Committee** has retained a strong focus on safe staffing and the quality of care. During this year the Trust has finalised its two remaining pillars of its medium term transformation plans with the publication of the Quality and Safety Plans. The committee is refocussing its forward plan to directly monitor the implementation and impact of these plans going forward. R&D is also accounted for via this committee.

- The **Finance and Investment Committee** retains a sharp focus on the Trust's financial position and the measures being taken to ensure the Trust manages the financial challenges that continue to face the NHS locally and nationally. It is also focussed on the Trust's investment in improving care and the physical environment across all of the Trust's sites as the Trust moves towards the opening of the Midland Metropolitan Hospital.

- The **Workforce and OD Committee** retain important oversight of the Trust's workforce transformation proposals that will be implemented through 2016/17. The committee also has oversight of the actions being taken to address skill shortages in areas for which there is a national as well as local shortage. It also takes delegated responsibility for education.

- The **Charitable Funds Committee** has oversight of the work underway to develop a more streamlined fund, and the launch of our new Midland Met appeal. The committee also retains oversight of how the funds are invested, how the money is being spent and importantly the impact for patients and the wider community of the spend from the Trust charities.

- The **Public Health, Equality and Community Development Committee** has focussed on volunteering, equality and diversity objectives and oversight of progress against the Public Health Plan.

Two committees have evolved as follows:

- The **Audit and Risk Committee** has over the past year retained a focus of issues including business continuity planning, information governance, the Board Assurance Framework (BAF), key accounting judgements and a review of Trust Standing Orders and Schemes of Delegation. Later on I will describe in greater detail the risks that have been flagged with the Audit and Risk Committee and subsequent actions taken to address these. ARM oversees both internal and clinical audit programmes, which we have integrated.

- The **Configuration Committee** played an important role in oversight of the stages leading up to the financial close and commencement of the build for the Midland Metropolitan Hospital. During 2016/17 the focus of the new **Major Project Authority (MPA)** Committee, which supersedes the Configuration Committee, will be to have oversight of all of the key transformation projects to ensure delivery, project alignment and effective flagging of interdependencies. This change is also reflected in our ISA 260 statement.

The pivotal decision making role of the Clinical Leadership Executive continues to evolve, and become both more visible and increasingly interactive. CLE has commenced a series of leadership sessions with Hay to shape its role. This is part of our wider long term leadership development strategy. Operationally, the Trust delivers care through seven Clinical Groups, each then sub-divided into directorates. The corporate group is our eighth and comprises seven directorates. Clinical services report to the Board through the Chief Operating Officer, who is supported by our Chief

Nurse and Medical Director as an executive triumvirate.

Risk assessment

The Risk Register is reported to the public Trust Board every month as well as the Audit and Risk Committee on a quarterly basis. The Risk Register is considered alongside the Trust's Integrated Performance Report and Financial Performance Report providing a rounded assessment and challenge to Trust performance and progress against key objectives. We continue to devote time at public Board meetings on pre mitigated red risks to test whether mitigation plans are sufficiently robust to provide assurance around the direction of travel on an issue. These risks have been previously examined through the executive Risk Management Committee, and assessed collectively at the CLE.

As of March 2016 the Risk Register had 29 key risks which were reported against monthly at Board level. 3 of these had red residual risk scores after mitigation. These related to a lack of Tier 4 bed facilities for children and young people with mental health conditions, a risk of further reduction or failure to recruit senior medical staff to Emergency Departments and significant reliance on non-recurrent measures and balance sheet flexibility to support the Trust's financial performance and future investment plans. Headline mitigating actions are reported and challenged at the Board and the Audit and Risk Committee. This reporting has led to focused challenge by the Board around sickness absence, financial performance and service delivery quality which means I am satisfied that this reporting is generating robust challenge over our performance on a regular basis.

New risks escalated to the Board in year have included risks in respect of IT system failures, reduced ability to provide interventional radiology services and reliance on non-recurrent measures and balance sheet flexibilities to support the Trust's financial performance. Risks that have been the subject of repeated challenge by the Board have included the management of sickness absence and the impact on infants of a national BCG vaccine shortage. As necessary the Board have approached regional and national bodies for assistance, evidenced by our discussion with PHE over BCG distribution, and with NHSI over the commissioning of oncology care.

Risks that have been removed during 2015/16 include High Dependency Unit one to one care as staffing levels were increased and are monitored monthly, risks to trauma patients requiring traction leading to delays which has been resolved since the fitting of new trauma tables and the risk around failure to achieve TDA sign off for the annual plan return and submission. The Trust continues to implement an electronic risk system. This enables clinical groups and corporate directorates to import their risk registers and update mitigating actions directly on to the system. This will become fully operational in quarter 1 of 2016/17, offering staff more widely visibility of the system – and we plan to become as open as we can across our Trust during the coming year. Ideally we would want complete staff visibility of the risk register as whole.

Risk and control framework

The Trust regularly reviews performance against external frameworks (e.g. NHS TDA Accountability Framework 2014/15, CQC and Monitor's published Quality Governance Framework) as well as internal targets on a broad range of indicators published in the Trust's Integrated Quality & Performance Report.

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 receives the Integrated Performance Report which sets out progress against a suite of performance indicators shown at Trust, group and directorate level. These are worked through in depth at a monthly Performance Management Committee meeting which I chair. In addition the Board considers the Board Assurance Framework on a quarterly basis which tracks progress against the agreed annual plan priorities of the Trust. I am satisfied by how our systems escalate operational and financial performance matters through to the relevant management level and ultimately the Board to ensure that matters are quickly flagged, addressed and long term mitigating actions put in place. Clinical Groups are performance assessed against the same Trust indicators and issues are performance managed with individual groups and operational owners via group reviews, which take place bi-monthly with the full executive. Each corporate directorate also undertakes a bi-monthly performance review of its KPIs in servicing and supporting clinical care.

In late 2015/16, the clinical audit and internal audit processes were aligned to directly reflect the Trust's CQC Improvement Plan. This focus will drive remaining implementation against the plan as we move through 2016. The clinical audits and key actions and learning arising from these are reported to the Audit and Risk Committee on a quarterly basis. The Trust's SUS (Secondary Users System) data quality is benchmarked monthly against other via the HSCIC SUS Data Quality Dashboards which is used to monitor compliance with mandatory fields and commissioning sets.

Accounts, including our quality account

As in prior years, we have a clear and well understood process for settling our financial and quality accounts. Last

year we were given an unqualified opinion in respect of the 2014/15 Trust accounts. An internal review of the 2015/16 draft suggests compliance with mandated guidance.

Last year the Trust received a limited assurance opinion on compliance with the Quality Account Regulations. The recommendations from our external auditors included the need to update the Trust's VTE policy and maternity pathways, inclusion of mandated indicators and improving the timetabling for the drafting and sharing of the Quality Account including presentation to the Trust's Quality and Safety Committee. These recommendations have been implemented in full, and this year's Quality Account has been commended by the external auditors.

Information security and data protection

There are clear arrangements for information security within the Trust, including distinct roles for our SIRO (Director of Governance) and Caldicott Guardian (Medical Director). Breaches and near miss issues are identified, acted upon and drawn as required to the attention of the relevant Board committee. During 2015/16 there was one serious information governance breach, which was reported to the ICO and Department of Health. The incident involved an agency member of staff who sent work information to a personal email account. The incident was investigated and actions taken immediately; the ICO subsequently confirmed no action would be taken against the Trust or the individual. The Trust's risk register process includes assessment of information security and data protection issues. An extensive IT infrastructure and information security investment programme is in progress.

The Trust's latest Information Governance Toolkit self-assessment declaration has led to an improvement on the previous year's score with the self-assessment score now at 86%. During 2015/16 there was a specific focus in terms of IT infrastructure and security for the purposes of increasing resilience across these along with policy and procedure compliance checks. This improvement was overseen with quarterly reviews personally with me as Accountable Officer. I am satisfied that sustained improvement will not require this level of intervention going forward.

Data quality

During 2013/14 the Trust developed and implemented a 'Performance Indicator Assessment' process, the Data Quality Kitemark' which provides assurance on underlying data quality and performance assessment. Each indicator is assessed against seven data quality domains to provide an overall data quality assurance rating which is included in the Integrated Quality & Performance Report.

The Trust has a data quality improvement plan in place to ensure continuous improvement in performance information and has made continued advances in this area through 2015/16 with continued development of the Integrated Quality & Performance dashboard reporting from patient and staff level to Trust position. The Trust audit plan includes a rolling programme of audit against all performance and quality indicators, which will be further strengthened by a Data Quality Group whose scope will be to embed continuous improvement in data quality, monitor and address data quality issues across the organisation with appropriate identification and implementation of training.

Data quality continues to be the focus of Board time in providing effective oversight and challenge. One of the key areas of concern for the Board has been the accuracy of safe staffing data, especially in respect of the number of nurses on shift per ward. The Board did not have adequate assurances that the Trust's electronic rostering system was providing accurate reporting to assure the levels of safe staffing across the Trust. As a consequence a manual reporting system had been implemented by the Chief Nurse with the matter subject to challenge at every public Board meeting. That manual system has remained in place until such a time as the Trust is assured of data quality.

Other data quality issues that have been flagged with the Audit and Risk Committee over the past year have included have included obstetrics CS ratio and elective and non-elective where there was a comprehensive and robust policy in place but issues around timeliness and validation, duplicated entries in respect of falls and serious injury and patient upgrades not formally being documented in respect of cancer waits. Action plans have been put in place to address these issues.

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Counter-fraud and probity

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 work plan is approved by the Audit & Risk Management Committee, is proactive in its role countering fraudulent activity within the Trust. This proactive engagement has included activities during November 2015 linked to fraud awareness month including a counter fraud message to all staff via payslips. The Trust continues to successfully prosecute former Trust employees who have found to have committed fraud. During 2015 a focussed quality assessment was undertaken at the Trust by NHS Protect in respect of compliance with the standards for fraud, bribery and corruption. This resulted in the Trust being rated as partially compliant in respect of the requirements to inform

and involve and compliant in respect of holding to account. In respect of inform and involve it was recognised that staff received training as part of their induction but that potentially more should be done in respect of staff who had been employed with the Trust for over 5 years. The Trust has instituted a comprehensive employee declaration system, with every one of over 7,000 staff being required to make a signed declaration. At the time of issue this process is 5% complete.

Whistleblowing and duty of candour

The Trust continues to invest in an independent reporting system which enables staff to raise whistleblowing concerns. Matters that are raised as whistleblowing concerns have been considered and addressed, and anonymised survey data from staff shows high levels of confidence in our system, responsiveness and integrity. The full Board, with staff-side, have reviewed the success of our efforts and considered residual weaknesses. The next step is the appointment of 8 Freedom to Speak Up guardians, which will take place in Q1 2016/17. These nationally mandated roles are scaled to provide a peer group, bandwidth, and crucially a guardian in each Group - tackling the key challenge, which is responsiveness to concerns 'in the middle' of our Trust. I am confident that as a Trust we continue to meet the requirements in respect of the duty of candour, having regard to both data on this topic, evaluation of it against complaints, and matters raised with the NHS TDA as was.

Safeguarding and DOL

I am satisfied that we have sufficient arrangements in place to prevent issues of deprivation of liberty, having taken specific account of the rise in cases associated with legal precedents of recent times. Safeguarding remains a key priority for the Board and the Trust as a whole with comprehensive polices and training in place. There remain major issues in both boroughs and we are playing our part in tackling those. A key risk for us remains that dual facing necessity.

Equality and diversity

The Board considers on a monthly basis progress against key equality and diversity priorities. Positive progress has been made during the past year in respect of analysing training requests and funding against protected characteristic data and training has been undertaken by the Board in respect of equality and diversity. Further work is needed in respect of Trust wide self-assessment against EDS2 and the promotion and support to active peer groups in each protective characteristic. The Public Health, Community Development & Equalities Board Committee retain focussed oversight of equality matters and in January signed off the Trust's Equality Report prior to publication.

REVIEW OF EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

Our systems for exercising suitable control over safe clinical, research and educational practice are extensive, and the strong infection control, mortality, and educational assessment position achieved by the Trust suggests that they are effective. VTE assessments for instance have shown compliance with national norms but fall short of the Trust ambition of 100%. All national cancer targets are met as well as planned care standards. Our Never Event controls are judged effective by the Trust and our regulators.

We have continued to deliver positive financial performance during the year, especially within the context of the national picture facing the NHS. The Trust delivered a surplus in 2015/16 but was a position underpinned by non-recurrent measures and contingencies. There remain risks to our medium term plans and related investment. Pay costs are now higher than plan. As a Trust we have evidenced our ability to deliver against CIP targets but these have not always been consistently to timescale.

There has been robust enforcement of the use of bank and agency staff with requests being signed off by the Chief Nurse and rooted through the bank team. This is enforced whilst always ensuring patient safety. This has had limited success in reducing the overall expenditure on bank and agency staff during the year but this has in part been a consequence of the additional beds that have been opened to meet demand over the winter period. The Trust's compliance against the agency framework cap is reported routinely to the Board's Quality and Safety Committee. Systematic action has been taken to remove payments that are above the framework cap with the exception of a limited number of doctor and clinician positions.

Engagement with both the Health and Safety Executive, and the Information Commissioner's Office, during 2015-2016 has resulted in approved plans to address issues identified by them. The sufficiency of our control environment is demonstrated by the pace of remedy, as well as the senior level focus these problems attracted.

We received one report in year from the Information Commissioners Office in respect of our handling of a Freedom of Information request relating to the purchase of land for the Midland Metropolitan Hospital. The Information Commissioners Office found that the public interest of maintaining the exception by which information was not shared outweighed the public interest for it to be disclosed in all but one of the issues highlighted. The Trust was asked to comply with the one request that did not meet the exception which it did within the required timescales.

The Trust's Improvement Plan reflecting the 2015 CQC review of the organisation. Our overall rating was requires improvement, with all community services either good or outstanding. Progress against the improvement plan has been considered and challenged at our public Board meetings, and across the Trust.

- As at March 2016, 43 of the recommendations and issues arising from the CQC report having been delivered with the issues addressed.
- In 11 areas improvements/ changes have been implemented but further evidence is needed around the impact of these changes for patients.
- There remain eight areas where further work or a different approach may be required to succeed. These include embedding the Ten out of Ten safety checklist, improving mandatory training compliance, and further strengthening discharge processes to meet the patient's preferred place of care / death. Least progress has been made in relation to ward related matters such as the introduction of patient centred care plans, drug storage installations at Sandwell General Hospital and ensuring patient / carer agreement with their care plan is obtained. This will continue to be a focus for the Board into 2016/17 with internal and clinical audit time given to investigating progress. This hence remains an issue going into 2016/17.

I highlighted in 2014/15 a series of ongoing control concerns. In two areas I remain to be entirely satisfied that we have settled the matter.

- **Do Not Resuscitate documentation** has been a continued focus of attention 2015/2016 to ensure that the practice common in much of the Trust is consistently achieved organisation wide. There remains work to do in this area, and as such continues to be a live risk for us. It is our intention to ensure consistent outstanding practice across the Trust.

- We have a strong Trust level **business continuity plan**. Significant work has been undertaken around Trust business continuity planning during the year. IT failures, junior doctors' strikes and power outages at the City Hospital site have enabled the testing of our business continuity planning during the course of the year. There remain concerns and assurance gaps in respect of both local planning, ensuring protection against known risks and effective communication channels. We will work to close those assurance gaps during the coming year. An Emergency Preparedness, Resilience & Response Group has been established. This meets on a monthly basis and reports into the Operational Management Committee. Following reviews of recent incidents, further work is required to develop a corporate standardised approach to the command & control of all incidents and business continuity events.

In two areas, I am content that our controls, if not always, our performance, match best practice in the sector. In both cases the finance team merit congratulation for their attention to improvement.

- Our continued reform of financial functions has identified opportunity to strengthen further our systems, and controls, in respect of **non-pay expenditure.** Cost improvements remain central to our LTFM going forward so renewed focus is needed during 2016/17.

- Sufficient progress has been made in respect of the governance of small to medium scale **capital project implementation** to the point that I now consider this matter closed. Strengthened project management and overall delivery has seen delivery to timescale of important projects.

During 2015/16, in addition to the two residual matters, and the wider Improvement Plan, I would highlight two further concerns. These are:

- The resilience of our **IT infrastructure** has come into sharp focus during the past year. In January 2016 there was a significant deterioration in the responsiveness of the Clinical Data Archive (CDA) which meant an inability to use the system on occasions which resulted in significant operational disruption. The internal review of this incident highlighted the use of old unsupported operating systems, ineffective prioritisation of core systems and a loss over time of in house expertise. The Trust has recently moved to procure an Electronic Patient Record system and the Board have seen the outcomes of a ranking of core IT systems and received assurances in respect of system mapping and documentation of systems going forward. The Trust continues to invest in its IT infrastructure but until such a time as new systems are implemented (2017-18 in full) there remain risks which will need to be effectively managed and mitigated.

- **HR data quality** is an issue for us. Internal audit reports over the past year have highlighted risks in respect of compliance with HR polices and procedures in respect of leave approval and compliance with sickness absence requirements. Sickness absence management in particular is a key priority as we look to make ongoing efficiency savings across the Trust including reducing bank and agency expenditure. Issues have also arisen during the year in respect of time lags in recording people's successful completion of mandatory training. There will be a real focus across the Trust in respect of managing sickness absence through quarter 1 of 2016-17 and concerted action to remedy HR data quality issues, which are principally about reconciling different source data, whilst working with national data systems which are mandated but not always fit for purpose.

Concluding remarks

I have set out some specific control issues that are a focus currently and for the coming year. On that basis I am able to confirm that there are effective systems in place for the discharge of statutory functions with these having been checked for irregularities and to ensure they are legally compliant. These systems of internal control underpin our work to continue to enhance the quality of care we deliver to the communities of Sandwell and West Birmingham.

Signed  **Toby Lewis Chief Executive (On behalf of the Board)**

Date 2/6/16

Remuneration and Staff Report

Remuneration Report

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 2016, these were:

- Richard Samuda (Chair)
- Olwen Dutton (Vice Chair)
- Harjinder Kang
- Paramjit Gill
- Michael Hoare (Non-Executive Director designate)

Remuneration for the Trust's Executive Directors is set by reference to job scope, personal responsibility and performance, and taking into account comparison with remuneration levels for similar posts, both within the National Health Service and the local economy. Whilst performance is taken into account in setting and reviewing remuneration, there are 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 2015/2016 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 2015/16, the composition of the Board members also changed; Executive Director Raffaela Goodby was appointed as an employee of the Trust on 1st December 2015.

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.

Raffaela Goodby, Director of Organisation Development.

Richard Samuda, Trust Chairman.

SALARIES AND ALLOWANCES OF SENIOR MANAGERS								
	2015-16				2014-15			
Name and Title	(a) Salary (bands of £5,000) £000	(b) Expenses payments (taxable) to nearest £00	(c) All pension related benefits (bands of £2,500) £000	(d) Total all payments and benefits (bands of £5,000) £000	(a) Salary (bands of £5000) £000	(b) Expenses payments (taxable) to nearest £100 £00	(c) All pension related benefits (bands of £2,500) £000	(d) Total all payments and benefits (bands of £5,000) £000
Richard Samuda, Chair	20-25	32	0	25-30	20-25	47	0	25-30
Olwen Dutton, Non Executive Director (Vice Chair)	5-10	0	0	5-10	5-10	0	0	5-10
Robin Russell, Non Executive Director (from 1/6/15)	5-10	0	0	5-10	0	0	0	0
Waseem Zaffar, Associate Non Executive Director (from 1/6/15)	5-10	0	0	5-10	0	0	0	0
Gianjeet Hunjan, Non Executive Director (until 16/8/15)	0-5	0	0	0-5	5-10	0	0	5-10
Sarindar Singh Sahota, Non Executive Director (until 1/8/15)	0-5	0	0	0-5	5-10	0	0	5-10
Harjinder Kang, Non Executive Director	5-10	0	0	5-10	5-10	0	0	5-10
Paramjit Gill Non Executive Director (from 14/4/14)	5-10	0	0	5-10	5-10	0	0	5-10
Michael Hoare, Non Executive Director Designate	5-10	0	0	5-10	5-10	0	0	5-10
Toby Lewis, Chief Executive	175-180	0	62.5-65.0	240-245	175-180	0	40-42.5	220-225
Antony Waite, Director of Finance & Performance Management	135-140	0	32.5-35.0	170-175	135-140	0	0	135-140
Colin Ovington, Chief Nurse	110-115	0	17.5-20.0	130-135	110-115	0	72.5-75	185-190
Roger Stedman, Medical Director*	165-170		17.5-20.0	185-190	170-175		42.5-45	215-220
Rachel Barlow, Chief Operating Officer	105-110	0	30.0-32.5	140-145	105-110	0	10-12.5	120-125
Mike Sharon, Director of Strategy & Organisational Development (until 2/4/14/14)	0	0	0	0	10-15	0	5-7.5	15-20
Kam Dhami, Director of Governance	95-100	0	25.0-27.5	125-130	95-100	0	7.5-10	105-110
Raffaela Goodby Director of Organisation Development (from 11/2/15) - (See Note 1)	95-100	0	10.0-12.5	110-115	10-15	0	0	10-15

Notes to Salaries and Allowances of Senior Managers

1. Raffaela Goodby was seconded to the Trust for the period 11/2/15 to 30/11/15 at which point the appointment was made on a substantive basis and employed direct by the Trust. The payments listed under salary represent the total salary paid during 2015/16 without any additional costs. The invoiced cost incurred by the Trust while employed at Birmingham City Council for the period 1/4/15 to 30/11/15, inclusive of National Insurance and VAT was in the banding £95k-100k. Salary received during direct employment with the Trust from 1/12/15 to 31/3/16 was in the band £30-35k
2. Non-Executive Directors - do not receive pensionable remuneration and therefore do not accrue any pension related benefits.
3. 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.
4. The banded remuneration listed for Roger Stedman, Medical Director, is solely for that role and there is no remuneration for Clinical Duties.

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.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Real Increase in CETV

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

PENSION BENEFITS								
Name and title	**Real increase in pension at age 60**	**Real increase in Lump sum at pension age**	**Total accrued pension at pension age at 31st March 2016**	**Lump sum at pension age related to accrued pension at 31st March 2016**	**Cash Equivalent Transfer Value at 31st March 2016**	**Cash Equivalent Transfer Value at 31st March 2015**	**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	2.5-5.0	0	40-45	120-125	609	639	0	0
Antony Waite, Director of Finance & Performance Management	0-2.5	0-2.5	45-50	135-140	844	783	52	0
Colin Ovington, Chief Nurse	0-2.5	0-2.5	50-55	160-165	1080	1043	25	0
Roger Stedman, Medical Director	0-2.5	0	40-45	115-120	675	663	3	0
Rachel Barlow, Chief Operating Officer	0-2.5	0	30-35	90-95	491	468	17	0
Kam Dhami, Director of Governance	0-2.5	0	30-35	95-100	529	508	15	0
Raffaela Goodby, Director of Workforce & Organisation Development (from 11 February 2015) - Pension Scheme Member from 1 December 2015	0-2.5	0	0-5	0	4	0	4	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 banded remuneration of the highest paid director in the Trust in the 2015/16 was £180,000 (2014/15, £180,000). This was seven times (2014/15, seven) the median remuneration of the workforce, which was £25,298 (2014/15, £26,974).

In 2015/16, five (2014/15, eight) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £190,000 to £275,000 (2014/15, £180,000 to £215,000)

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 6879, and the change in average number of WTE employed across the year was a reduction of 231. The change in WTE employed from March 2015 to March 2016 was a reduction of 98. 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 2014/15 and 2015/16 by 27% (from £213,556 to £272.256,). However, this includes elements of pay that 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 2015/16 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 as of 31 March 2016, for more than £220 per day and that last longer than six months

	Number
Number of existing engagements as at 31 March 2016	6
Of which, the number that have existed:	
for less than 1 year at the time of reporting	0
for between 1 and 2 years at the time of reporting	0
for between 2 and 3 years at the time of reporting	1
for greater than 3 years	5

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.

There were no new off payroll engagements during 2015/16 of more than £220 per day lasting longer than six months.

There are no off payroll engagements of Board members or senior officials with significant financial responsibility between 01 April 2015 and 31 March 2016, however a Board member was seconded from Birmingham City Council from 11 February 2015 until 30th November 2015 at which point the individual was employed directly by the Trust.

The Trust continues to make progress to reduce the number of non substantive (agency, bank and other off payroll engagements) staff it uses from 9 in 2014/15 to 6 in 2014/15, i.e a reduction of 33%.

Staff Numbers - number of employees under contract service

	2015-16			2014-15
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	**799**	726	73	805
Ambulance staff	**0**	0	0	0
Administration and estates	**1,341**	1,213	128	1,469
Healthcare assistants and other support staff	**1,775**	1,537	238	1,847
Nursing, midwifery and health visiting staff	**2,250**	1,887	363	2,245
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**714**	683	31	744
Social Care Staff	**0**	0	0	0
Healthcare Science Staff	**0**	0	0	0
Other	**0**	0	0	0
TOTAL	**6,879**	**6,046**	**833**	7,110
Of the above - staff engaged on capital projects	**46**	26	20	25

Exit Packages

Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	**Cost of compulsory redundancies**	**Number of other departures agreed**	**Cost of other departures agreed.**	**Total number of exit packages**	**Total cost of exit packages**	**Number of Departures where special payments have been made**	**Cost of special payment elemer included in exi packages**
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**	**£**
Less than £10,000	1	7,166	0	0	**1**	**7,166**	0	
£10,000-£25,000	2	31,743	0	0	**2**	**31,743**	0	
£25,001-£50,000	2	71,404	1	40,770	**3**	**112,174**	0	
£50,001-£100,000	3	220,426	0	0	**3**	**220,426**	0	
£100,001 - £150,000	3	379,312	0	0	**3**	**379,312**	0	
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	
>£200,000	0	0	0	0	**0**	**0**	0	
Total	**11**	**710,051**	**1**	**40,770**	**12**	**750,821**	**0**	

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions 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.

Exit Packages (cont)

	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	1	41
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval*	0	0
Total	1	41

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

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 7.4 which will be the number of individuals.

*includes any non-contractual severance payment made following judicial mediation, and amounts relating to non-contractual payments in lieu of notice.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report

Our workforce

During 2015/16 the Trust delivered the second phase of it's workforce change programme, Safe and Sound. This programme has the ambition of delivering the best integrated services whilst being affordable and efficient. The Trust is committed to maintaining safe staffing levels and preparing the organisation for the future in terms of its staffing levels, skills, knowledge and competence. During the past year the organisation has reduced its establishment by 204 whole time equivelant (WTE) posts. This meant that the majority of colleagues were deployed in to new roles inside or outside our Trust and a small number of colleagues remain in trial periods or are at risk of redundancy. All changes were implemented in line with our organisational change policy and included statutory consultation.

Health and wellbeing

Sickness absence remains above the Trust's target with a year end figure of 4.9% which is a slight decrease on last year's figure. The past year has seen some of the clinical groups develop a strong grip on sickness, and robust executive leadership is now in place by the Director of Organisation Development. Surgery B remain as the leaders in managing sickness, with significant progress made by Community and Therapies and Imaging to improving their position in the past 12 months. The Flu Jab Campaign was the most successful in the region with 73.3% of our patient facing staff taking up the free flu jab, against a national average of frontline healthcare workers of 50.8% The campaign has won national awards and been featured as a positive case study on the NHS Employers Website. 'Flu Fighter Fred' was an honoured guest at the annual staff awards and the work of the Occupational Health Team and the peer vaccinator programme was recognised and celebrated. The Trust continue to focus on healthy eating and wellbeing campaigns including the 'Go Green' campaign which has reduced the number of chips sold in the Trust by half in the past 12 months. This will continue to be a focus in 2016/17 as an important contribution to the health and wellbeing of our workforce.

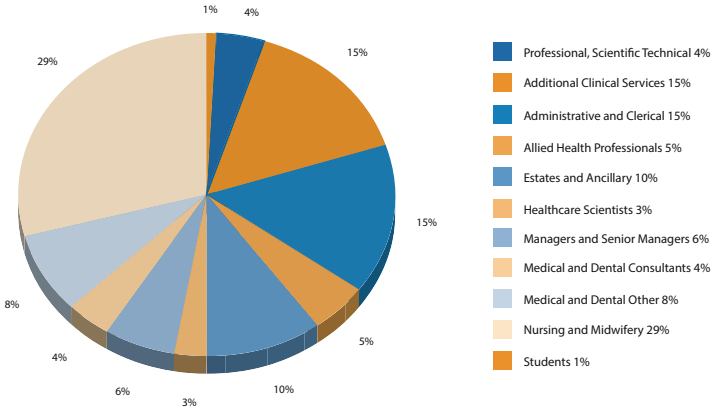
Staff safety and security

The safety and security of our workforce has been a key focus for us in 2015/16 with a small number of unfortunate and serious incidents of violence against our staff. The Trust responded taking each incident seriously and have issued over 3000 personal attack alarms, implemented protected 'night time worker' car parks, installed new lighting in our car parks for patients and staff, held a 'shared learning topic' on personal safety in January that over 1800 staff took part in, as well as offered personal support from our award winning in house Security Team for their work with the Trust. The Security Team received an award from the Chairman and Chief Executive for their bravery and for providing an excellent service to the Trust.

Gareth Hughes, Ernie Holmes, Chris Rickards, Dale McPhee and Estelle Greenwood get their hands dirty at the Greenhouse Renovation event with Lloyds Bank. The greenhouses at City Hospital have been renovated by local residents with support from volunteers from the Trust and elsewhere.

Ben Mears, the Trust's new Security Manager. The Trust has invested in improving the safety and security of our workforce.

Workforce Profile 2015/16



Our workforce is typical of most NHS provider organisations with female staff making up the majority of employees, in our case 76% of our workforce. 44% of colleagues have worked in our organisation for more than 10 years and only 16% of the workforce has less than 12 months service.

Workforce profile inc sex of directors and employees

	Male	Female
Directors	60%	40%
All Staff	22%	78%

Senior managers by band

Band 8 - Range A	58
Band 8 - Range B	21
Band 8 - Range C	21
Band 8 - Range D	12
Band 9	7
Chair	1
Directors & Chief Executive	10

Education plan

During this year the Trust developed and launched an ambitious three year education learning and development plan. The plan sets out the journey the Trust will take to becoming a learning organisation, working with education establishments, partners and community groups to commission and deliver learning opportunities to all of our 7000 colleagues. The aims and objectives are centered on attracting talented people to our Trust, induction and the first 100 days, developing and retaining skilled colleagues and how we develop senior leaders and specialists.

Appraisal and revalidation

SWBH are committed to appraising all of its workforce, including setting annual objectives and ensuring that each and every colleague has the opportunity for a personal development conversation with their line manager, to talk about learning for the year ahead.

Recruitment activity

During this year the Trust has undertaken a number of focused recruitment activities, including innovative approaches to nursing recruitment. The Trust have extended notice periods, implemented 'One Stop' recruitment days where offers are made and checks undertaken in a single session, offered a popular refer a friend scheme with financial incentives after a probationary period has been completed, guaranteed jobs for students who have completed their training with the Trust, streamlined the recruitment processes for all applicants as well as offering an internal recruitment first opportunity for our current workforce. The Trust has also focused on increasing our number of apprentices by working with local colleges, and offering accommodation to young people who are homless or at risk of homelessness in our Live and Work Project, which was visited by Prince William in December.

Sickness absence data and actions

Sickness absence remains a focus for the Trust and absence remains high at 4.83% in March 2016. The Trust has

The Trust's Flu Fighting team win the award for Digital and Social Media at the NHS Employers Flu Fighter Award ceremony 2016.

One of the Trust's newly qualified apprentices, Charles Matovu.

implemented a series of actions including a robust confirm and challenge process thorugh each clinical group and corporate directorate, a focus on return to work interviews which have increased dramatically over the year, a local sickness absence line where colleagues must call a central number to report their sickness, and a focus on applying the sickness absence procedure in cases of repeated absence that cannot be sustained by the Trust. There have also been a number of well being activities that have taken place to support colleagues in increasing their well being including walking clubs, holistic therapies, the launch of a new Musculoskeletal (MSK) service to offer fast advice and support to our staff.

Listening to our staff

We implement the largest staff survey programme, Your Voice, in the NHS, polling every member of staff four times a year. Your Voice asks for staff opinions through questions that generate a score for engagement, advocacy, motivation and involvement that can be compared by directorate. Each survey has an anonymous comments field so that staff can share their suggestions. This year the survey has improved its response by being available for completion on wards and in front line areas on iPads. The responses have informed the Trust's action plans on sickness, safety, security, education and learning as well as learning from incidents.

850 members of staff where invited to take part in the national staff survey. As expected, our response rate remains low, due to the extensive surveying programme that we run across our workforce. Our engagement score as reported by the national NHS staff survey is 3.77 compared to a national average for acute and community Trusts of 3.79.

- 95% of staff reported that their role makes a difference to patients
- No staff reported experiencing physical violence from staff in the past 12 months
- Staff rated the Trust as 3.88 for effective team working, compared to the national average of 3.77
- 25% of staff reported experiencing harassment, bullying or abuse from staff in the last 12 months, compared to 22% in 2014 and the national average of 24%
- 87% of staff reported that they believe the Trust provides equal opportunities for career progression or promotion, an improvement on the 2014 score of 83% and the same as the national average

Support for disabled employees

We are positive about disabled people and support staff with adjustments that will enable them to fulfil their job roles. We encourage staff to declare whether they have a disability. 175 employees have a recorded disability.

Apprentice programme

This past year has seen the launch and a subsequent award for a hugely successful and innovative apprenticeship scheme, created to help some of the disadvantaged youths in Sandwell and Birmingham. The Live and Work scheme saw the old nurses' accommodation at Sandwell Hospital undergo refurbishment, turning it into a living space for 27 homeless young people. This provides them with somewhere safe and affordable to live, and as part of the programme they are given an apprenticeship on site. The Trust approached St Basils – the largest youth homelessness charity in the Midlands – with the idea back in 2013, and with support from local councils and Health Education West Midlands it has come on in leaps and bounds. It's been so successful that the Trust was awarded the title Large Apprentice Employer of the Year and received a Special Recognition Award for the scheme at the Health Education England NHS Apprenticeship Recognition Awards 2016. Therapies Assistant Apprentice Juanita Grant was also commended as a Clinical Intermediate Apprentice of the Year, an excellent example of why this scheme is so important. The accolades also attracted royal attention and Prince William, a Patron of St Basils charity, visited Sandwell Hospital in December to meet the team and see the work that they do.

Equality, Diversity and Inclusion

We aim to consistently provide quality healthcare that meets the needs of our local communities and make sure that the services we offer are inclusive. Our staff work hard to create an environment which ensures equal access regardless of age, disability, gender, religion or belief, ethnic background, sexual orientation, gender reassignment, or socio-economic status. This year we launched our mutual respect and tolerance guidelines that set out clear standards of behaviour for staff, patients and visitors. We have been award winners in the Sandwell and West Birmingham Clinical Commissioning Group's Equality awards for our pioneering work in supporting young apprentices with hospital accommodation, whilst they learn and work as part of the SWBH family. Our organ donation team were finalists in this awards scheme, for their work at encouraging organ donation among diverse groups within the community where willingness to donate is low.

This year we ran our first monthly campaigns to raise awareness of protected characteristics, focussing on gender parity for International Women's Day and a programme of training for staff in deaf awareness and basic BSL. We will continue with our monthly themes throughout the year ahead. As a service provider, we ensure that the needs of our patients inform the provision and delivery of our services, with the adoption of the equality delivery system2 template. Our new volunteering programme has recruited many from our diverse population and we continue to work with community groups to offer volunteering and work experience opportunities. The Trust Board is committed to developing ever more consistent links into our local communities, working with voluntary sector, faith, and grassroots organisations. The developing role of the Trust charity has further established links between the Trust and local organisations. Sandwell Women's Aid is working in partnership with us, funded through the Trust charity, placing independent domestic violence advisors in the Emergency Department at Sandwell Hospital.

Shagaf Bakour, Consultant Obstetrician and Gynaecologist, making her pledge for International Women's Day in 2016.

Rakesh Bhatt, Hindu Chaplain at our multifaith blessing ceremony on our new hospital site on Grove Lane, Smethwick.

Sustainability Report 2015/16

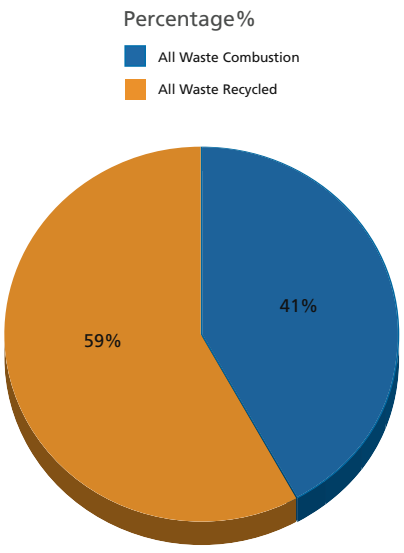
A sustainable health care system is achieved by delivering high quality care and improved public health without exhausting resources or causing excessive environmental damage. As a consumer of resources, Sandwell and West Birmingham Hospital NHS Trust recognise that we have a responsibility to work in a sustainable way, using those resources as wisely and efficiently as possible. Since 2011 we have been working to reduce our environmental impact through energy efficiency, water and waste reduction, staff engagement and other sustainable initiatives. We are working to deliver our Sustainability Action Plan and believe that Sustainability should be embedded in all areas of our organisation.

Gas - Compared with 2014/15 the Gas Consumption across the Trust has reduced by 5.2%. This has been due to a combination of measures, including the introduction of more efficient boilers.

Electricity - Compared with last year, electricity consumption has reduced by 0.9%. One of the major aims of the Trust has been to stabilise our electricity use and this has been achieved through the use of energy efficient technologies such as LED lighting, improved monitoring and staff engagement. The solar panels at Rowley Hospital and The Birmingham Midland Eye Centre also assist in reducing our consumption from the national grid.

Water – Water consumption has also stabilised and has shown a slight reduction this year. Water is essential in maintaining high levels of hygiene but through on-going improvements and the estate rationalisation plans it is hoped that water consumption will fall further.

Waste – Since 2014 the Trust has diverted all waste from landfill. 41% of the waste produced by the Trust, including clinical waste, is sent for incineration, with energy recovery. The remaining waste is recycled at a local facility. In addition we separately recycle cardboard, batteries and some metals. The amount of waste the Trust produces has remained stable, with a very slight decrease in volume of 0.4%



Our Sustainability Plans

As part of the Trust's Public Health Plan, in 2014 we set the following 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 have been achieved. Encouraged by this we have made further progress in improving sustainable travel, including more facilities for cyclist and trialling an electric vehicle. We also have a growing number of Sustainability Champions who help increase the awareness of sustainability throughout the Trust.

Birmingham Treatment Centre will continue to provide outpatient care, diagnostics and day case surgery when Midland Met opens.

Sandwell Hospital will remain and become the Sandwell Treatment Centre. An urgent care centre will be provided on the site. The Trust headquarters is here.

Rowley Regis Hospital is becoming a vibrant health care hub offering more convenient healthcare for local residents.

Leasowes Intermediate Care Centre provides rehabilitation services to help get people home from hospital.

Our finances and investments

Throughout the 2015/16 finance year the team at SWBH Trust has been focussed on ensuring delivery of the required performance levels across quality, safety, staff and financial. These four pillars of performance are interdependent and particularly critical as the Trust prepares for service provision in the context of the new Midland Met Hospital. The challenges facing the NHS are well documented nationally and have been experienced locally by the Trust. Therefore achievement of the required financial target, and one which is in line with the original plan, represents a significant achievement.

However, any celebration is muted given the challenge that faces the Trust in the new financial year. Operational pressures driven by A&E activity and delayed transfers of care continue to be compounded by challenges in recruiting certain staff groups. Managing these external pressures alongside delivery of the savings programme has resulted in slippage on the various cost saving schemes. Consequently the Trust's reported position does not reflect underlying operational performance and it is this that will be addressed in the coming financial year.

The 2016/17 financial year will be dominated by achieving underlying performance levels consistent with the service provision required for the Midland Met Hospital. It is likely that this will involve a financial performance that is below the level assumed for the MMH investment; a planned deficit position has been discussed by the Trust board. It is expected that the original financial performance trajectory that was envisaged as part of the MMH investment plan will not be recovered until the 2017/18 financial year.

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 2015/16 the Trust agreed an income and expenditure target surplus of £3.857m. This was amended during the year and set at a revised level of £5.006m. Achievement of this higher target was subject to resolution of factors beyond the direct control of the Trust. In the final instance these were not resolved in the Trust's favour and so the Trust has delivered a surplus of £3,857m in line with the original target surplus. On the basis of this performance the Trust has met its main budgetary objective of break even.
For the purpose of measuring statutory accounts performance, the Trust generated a surplus in year of £3.857m.

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 2015/16 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	2015/16	2014/15
	£000s	£000s
Income for Patient Activities	405,531	403,189
Income for Education, Training, Research & Other Income	38,167	43,401
Total Income	443,698	446,590
Pay Expenditure	(295,516)	(292,253)
Non Pay Expenditure including Interest Payable and Receivable	(147,586)	(144,427)
Public Dividend Capital (PDC) - Payment	(4,850)	(5,325)
Total Expenditure (Including Impairments and Reversals)	(447,952)	(442,005)
Surplus/(Deficit) per Statutory Accounts	(4,254)	4,585
Exclude Impairments and Reversals	8,390	(263)
Adjustment for elimination of Donated and Government Grant Reserves	(279)	331
Total Income	3,857	4,653

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 from plans. The scale of the divergence is such that the operational performance would have resulted in a deficit position rather than the reported surplus. Challenges to achieving the required level of operational performance throughout the year have been consistent and include elective capacity, interim staffing levels and inter-NHS charges for maternity activity. As a consequence of these factors capacity management in relation to theatre utilisation and ward staffing has been a focus of the business planning work undertaken in readiness for the 2016/17 financial year. This has been and will continue to be an organisational competency that is subject to review and challenge by the accountable officers and by the Board's Finance and Investment Committee.

CRL

Further detailed information on capital spend is shown below at 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 £19.860m for 2015/16, the Trust's capital expenditure was £19.820m, thereby undershooting by £0.040m 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 £1.217m, the Trust's cash flow financing was £1.431m, thereby undershooting by £0.214m 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 £443.698m in 2015/16 are shown below in Figure 6.2 which shows an overall decrease of £2.892m, 0.65%.

Income reduced from CCGs by £5.408m in respect of direct patient care, reflecting the change in funding arrangements for various Community Health activities that are now funded via the Local Authorities and as a consequence the Local Authority Income has increased by £5.585m. Other income sources were broadly stable and/or are too small to have a material impact on the financial performance of the Trust.

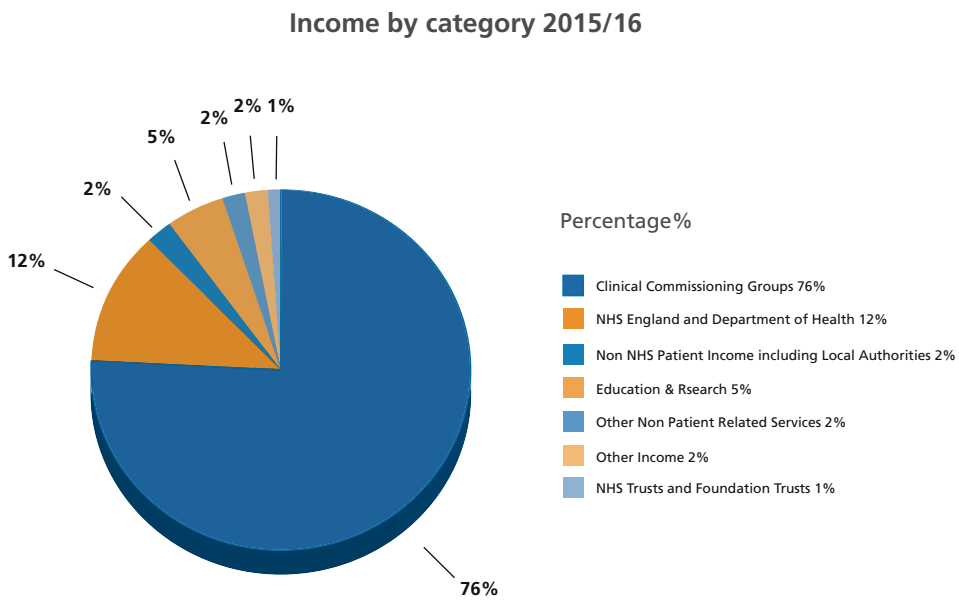
Figure 6.2

Sources of Income	2015/16	2014/15
	£000s	£000s
NHS England and Department of Health	53,895	53,706
NHS Trusts and Foundation Trusts	4,078	2,600
Clinical Commissioning Groups	338,649	344,057
NHS Other (including Public Health England and Prop Co)	1,605	1,107
Non NHS Patient Income including Local Authorities	7,304	1,719
Education & Research	20,028	21,005
Other Non-Patient Related Services	7,288	10,122
Other Income	10,851	12,274
Total Income	443,698	446,590

Within Figure 6.3, the pie chart below, the largest element 76% of the Trust's resources flowed directly from CCGs and 12% from NHS England 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.

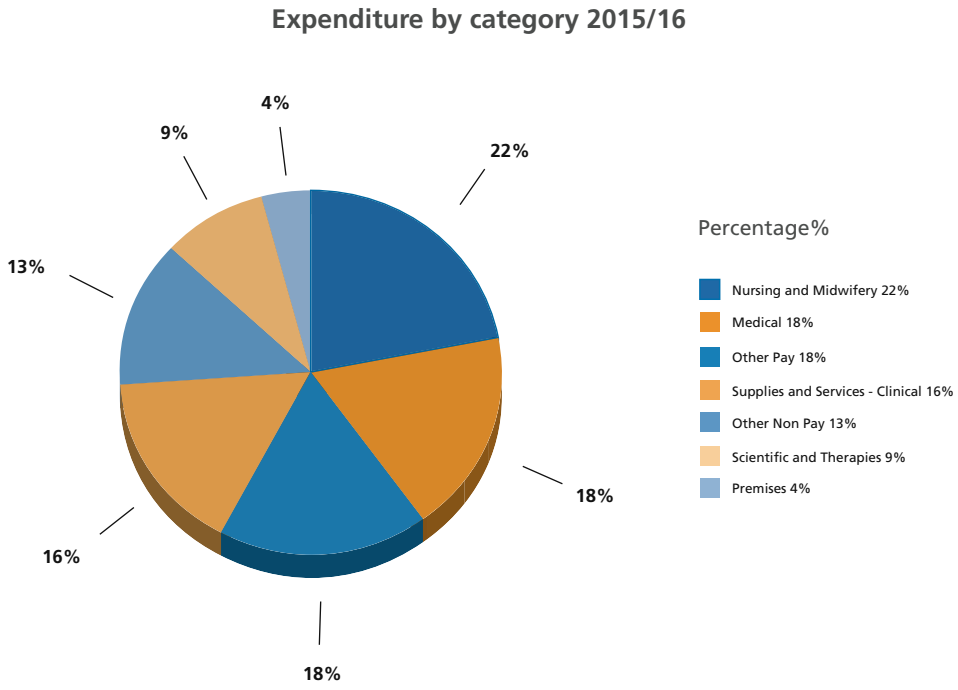
Figure 6.3



Expenditure

Figure 6.4, the pie chart below shows that 58% of the Trust's cost was pay and, within this, the three largest groups were nursing and midwifery 22%, medical staff 18% and scientific and therapeutic 9%. The remaining 42% of operational expenditure was non pay, the largest element of which was clinical supplies and services which included drug costs at 16%.

Figure 6.4

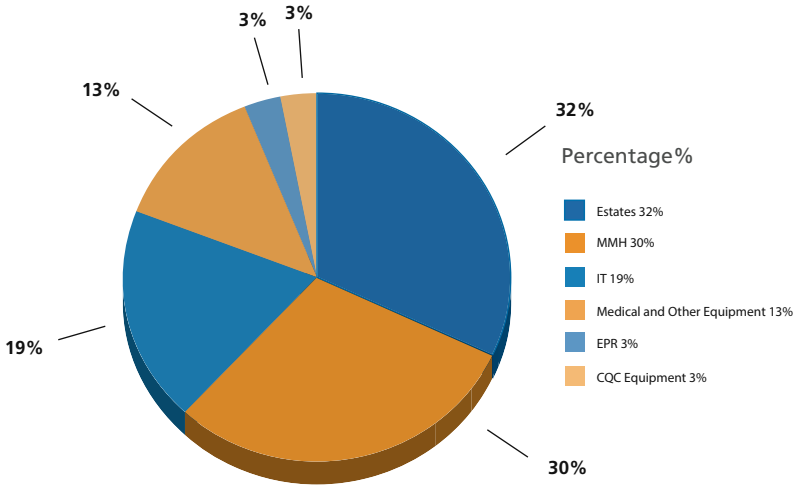


Use of Capital Resources

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 £19.820m on capital items during 2015/16. A breakdown of this expenditure is shown in the pie chart below.

Capital spend 2015/16

Figure 6.5



The Trust spent a significant proportion – 99.81% - of its capital budget on the Midland Metropolitan Hospital (MMH) and Estates. Specifically, £12.286m was spent on MMH and upgrading the Trust's Estate, including ensuring compliance with statutory standards. Medical and Other Equipment accounted for £2.547m while £0.660m was spent on equipment identified for clinical quality improvement. IT spend totalled £4.327m of which £0.580m was for the Electronic Patient Record system.

Staff Sickness

Staff sickness absence	2015	2014
Total days lost	69,941	66,120
Total staff years	6,201	6,492
Average working days lost	11.28	10.2

Staff sickness data will be provided on a national basis by DH for 2015/16 and covers the calendar year ended 31 December 2015 (31 December 2014 for prior year comparative data)

Audit

The Trust's External Auditors are KPMG LLP. They were appointed for 2014/15, 2015/16 and 2016/17 by the Audit Commission. Further to the demise of the Audit Commission, the Trust itself will take responsibility for the appointment of its auditors. 2017/18 will be the first years accounts affected by this change.

The cost of the work undertaken by the Auditor in 2015/16 was £122k including VAT. The fee in respect of auditing charitable fund accounts was excluded from this sum, but included £10k for audit of the Quality Accounts and a review of both Managed Equipment services and Midland Metropolitan business cases amounting to £12k.

As far as the Directors are aware, there is no relevant audit information of which the Trust's Auditors are unaware. In addition the Directors have taken all the steps they ought to have taken as directors to ensure they are 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 2016 were Robin Russell (Chair) and Olwen Dutton.

KPMG

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 2016 under the Local Audit and Accountability Act 2014. 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 and Staff 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 5 of the Local Audit and Accountability Act 2014. 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, the Accountable Officer 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.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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 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 and accounts 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.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice 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 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

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 2016 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

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit 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; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or

- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We have nothing to report in respect of the above responsibilities.

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 Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Bostock for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One Snowhill
Snow Hill Queensway
Birmingham B4 6GH
United Kingdom

2 June 2016

FINANCIAL STATEMENTS

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 these 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 the 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 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)
2/6/16

Anthony M Waite
(Director of Finance & Performance Management)
2/6/16

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	7.1	**(295,516)**	(292,253)
Other operating costs	5	**(145,715)**	(142,315)
Revenue from patient care activities	2	**405,531**	403,189
Other operating revenue	3	**38,167**	43,401
Operating surplus/(deficit)		**2,467**	12,022
Investment revenue	9	**136**	109
Other gains and (losses)	10	**50**	0
Finance costs	11	**(2,057)**	(2,221)
Surplus/(deficit) for the financial year		**596**	9,910
Public dividend capital dividends payable		**(4,850)**	(5,325)
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**(4,254)**	4,585

Other Comprehensive Income

	2015-16 £000s	2014-15 £000s
Impairments and reversals taken to the revaluation reserve	**(36,230)**	2,421
Net gain/(loss) on revaluation of property, plant & equipment	**0**	0
Net gain/(loss) on revaluation of intangibles	**0**	0
Net gain/(loss) on revaluation of financial assets	**0**	0
Other gain /(loss) (explain in footnote below)	**0**	0
Net gain/(loss) on revaluation of available for sale financial assets	**0**	0
Net actuarial gain/(loss) on pension schemes	**0**	0
Other pension remeasurements	**0**	0
Reclassification adjustments		
On disposal of available for sale financial assets	**0**	0
Total Other Comprehensive Income	**(36,230)**	2,421
Total comprehensive income for the year*	**(40,484)**	7,006

Financial performance for the year

Retained surplus/(deficit) for the year	**(4,254)**	4,585
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**1,368**	0
Impairments (excluding IFRIC 12 impairments)	**7,022**	(263)
Adjustments in respect of donated gov't grant asset reserve elimination	**(279)**	331
Adjustment re absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**3,857**	4,653

A Trust Reported NHS financial performance position is derived from its Retained Surplus/ (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. Where there is a positive financial consequence, the performance figures are not adjusted.

b) The Trust is required to revalue its Land and Buildings on a regular basis as a result of the IFRS implementation and this has resulted in an impairment of its Land and Buildings of £44.5m, £36.2m of which was absorbed by the Revaluation Reserve which has been built up over a number of years. However, an impairment of £8.3m has been recognised in the I&E account (represented as £7.0m impairments and £1.3m IFRIC12 impairments) 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 the Trust recording income of £0.527m. Income resulting from the application of this change which has no cash impact and is not chargeable for overall budgeting purposes is removed as a technical adjustment. In addition the revenue impact of depreciation, £0.248m, relating to Donated assets was previously offset by a release from the Donated Asset Reserve. Following revision to the reporting manuals this cost is charged to the Trusts expenditure without any offset. This is therefore not considered part of the Trusts operating position and is adjusted. The net impact of these two adjustments is reported above as a technical adjustment to the Financial Performance of the Trust of (£0.279m)

The notes on pages 95 to 125 form part of this account

Statement of Financial Position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	12	**196,381**	233,309
Intangible assets	13	**386**	677
Investment property		**0**	0
Other financial assets		**0**	0
Trade and other receivables	18.1	**846**	890
Total non-current assets		**197,613**	234,876
Current assets:			
Inventories	17	**4,096**	3,467
Trade and other receivables	18.1	**16,308**	17,128
Other financial assets		**0**	0
Other current assets		**0**	0
Cash and cash equivalents	19	**27,296**	28,382
Sub-total current assets		**47,700**	48,977
Non-current assets held for sale		**0**	0
Total current assets		**47,700**	48,977
Total assets		**245,313**	283,853
Current liabilities			
Trade and other payables	20	**(54,144)**	(46,761)
Other liabilities		**0**	0
Provisions	23	**(1,472)**	(4,502)
Borrowings	21	**(1,306)**	(1,017)
Other financial liabilities		**0**	0
DH revenue support loan	21	**0**	0
DH capital loan	21	**0**	(1,000)
Total current liabilities		**(56,922)**	(53,280)
Net current assets/(liabilities)		**(9,222)**	(4,303)
Total assets less current liabilities		**188,391**	230,573
Non-current liabilities			
Trade and other payables	20	**0**	0
Other liabilities		**0**	0
Provisions	23	**(3,095)**	(2,986)
Borrowings	21	**(25,591)**	(26,898)
Other financial liabilities		**0**	0
DH revenue support loan	21	**0**	0
DH capital loan	21	**0**	0
Total non-current liabilities		**(28,686)**	(29,884)
Total assets employed:		**159,705**	200,689
FINANCED BY:			
Public Dividend Capital		**161,710**	162,210
Retained earnings		**(17,993)**	(13,758)
Revaluation reserve		**6,930**	43,179
Other reserves		**9,058**	9,058
Total Taxpayers' Equity:		**159,705**	200,689

The notes on pages 95 to 125 form part of this account

The financial statements on page 91 to 94 were approved by the Board on 2/6/16 and signed on it's behalf by

Chief Executive: 

Date: 2/6/16

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**162,210**	**(13,758)**	**43,179**	**9,058**	**200,689**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year		(4,254)			**(4,254)**
Net gain / (loss) on revaluation of property, plant, equipment			0		**0**
Net gain / (loss) on revaluation of intangible assets			0		**0**
Net gain / (loss) on revaluation of financial assets			0		**0**
Net gain / (loss) on revaluation of available for sale financial			0		**0**
Impairments and reversals			(36,230)		**(36,230)**
Other gains/(loss) (provide details below)				0	**0**
Transfers between reserves		19	(19)	0	**0**
Reclassification Adjustments					
Transfers between Reserves in respect of assets transferred under absorption	0	0	0	0	**0**
On disposal of available for sale financial assets			0		**0**
Reserves eliminated on dissolution		0	0	0	**0**
Originating capital for Trust established in year	0				**0**
Permanent PDC received - cash	0				**0**
Permanent PDC repaid in year	(500)				**(500)**
PDC written off	0	0			**0**
Transfer due to change of status from Trust to Foundation Trust	0	0	0	0	**0**
Other movements	0	0	0	0	**0**
Net actuarial gain/(loss) on pension				0	**0**
Other pensions remeasurement				0	**0**
Net recognised revenue/(expense) for the year	**(500)**	**(4,235)**	**(36,249)**	**0**	**(40,984)**
Balance at 31 March 2016	**161,710**	**(17,993)**	**6,930**	**9,058**	**159,705**
Balance at 1 April 2014	**161,640**	**(19,484)**	**41,899**	**9,058**	**193,113**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year		4,585			4,585
Net gain / (loss) on revaluation of property, plant, equipment			0		0
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			2,421		2,421
Other gains / (loss)				0	0
Transfers between reserves		1,141	(1,141)	0	0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource	0	0	0	0	0
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under absorption		0	0		0
On disposal of available for sale financial assets			0		0
Originating capital for Trust established in year	0				0
New temporary and permanent PDC received - cash	570				570
New temporary and permanent PDC repaid in year	0				0
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension				0	0
Other pension remeasurement				0	0
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**

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**2,467**	12,022
Depreciation and amortisation	5	**12,946**	13,363
Impairments and reversals	14	**8,390**	(263)
Other gains/(losses) on foreign exchange	10	**0**	0
Donated Assets received credited to revenue but non-cash	3	**(527)**	(51)
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest paid		**(2,011)**	(2,221)
PDC Dividend (paid)/refunded		**(4,607)**	(5,170)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**(629)**	(195)
(Increase)/Decrease in Trade and Other Receivables		**864**	391
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**10,270**	(10,383)
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions utilised		**(3,139)**	(3,331)
Increase/(Decrease) in movement in non cash provisions		**199**	185
Net Cash Inflow/(Outflow) from Operating Activities		**24,223**	4,347
Cash Flows from Investing Activities			
Interest Received		**136**	109
(Payments) for Property, Plant and Equipment		**(22,925)**	(15,388)
(Payments) for Intangible Assets		**(53)**	0
(Payments) for Investments with DH		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**50**	0
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Investment with DH		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(22,792)**	(15,279)
Net Cash Inform / (outflow) before Financing		**1,431**	(10,932)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received		**0**	570
Gross Temporary (2014/15 only) and Permanent PDC Repaid		**(500)**	0
Loans received from DH - New Capital Investment Loans		**0**	0
Loans received from DH - New Revenue Support Loans		**0**	0
Other Loans Received		**0**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(1,000)**	(2,000)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**0**	0
Other Loans Repaid		**0**	0
Cash transferred to NHS Foundation Trusts or on dissolution		**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(1,017)**	(1,064)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**(2,517)**	(2,494)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(1,086)**	(13,426)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**28,382**	41,808
Effect of exchange rate changes in the balance of cash held in foreign currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**19**	**27,296**	28,382

NOTES TO THE ACCOUNTS

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 2015-16 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 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 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. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Board of Sandwell and West Birmingham Hospitals NHS Trust acts as a corporate Trustee for the Charitable Funds, however it has confirmed that the Charitable Funds are not material to the Trust accounts and has therefore not consolidated.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS 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.

1.5.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS 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 IAS 27 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 2015 / 2016 were £1.161m and total resources expended were £1.918m which are only 0.43% of the Trust's Exchequer Funds.

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 2015-16.

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

PFI Asset Valuation

From 1st April 2015, the Trust has accounted for the Valuation of its PFI Hospital (BTC) on the basis of Depreciated Replacement Cost excluding VAT. When determining the change in treatment, the Trust sought advice from its appointed VAT Advisors to confirm the appropriateness of its judgement.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.5.2 Key sources of estimation uncertainty

Property Valuation

Assets relating to land and buildings were subject to a formal valuation at 1st April 2015, completed on an 'alternate MEA' basis. An Existing Use Value alternative MEA approach was used which assumes the asset would be replaced with a modern equivalent, i.e. not a building of identical design - but with the same service potential as the existing assets. The alternative modern equivalent asset may well be smaller (reduced Gross Internal Area) than the existing asset which reflects the challenges Healthcare Providers face when utilising historical NHS Estate. A subsequent valuation was performed at 31st March 2016 to ensure a true and fair view was reflected.

1.6 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 NHS 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.

1.7 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.

1.8 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.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.9 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.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

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.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.9 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.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

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
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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.

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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.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.16 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.16 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.

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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.

Notes to the Accounts - 1. Accounting Policies (Continued)

Other assets contributed by the NHS trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the NHS trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.17 Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.18 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.

1.19 Provisions
Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS 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 0.80% in real terms (1.37% 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.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.20 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 NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 23

1.21 Non-clinical risk pooling

The NHS 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.

1.22 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.

1.23 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 NHS 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 NHS 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.

1.24 Financial assets

Financial assets are recognised when the NHS 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 NHS 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

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

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 NHS 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.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.25 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the NHS 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 amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets* ; and

● The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

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 NHS 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.

1.26 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.

1.27 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.

1.28 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 32 to the accounts

Notes to the Accounts - 1. Accounting Policies (Continued)

1.29 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS 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.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.30 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 their own risks (with insurance premiums then being included as normal revenue expenditure).

1.31 Subsidiaries

Material entities over which the NHS trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.32 Associates

Material entities over which the NHS trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the NHS trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the NHS trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the NHS trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.33 Joint arrangements

Material entities over which the NHS trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the NHS body is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method

1.34 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 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.

1.35 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	**629**	162
NHS England	**53,199**	53,706
Clinical Commissioning Groups	**338,649**	344,057
Foundation Trusts	**3,449**	2,438
Department of Health	**196**	0
NHS Other (including Public Health England and Prop Co)	**1,303**	1,107
Additional income for delivery of healthcare services	**500**	0
Non-NHS:		
Local Authorities	**5,640**	0
Private patients	**159**	193
Overseas patients (non-reciprocal)	**192**	230
Injury costs recovery	**1,283**	1,175
Other	**332**	121
Total Revenue from patient care activities	**405,531**	403,189

3. Other operating revenue

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	**0**	714
Patient transport services	**166**	259
Education, training and research	**20,028**	21,005
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure -non- NHS	**0**	36
Receipt of donations for capital acquisitions - Charity	**527**	51
Support from DH for mergers	**0**	**0**
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**6,595**	9,062
Income generation (Other fees and charges)	**6,544**	4,766
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**0**	0
Other revenue	**4,307**	7,508
Total Other Operating Revenue	**38,167**	43,401
Total operating revenue	**443,698**	446,590

4. Overseas Visitors Disclosure

	2015-16 £000	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**192**	230
Cash payments received in-year (re receivables at 31 March 2015)	**98**	11
Cash payments received in-year (iro invoices issued 2015-16)	**33**	43
Amounts added to provision for impairment of receivables (re receivables at 31 March 2015)	**0**	0
Amounts added to provision for impairment of receivables (iro invoices issued 2015-16)	**162**	187
Amounts written off in-year (irrespective of year of recognition)	**86**	162

5. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	**1,020**	573
Services from CCGs/NHS England	**0**	86
Services from other NHS bodies	**2,146**	2,736
Services from NHS Foundation Trusts	**7,434**	7,401
Total Services from NHS bodies*	**10,600**	10,796
Purchase of healthcare from non-NHS bodies	**1,596**	1,438
Purchase of Social Care	**0**	
Trust Chair and Non-executive Directors	**66**	85
Supplies and services - clinical	**71,033**	73,094
Supplies and services - general	**6,485**	5,819
Consultancy services	**852**	2,230
Establishment	**3,884**	4,764
Transport	**1,527**	1,619
Service charges - ON-SOFP PFIs and other service concession arrangements	**863**	1,006
Service charges - On-SOFP LIFT contracts	**0**	0
Total charges - Off-SOFP PFIs and other service concession arrangements	**0**	0
Total charges - Off-SOFP LIFT contracts	**0**	0
Business rates paid to local authorities	**1,299**	1,799
Premises	**16,207**	16,801
Hospitality	**0**	0
Insurance	**110**	98
Legal Fees	**49**	191
Impairments and Reversals of Receivables	**515**	(9)
Inventories write down	**57**	50
Depreciation	**12,714**	13,126
Amortisation	**232**	237
Impairments and reversals of property, plant and equipment	**8,278**	(263)
Impairments and reversals of intangible assets	**112**	0
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Internal Audit Fees	**197**	193
Audit fees	**91**	133
Other auditor's remuneration - Taxation	**8**	0
Other auditor's remuneration - Other	**19**	7
Clinical negligence	**6,476**	6,676
Research and development (excluding staff costs)	**242**	297
Education and Training	**1,206**	1,102
Change in Discount Rate	**(23)**	(14)
Other	**1,020**	1,040
Total Operating expenses (excluding employee benefits)	**145,715**	142,315
Employee Benefits		
Employee benefits excluding Board members	**294,183**	291,090
Board members	**1,333**	1,163
Total Employee Benefits	**295,516**	292,253
Total Operating Expenses	**441,231**	434,568

*Services from NHS bodies does not include expenditure which falls into a category below

6. Operating Leases

6.1. Sandwell and West Birmingham Hospitals NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense					
Minimum lease payments				**138**	90
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**138**	90
Payable:					
No later than one year	18	0	113	**131**	98
Between one and five years	73	0	143	**216**	153
After five years	146	0	0	**146**	117
Total	**237**	**0**	**256**	**493**	368
Total future sublease payments expected to be received:				0	0

7. Employee benefits and staff numbers

7.1. Employee benefits

	2015-16		
	Total £000s	**Permanently employed £000s**	**Other £000s**
Employee Benefits - Gross Expenditure			
Salaries and wages	**253,134**	212,148	40,986
Social security costs	**18,800**	17,587	1,213
Employer Contributions to NHS BSA - Pensions Division	**26,766**	25,843	923
Other pension costs	**0**	0	0
Termination benefits	**0**	0	0
Total employee benefits	**298,700**	**255,578**	**43,122**
Employee costs capitalised	**3,184**	1,586	1,598
Gross Employee Benefits excluding capitalised costs	**295,516**	**253,992**	**41,524**

Employee Benefits - Gross Expenditure 2014-15	**Total £000s**	**Permanently employed £000s**	**Other £000s**
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
Other pension costs	0	0	0
Termination benefits	79	79	0
TOTAL - including capitalised costs	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

7.2. Staff Numbers

	2015-16			2014-15
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	**799**	726	73	805
Ambulance staff	**0**	0	0	0
Administration and estates	**1,341**	1,213	128	1,469
Healthcare assistants and other support staff	**1,775**	1,537	238	1,847
Nursing, midwifery and health visiting staff	**2,250**	1,887	363	2,245
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**714**	683	31	744
Social Care Staff	**0**	0	0	0
Healthcare Science Staff	**0**	0	0	0
Other	**0**	0	0	0
TOTAL	**6,879**	**6,046**	**833**	7,110
Of the above - staff engaged on capital projects	**46**	26	20	25

7.3. Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	69,941	66,120
Total Staff Years	6,201	6,492
Average working Days Lost	11.28	10.18

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	**4**	7
	£000s	£000s
Total additional pensions liabilities accrued in the year	**201**	468

7.4. Exit Packages agreed in 2015-16

2015-16

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	1	7,166	0	0	**1**	**7,166**	0	0
£10,000-£25,000	2	31,743	0	0	**2**	**31,743**	0	0
£25,001-£50,000	2	71,404	1	40,770	**3**	**112,174**	0	0
£50,001-£100,000	3	220,426	0	0	**3**	**220,426**	0	0
£100,001 - £150,000	3	379,312	0	0	**3**	**379,312**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**11**	**710,051**	**1**	**40,770**	12	750,821	**0**	**0**

2014-15

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	1	1,395	0	0	**1**	**1,395**	0	0
£10,000-£25,000	1	13,377	0	0	**1**	**13,377**	0	0
£25,001-£50,000	0	0	0	0	**0**	**0**	0	0
£50,001-£100,000	1	64,142	0	0	**1**	**64,142**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**3**	**78,914**	**0**	**0**	3	78,914	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions 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.

7.5. Exit packages - Other Departures analysis

	2015-16 Agreements	Total value of agreements	2014-15 Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	1	41	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	1	41	0	0
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

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

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 7.4 which will be the number of individuals.

*includes any non-contractual severance payment made following judicial mediation, and amounts relating to non-contractual payments in lieu of notice.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

7.6. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that 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 scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) 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 scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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. These accounts can be viewed on the NHS Pensions website and are published annually. 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 schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed 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.

8. Better Payment Practice Code

8.1. Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**112,909**	**157,420**	121,899	154,330
Total Non-NHS Trade Invoices Paid Within Target	**99,996**	**138,820**	111,495	141,219
Percentage of Non-NHS Trade Invoices Paid Within Target	**88.56%**	**88.18%**	91.47%	91.50%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,022**	**28,228**	3,787	**27,132**
Total NHS Trade Invoices Paid Within Target	**1,449**	**18,762**	2,903	**20,812**
Percentage of NHS Trade Invoices Paid Within Target	**71.66%**	**66.47%**	76.66%	76.71%

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.

8.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	**2**	0
Total	**2**	0

9. Investment Revenue

	2015-16 £000s	2014-15 £000s
Interest revenue		
Bank interest	**136**	109
Total investment revenue	**136**	109

10. Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**50**	0
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	0
Total	**50**	0

11. Finance Costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	**4**	21
Interest on obligations under finance leases	**0**	3
Interest on obligations under PFI contracts:		
- main finance cost	**1,391**	1,437
- contingent finance cost	**618**	710
Interest on late payment of commercial debt	**2**	0
Total interest expense	**2,015**	2,171
Other finance costs	**0**	0
Provisions - unwinding of discount	**42**	50
Total	**2,057**	2,221

12.1. Property, plant and equipment

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	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	£000's
Cost or valuation:									
At 1 April 2015	37,740	160,654	922	6,303	101,421	3,833	27,362	1,997	**340,232**
Additions of Assets Under Construction				5,855					**5,855**
Additions Purchased	0	5,958	0		3,155	0	4,327	0	**13,440**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	527	0	0	0	**527**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	0	**0**
Additions Leased (including PFI/LIFT)	0	472	0		0	0	0	0	**472**
Reclassifications	0	2,797	(922)	(1,875)	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(3,572)	0	0	0	**(3,572)**
Upward revaluation/positive indexation	(7,446)	(6,580)	0	0	0	0	0	0	**(14,026)**
Impairment/reversals charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Impairments/reversals charged to reserves	(13,654)	(22,576)	0	0	0	0	0	0	**(36,230)**
At 31 March 2016	**16,640**	**140,725**	**0**	**10,283**	**101,531**	**3,833**	**31,689**	**1,997**	**306,698**
Depreciation									
At 1 April 2015	0	0	0		80,792	3,119	21,552	1,460	**106,923**
Reclassifications	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		(3,572)	0	0	0	**(3,572)**
Upward revaluation/positive indexation	(7,446)	(6,580)	0		0	0	0	0	**(14,026)**
Impairments/reversals charged to operating expenses	7,446	832	0		0	0	0	0	**8,278**
Charged During the Year	0	5,748	0		4,780	176	1,909	101	**12,714**
At 31 March 2016	**0**	**0**	**0**	**0**	**82,000**	**3,295**	**23,461**	**1,561**	**110,317**
Net Book Value at 31 March 2016	**16,640**	**140,725**	**0**	**10,283**	**19,531**	**538**	**8,228**	**436**	**196,381**
Asset financing:									
Owned - Purchased	16,640	120,940	0	10,283	18,563	538	8,227	436	**175,627**
Owned - Donated	0	325	0	0	968	0	1	0	**1,294**
Owned - Government Granted	0	842	0	0	0	0	0	0	**842**
On-SOFP PFI contracts	0	18,618	0	0	0	0	0	0	**18,618**
Total at 31 March 2016	**16,640**	**140,725**	**0**	**10,283**	**19,531**	**538**	**8,228**	**436**	**196,381**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	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	£000's
At 1 April 2015	18,338	24,377	438	0	26	0	0	0	**43,179**
Movements (specify)	(13,654)	(22,138)	(438)	0	(19)	0	0	0	**(36,249)**
At 31 March 2016	**4,684**	**2,239**	**0**	**0**	**7**	**0**	**0**	**0**	**6,930**

Additions to Assets Under Construction in 2015-16

Land	0
Buildings excl Dwellings	5,855
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**5,855**

12.2. Property, plant and equipment prior-year

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	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	£000's
Cost or valuation:									
At 1 April 2014	44,171	167,905	967	0	99,496	3,712	25,061	1,992	**343,304**
Additions of Assets Under Construction				6,303					**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	0	51	0	0	0	**51**
Additions Leased (including PFI/LIFT)	0	206	0		0	0	0	0	**206**
Disposals other than for sale	0	0	0	0	(2,169)	0	(63)	0	**(2,232)**
Revaluation	(6,816)	(13,724)	(69)	0	0	0	0	0	**(20,609)**
Reversal of Impairments charged to reserves	385	2,012	24	0	0	0	0	0	**2,421**
At 31 March 2015	**37,740**	**160,654**	**922**	**6,303**	**101,421**	**3,833**	**27,362**	**1,997**	**340,232**
Depreciation									
At 1 April 2014	7,261	6,856	13	0	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)**
Revaluation	(6,816)	(13,724)	(69)		0	0	0	0	**(20,609)**
Impairments/negative indexation charged to operating expenses	0	1,273	12	0	0	0	0	0	**1,285**
Reversal of Impairments charged to operating expenses	(445)	(1,103)	0	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**	**0**	**80,792**	**3,119**	**21,552**	**1,460**	**106,923**
Net Book Value at 31 March 2015	**37,740**	**160,654**	**922**	**6,303**	**20,629**	**714**	**5,810**	**537**	**233,309**
Asset financing:									
Owned - Purchased	37,740	139,344	922	6,303	19,902	714	5,810	537	**211,272**
Owned - Donated	0	394	0	0	727	0	0	0	**1,121**
Owned - Government Granted	0	951	0	0	0	0	0	0	**951**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	19,965	0	0	0	0	0	0	**19,965**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2015	**37,740**	**160,654**	**922**	**6,303**	**20,629**	**714**	**5,810**	**537**	**233,309**

12.3. Property, plant and equipment (cont)

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 1st April 2015. Valuation was undertaken with reference to the size, location and Service Potential of existing buildings and the basis on which they would be replaced by Modern Equivalent Assets. The Trust also revalued the property assets at 31st March 2016 to recognise any potential changes in indices since the 1st April 2015.

The Trust owns Non Operational Land assets which are currently held as surplus assets. These assets are required to be valued at 'Fair Value' in accordance with IFRS13. The valuation technique applied by the appointed Valuer in respect of all the Fair Value figures contained in his assessment was the market approach using prices and other relevant information generated by market transactions involving identical or comparable assets.

Asset lives for currently held assets are as follow:-

	Years
Buildings exc Dwellings	12 to 50
Plant & Machinery	0 to 10
Transport Equipment	0 to 6
Information Technology	0 to 9
Furniture and Fittings	0 to 9
Software Licences	0 to 5
Licences and Trademarks	0 to 1

13. Intangible non-current assets

13.1. Intangible non-current assets

2015-16	**IT - in-house & 3rd party software**	**Computer Licenses**	**Licenses and Trademarks**	**Patents**	**Development Expenditure - Internally Generated**	**Total**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
At 1 April 2015	**0**	**2,901**	**0**	**213**	**0**	**3,114**
Additions Purchased	0	53	0	0	0	**53**
Reclassifications	0	0	213	(213)	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
At 31 March 2016	**0**	**2,954**	**213**	**0**	**0**	**3,167**
Amortisation						
At 1 April 2015	**0**	**2,437**	**0**	**0**	**0**	**2,437**
Impairments/reversals charged to operating expenses	0	0	112	0	0	**112**
Charged During the Year	0	232	0	0	0	**232**
At 31 March 2016	**0**	**2,669**	**112**	**0**	**0**	**2,781**
Net Book Value at 31 March 2016	**0**	**285**	**101**	**0**	**0**	**386**
Asset Financing: Net book value at 31 March 2016 comprises:						
Purchased	0	285	101	0	0	**386**
Total at 31 March 2016	**0**	**285**	**101**	**0**	**0**	**386**
Revaluation reserve balance for intangible non-current assets						
						£000's
At 1 April 2015	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**

13.2. Intangible non-current assets prior year

2014-15	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:						
At 1 April 2014	0	2,901	0	185	0	3,086
Additions - purchased	0	0	0	28	0	28
At 31 March 2015	0	2,901	0	213	0	3,114
Amortisation						
At 1 April 2014	0	2,200	0	0	0	2,200
Charged during the year	0	237	0	0	0	237
At 31 March 2015	0	2,437	0	0	0	2,437
Net book value at 31 March 2015	0	464	0	213	0	677
Net book value at 31 March 2015 comprises:						
Purchased		464		213		677
Total at 31 March 2015	0	464	0	213	0	677

13.3. 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 2016.

14. Analysis of impairments and reversals recognised in 2015-16

	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	18,434
Changes in market price	(10,156)
Total charged to Annually Managed Expenditure	**8,278**
Total Impairments of Property, Plant and Equipment changed to SoCI	**8,278**
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	112
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**112**
Total Impairments of Intangibles charged to SoCI	**112**
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	**0**
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Financial Assets charged to SoCI	**0**
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total impairments of non-current assets held for sale charged to SoCI	**0**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**8,390**
Overall Total Impairments	**8,390**
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

14.1 Analysis of impairments and reversals recognised in 2015-16

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total
	£000s	£000s	£000s	£000s	**£000s**
Impairments and reversals taken to SoCI	0	0	0	0	
Loss or damage resulting from normal operations	0	0	0	0	**0**
Over-specification of assets	0	0	0	0	**0**
Abandonment of assets in the course of construction	0	0	0	0	**0**
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
	0	0	0	0	
Unforeseen obsolescence	0	112	0	0	**112**
Loss as a result of catastrophe	0	0	0	0	**0**
Other	18,434	0	0	0	**18,434**
Changes in market price	(10,156)	0	0	0	**(10,156)**
Total charged to Annually Managed Expenditure	**8,278**	**112**	**0**	**0**	**8,390**
Total Impairments of Property, Plant and Equipment changed to SoCI	**8,278**	**112**	**0**	**0**	**8,390**

Donated and Gov Granted Assets, included above	**£000s**
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**

15. Commitments

15.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment	**2,177**	1,749
Intangible assets	**0**	0
Total	**2,177**	1,749

16. Intra-Government and other balances

	Current receivables	**Non-current receivables**	**Current payables**	**Non-current payables**
	£000s	**£000s**	**£000s**	**£000s**
Balances with Other Central Government Bodies	1,173	0	6,584	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	32	0
Balances with NHS bodies inside the Departmental Group	10,314	0	11,756	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	4,821	846	37,078	25,591
At 31 March 2016	**16,308**	**846**	**55,450**	**25,591**
prior period:				
Balances with Other Central Government Bodies	1,286	0	3,625	0
Balances with Local Authorities	443	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS bodies inside the Departmental Group	11,156	0	9,500	0
Balances with Public Corporations and Trading Funds	0	0	0	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**

17. Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**1,584**	**1,710**	**0**	**173**	**0**	**0**	**3,467**	0
Additions	35,689	507	0	21	0	0	**36,217**	0
Inventories recognised as an expense in the period	(35,455)	0	0	(76)	0	0	**(35,531)**	0
Write-down of inventories (including losses)	(57)	0	0	0	0	0	**(57)**	0
Balance at 31 March 2016	**1,761**	**2,217**	**0**	**118**	**0**	**0**	**4,096**	**0**

The value of Consumables Inventories "Additions" and "recognised as an expense during the year" is not separable for the purpose of this note and shown as a net movement, however the value of adjustments to Consumable Inventory items is included within total expenditure in Note 5 of these Accounts

18.1. Trade and other receivables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS receivables - revenue	**10,372**	9,016	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	2,007	**0**	0
Non-NHS receivables - revenue	**3,665**	1,667	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,310**	2,802	**0**	0
PDC Dividend prepaid to DH	**0**	0		
Provision for the impairment of receivables	**(1,819)**	(1,384)	**(238)**	(260)
VAT	**1,115**	1,286	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**1,665**	1,734	**1,084**	1,150
Total	**16,308**	17,128	**846**	890
Total current and non current	**17,154**	18,018		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with NHS Clinical Commissioning Groups (CCG's) . As CCG's are funded by Government to buy NHS patient care no credit scoring of them is considered necessary.

18.2. Receivables past their due date but not impaired

	31 March 2016 £000s	31 March 2015 £000s
By up to three months	**1,038**	884
By three to six months	**1,323**	520
By more than six months	**2,013**	260
Total	**4,374**	1,664

18.3. Provision for impairment of receivables

	2015-16 £000s	2014-15 £000s
Balance at 1 April 2015	**(1,644)**	(1,863)
Amount written off during the year	**102**	210
Amount recovered during the year	**0**	66
(Increase)/decrease in receivables impaired	**(515)**	(57)
Transfers to NHS Foundation Trust on authorisation as FT	**0**	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2016	**(2,057)**	(1,644)

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.

19. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**28,382**	41,808
Net change in year	**(1,086)**	(13,426)
Closing balance	**27,296**	28,382
Made up of		
Cash with Government Banking Service	**27,272**	28,359
Cash in hand	**24**	23
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**27,296**	28,382
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**27,296**	28,382
Third Party Assets - Bank balance (not included above) (See Note 32)	**2**	0

20. Trade and other payables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS payables - revenue	**10,203**	1,407	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**2,406**	7,306	**0**	0
Non-NHS payables - revenue	**3,841**	1,864	**0**	0
Non-NHS payables - capital	**4,965**	8,121	**0**	0
Non-NHS accruals and deferred income	**26,966**	24,651	**0**	0
Social security costs	**2,746**	2,779		
PDC Dividend payable to DH	**347**	105		
Accrued Interest on DH Loans	**0**			
VAT	**0**	0	**0**	0
Tax	**2,670**	528		
Payments received on account	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**54,144**	46,761	**0**	0
Total payables (current and non-current)	**54,144**	**46,761**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved (number)	**0**	0		
Outstanding Pension Contributions at the year end	**1,158**	318		

21. Borrowings

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
Loans from Department of Health	**0**	1,000	**0**	0
Loans from other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**1,306**	1,017	**25,591**	26,898
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**1,306**	**2,017**	**25,591**	**26,898**
Total borrowings (current and non-current)	**26,897**	**28,915**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	0	1,306	**1,306**
1 - 2 Years	0	903	**903**
2 - 5 Years	0	3,087	**3,087**
Over 5 Years	0	21,601	**21,601**
TOTAL	**0**	**26,897**	**26,897**

22. Deferred income

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Opening balance at 1 April 2015	**4,858**	4,138	**0**	0
Deferred revenue addition	**4,707**	4,858	**0**	0
Transfer of deferred revenue	**(4,858)**	(4,138)	**0**	0
Current deferred Income at 31 March 2016	**4,707**	4,858	**0**	0
Total deferred income (current and non-current)	**4,707**	4,858		

23. Provisions

	Total	Comprising: Early Departure Costs	Legal Claims	Restructuring	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**7,488**	1,056	391	472	4,563	1,006
Arising during the year	**1,010**	36	224	0	439	311
Utilised during the year	**(3,139)**	(90)	(195)	(152)	(1,952)	(750)
Reversed unused	**(811)**	(49)	(47)	(250)	(209)	(256)
Unwinding of discount	**42**	14	0	0	28	0
Change in discount rate	**(23)**	(4)	0	0	(19)	0
Transfers to NHS Foundation Trusts on being authorised as FT	**0**	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0	0	0	0	0
Balance at 31 March 2016	**4,567**	**963**	**373**	**70**	**2,850**	**311**
Expected Timing of Cash Flows:						
No Later than One Year	**1,472**	88	373	70	630	311
Later than One Year and not later than Five Years	**881**	351	0	0	530	0
Later than Five Years	**2,214**	524	0	0	1,690	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£000s
As at 31 March 2016	130,664
As at 31 March 2015	70,329

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.

Other provisions cover Injury Benefits £2,352,000, HMRC Off Payroll Engagement £325,000 and National Poisons potential expenditure of £100,000

Injury benefit provisions are calculated with reference to the NHS Pensions Agency and actuarial tables for life expectancy.

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.

24. Contingencies

	31 March 2016 £000s	31 March 2015 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(202)**	(193)
Other - Pension and Injury Benefits	**(507)**	(467)
Net value of contingent liabilities	**(709)**	(660)

25. PFI and LIFT - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

A contract for the development of a new hospital was signed by the Trust and its PFI partner on 11/12/2015. The purpose of the scheme is to deliver a modern, state of the art acute hospital facility on the Grove Lane site in Smethwick, Birmingham.

The Midland Metropolitan Hospital (MMH) will be fully operational in 2018. The hospital is being delivered through PF2 and which involves an 30 year concession period ending in 2048/49. At the end of that concession period the asset shall pass into the ownership of the Trust or successor body.

The anticipated asset value of the hospital when brought into use will be £323,638,000

The Trust shall receive £97m of Public Dividend Capital which it expects to pay to its PFI partner as a contribution to the costs of the hospital development

The Trust is contractually committed to a total Unitary Payment cost in respect of the Midland Metropolitan Hospital of £698,443,000 payable over the life of the 30 year concession

Note 12.1 (Property, Plant and Equipment) includes £10,283,792 (2014.15 £4,426,994) as Assets under Construction in respect of the Midland Metropolitan Hospital. This represents costs incurred directly by the Trust in support of the hospital development

The Trust currently operates the Birmingham Treatment Centre (BTC) under a PFI concession. The values below represent the financial obligations relating to the BTC only

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI

	Total 2015-16 £000s	2014-15 £000s
Total charge to operating expenses in year - Off SoFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**863**	1,006
Total	**863**	1,006
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**929**	1,321
Later than One Year, No Later than Five Years	**3,955**	5,766
Later than Five Years	**17,741**	33,230
Total	**22,625**	40,317

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 financial year

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI

	Total 2015-16 £000s	2014-15 £000s
Total charge to operating expenses in year - Off SoFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**863**	1,006
Total	**863**	1,006
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**929**	1,321
Later than One Year, No Later than Five Years	**3,955**	5,766
Later than Five Years	**17,741**	33,230
Total	**22,625**	40,317

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 financial year

Imputed "finance lease" obligations for on SOFP PFI contracts due

26. Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes

	2015-16 Income £000s	2015-16 Expenditure £000s	2014-15 Income £000s	2014-15 Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI / LIFT)				
Depreciation charges		450		546
Interest Expense		2,005		2,146
Impairment charge - AME		1,368		0
Impairment charge - DEL		0		0
Other Expenditure		863		1,006
Revenue Receivable from subleasing	0		0	
Impact on PDC dividend payable		(284)		(292)
Total IFRS Expenditure (IFRIC12)	**0**	**4,402**	**0**	**3,406**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		3,643		3,952
Net IFRS change (IFRIC12)		**759**		**(546)**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		**414**		0
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		**656**		199

	2015-16 Income/ Expenditure IFRIC 12 YTD £000s	2015-16 Income/ Expenditure ESA 10 YTD £000s
Revenue costs of IFRS12 compared with ESA10		
Depreciation charges	**450**	
Interest Expense	**2,005**	
Impairment charge - AME	**1,368**	
Impairment charge - DEL	**0**	
Other Expenditure		
Service Charge	**863**	3643
Contingent Rent	**0**	
Lifecycle	**0**	
Impact on PDC Dividend Payable	**(284)**	
Total Revenue Cost under IFRIC12 vs ESA10	**4,402**	**3,643**
Revenue Receivable from subleasing	**0**	**0**
Net Revenue Cost/(income) under IDRIC12 vs ESA10	**4,402**	**3,643**

27. Financial Instruments

27.1. 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 NHS Trust has with commissioners and the way those commissioners are financed, the NHS 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 NHS 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 NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within theTrust's standing financial instructions and policies agreed by the board of directors. Trust 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 strategic health 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 2016 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.

27.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0			**0**
Receivables - NHS		10,372		**10,372**
Receivables - non-NHS		3,665		**3,665**
Cash at bank and in hand		27,296		**27,296**
Other financial assets	0	0	0	**0**
Total at 31 March 2016	**0**	**41,333**	**0**	**41,333**
Embedded derivatives	0			0
Receivables - NHS		11,023		11,023
Receivables - non-NHS		2,199		2,199
Cash at bank and in hand		28,382		28,382
Other financial assets	0	0	0	0
Total at 31 March 2015	0	41,604	0	41,604

27.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
			£000s
Embedded derivatives	0		**0**
NHS payables		10,203	**10,203**
Non-NHS payables		3,841	**3,841**
Other borrowings		0	**0**
PFI & finance lease obligations		26,897	**26,897**
Other financial liabilities	0	0	**0**
Total at 31 March 2016	**0**	**40,941**	**40,941**
Embedded derivatives	0		0
NHS payables		1,407	1,407
Non-NHS payables		36,871	36,871
Other borrowings		0	0
PFI & finance lease obligations		27,915	27,915
Other financial liabilities	0	0	0
Total at 31 March 2015	0	66,193	66,193

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.

28. Events after the end of the reporting period

On 1/05/16 the trust entered into a Managed Service Contract for the provision and maintenance of imaging equipment. The contract is for a period of 10 years with an option to extend for a further 2 years. The estimated value of the contract is £30m and anticipated capital value of equipment to be provided under the contract is £18m.

29. 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 the year 2015/16 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 are listed below

NHS Sandwell & West Birmingham CCG
Birmingham and the Black Country
NHS Birmingham Cross City CCG
Health Education England
NHS Birmingham South & Central CCG
NHS Walsall CCG
NHS Litigation Authority
NHS Business Services Authority

In addition, 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 Department for Education and Skills in respect of University Hospitals Birmingham NHS Foundation Trust, Sandwell MBC and Birmingham City Council.

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 Trust board.

30. Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	150,889	125
Special payments	210,982	66
Total losses and special payments	361,871	191

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

Details of cases individually over £300,000

There were no individual cases where the value of losses or special payments exceeded £300,000 in either 2015-16 or 2014-15.

31. 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.

31.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
Turnover	327,536	348,475	359,161	384,774	387,870	424,144	433,007	439,022	446,590	**443,698**
Retained surplus/(deficit) for the year	3,399	6,524	2,547	(28,646)	(6,885)	4,540	(3,441)	(2,505)	4,585	**(4,254)**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	0									
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0								
Adjustments for impairments			0	36,463	9,533	(2,395)	8,872	8,922	(263)	**8,390**
Adjustments for impact of policy change re donated/government grants assets						358	1,092	334	331	**(279)**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				(557)	(455)	(640)	0	0	0	**0**
Absorption accounting adjustment							0	0	0	**0**
Other agreed adjustments	5,726	0	0	0	0	0	**0**	0	0	**0**
Break-even in-year position	**9,125**	**6,524**	**2,547**	**7,260**	**2,193**	**1,863**	**6,523**	**6,751**	**4,653**	**3,857**
Break-even cumulative position	**(4,402)**	**2,122**	**4,669**	**11,929**	**14,122**	**15,985**	**22,508**	**29,259**	**33,912**	**37,769**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust'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.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	2.79	1.87	0.71	1.89	0.57	0.44	1.51	1.54	1.04	**0.87**
Break-even cumulative position as a percentage of turnover	-1.34	0.61	1.30	3.10	3.64	3.77	5.20	6.66	7.59	**8.51**

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.

31.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

31.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	**(1,217)**	11,130
Cash flow financing	**(1,431)**	10,932
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**(1,431)**	10,932
Underspend against EFL	**214**	198

31.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**20,347**	17,346
Less: book value of assets disposed of	**0**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(527)**	(51)
Charge against the capital resource limit	**19,820**	17,295
Capital resource limit	**19,860**	17,330
Underspend against the capital resource limit	**40**	35

32. Third party assets

The Trust held 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.

	31 March 2016 £000s	31 March 2015 £000s
Third party assets held by the Trust - Patients' Monies	**2**	0

33. 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 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.

REVIEW OF 2015/2016 - CHARITY FINANCES

The Financial information presented below is drawn from the draft Charity Accounts that are subject to on-going audit and finalisation. More information about the work of the charity through the year can be found on pages 58-59.

Income and Expenditure

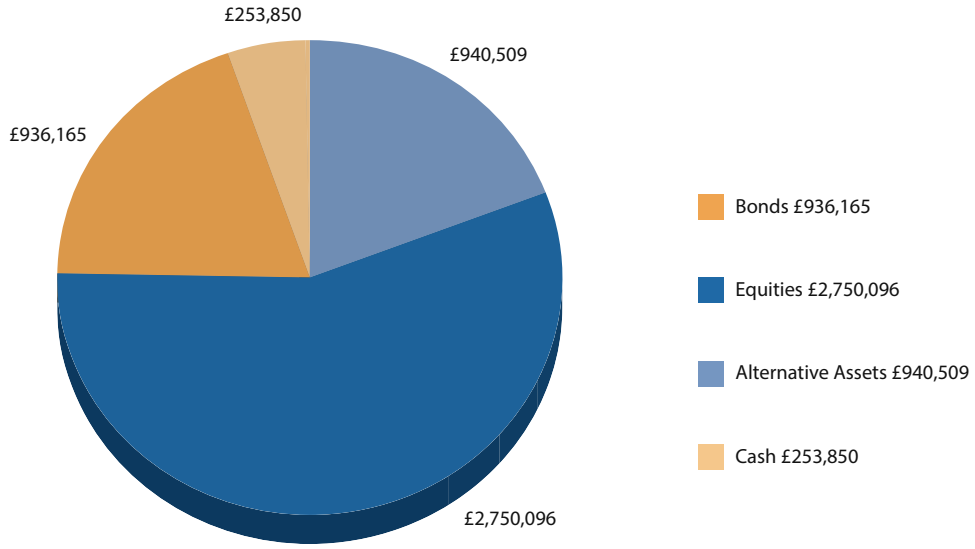
The table below summarises the overall analysis of the income and expenditure position for 2015/16 extracted from the Statement of Financial Activities as detailed in Appendix 2.

	Unrestricted Funds	Restricted Funds	Total
	£000's	£000's	£000's
OPENING FUND BALANCE (1 April 2015)	4,121	2,802	6,923
ADD:	961	210	1,170
Donations / Legacies / Grants and other incoming resources for the year	62	42	104
Interest and Dividends for the year	(1,340)	(596)	(1,936)
LESS:			
Expenditure for the year			
Transfers in the year			
I&E SURPLUS / (DEFICIT) FOR YEAR	(318)	(344)	(662)
Investment gains (losses) recognised in the year	(123)	(68)	(191)
CLOSING FUND BALANCE (31 March 2015)	3,680	2,391	6,070

The net assets of the Charity as at 31 March 2016 were £6.070 million (2015: £6,923million). Overall net assets reduced during the year by £0.853 million.

The Trust Charity received a total of £1.274m from the following sources:-

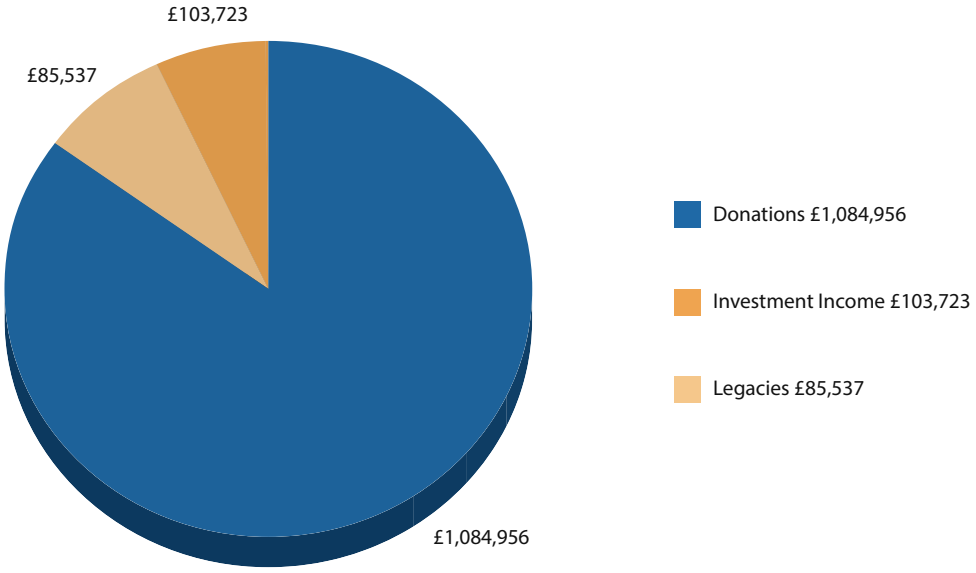
Managed Investments - Asset Allocation



The Trust Charity continues to be heavily dependent upon the generosity of the general public, grants from commercial and non-commercial organisations and income from investments held to fulfil its objectives. The Trust Charity is grateful to the individuals, families, groups, companies and sponsors who gave so generously of their time & money.

The Trust Charity committed £1.936m during the year to make a difference to the care experience of patients, carers, staff and the local community. The main areas of expenditure were:-

Income 2015/16



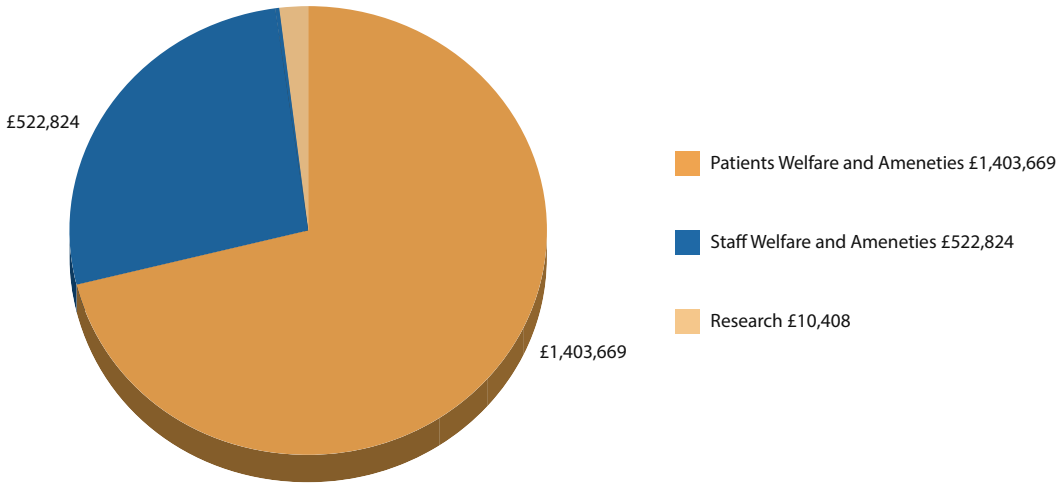
The use of these funds has enabled the Trust Charity to make a real difference to patients. You can see more on pages 58 and 59.

Investments

The Charity has an ethical approach to investment and moderate risk appetite in the management of its funds.

The funds of the Charity were invested as follows at 31 March 2016:-

Expenditure 2015/16



Further information can be found in the annual report and accounts of the Trust Charity which will be available on request from the Trust Secretary from 8 July 2016 following their consideration & approval by the Trust Board acting as Corporate Trustee.

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

If you are unable to find the information you need on the website, then please contact the Communications Team by telephone on 0121 507 5303, by email at swbh.comms@nhs.net, or by post at:
Communications Department
Trinity House
Sandwell General Hospital
Lyndon
West Bromwich
West Midlands
B74 4HJ

The Freedom of Information Act (2000) entitles you to request information on a variety of subjects, including our services, infection rates, performance, and staffing. For more details on how to make a Freedom of Information request you can visit our website – click Contact and scroll to Freedom of Information on the left hand side.

How to find us

For more details on how to get to our hospital sites, you can go on our website and select the 'Contact Us' tab. To contact us by telephone, please call 0121 554 3801.

Birmingham City Hospital (this site includes Birmingham Treatment Centre, Birmingham Eye Centre, the Birmingham Skin Centre, and our midwife-led facility Serenity.) Dudley Road Birmingham West Midlands B18 7QH	**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 entrances of each hospital site. Vehicles are parked and left at the owner's risk. Spaces for disabled badge holders can be found at various points all around our site. The car parks operate a pay by 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 located by Hearing Services.

Reduced car parking charges

If a patient is seen more than one hour late in clinic, then they do not have to pay extra for their parking. Ask for a form at the reception desk, then please take the completed form to either the BTC Reception (at City), or to the General Enquires desk (found in the main reception at Sandwell). Please note there will still be a minimum charge of £2.80. You will then be given a ticket that allows you to exit the car park without further charge.

Parking rates from May 2016/17		
Standard Tariff (except Rowley Regis) Up to 15 minutes - FREE Up to 1 hour - £2.80 Up to 2 hours -£3.80 Up to 3 hours -£4.30 Up to 5 hours -£4.80 Up to 24 hours - £5.30 Concessions One Shot Tickets - 4 for £10	**Rowley Regis** Up to 15 minutes – FREE Up to 6 hours - £2.80 From 6-24 hours - £5.30	**Season Tickets** 3 days £9 (+ £5 refundable deposit) 7 days £18 (+ £5 refundable deposit) 3 months £42 (+ £5 refundable deposit)

Parking rates from May 2016/17		
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.	**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 can receive a token to allow free exit from hospital car parks. Bring proof of your benefits to any of the main receptions, or to the City Hospital Cash Office (located on the ground floor main corridor).

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 help and support with the power to negotiate solutions or speedy resolutions of problems, PALS also acts as a gateway to independent advice and will help solve your problem either formally or informally.
Contact PALS by emailing swb-tr.pals@nhs.net or by phoning 0121 507 5836 (10am – 4pm, Monday – Friday). Please leave a message if the line is engaged/you are calling outside office hours.

To make an official complaint

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

Or by emailing swbh.complaints@nhs.net, or by phoning 0121 507 4346 (10am – 4pm, Monday – Friday). Please leave a message if the line is engaged/you are calling outside office hours.

PALS team members Norma Bayliss and Lorna Turner. The service supports patients and family members with advice, information and help to resolve concerns.

We have invested in the facilities at Rowley Regis Hospital to offer more convenient healthcare. Extra car parking is just one of the improvements we have made.

April - Quality improvement half days get off to a good start.

May - Trust Board agree Approval Business Case for Midland Metropolitan Hospital.

June - Trust awarded 'Birmingham Connected Sustainable Travel' Award.

July - Trust launches new "in-house" volunteering scheme.

August - Two new cardiac catheter labs open at City Hospital.

September - Jasper Carrott unveils organ donation memorial at City Hospital.

October - Trust celebrates excellence with our largest ever Staff Awards.

November - Children and Young People's services hailed as 'Outstanding' by CQC.

December - Duke of Cambridge visits Sandwell Hospital to see innovative 'Live and Work' project.

January - First Black Country Alliance conference takes place bringing together clinical leaders, consultants and nurses from three Trusts.

February - Respiratory service chosen by Royal College of Physicians to take part in Future Hospitals Project.

March - Trust joins John's campaign to support carers to stay overnight with dementia patients.

the trust charity

making **everyone** matter

Want to be part of something that makes a real difference?

The trust charity grants more than £1 million every year, supporting vital health and wellbeing services across Sandwell and West Birmingham.

From the latest in healthcare equipment, research and technology to patient support groups and volunteering programmes, the trust charity funds services that go above and beyond what the NHS can pay for.

It's not just our patients and staff who benefit. The trust charity supports services that are run in partnership with voluntary organisations in the community that are aimed at supporting people's wellbeing

You can be part of one of the most exciting fundraising programmes around.

To find out more, get involved or make a donation:

Contact: the trust charity team on 0121 507 5064 or 0121 507 6146

http://www.swbh.nhs.uk/our-charity/

We're waiting to hear from you!

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