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NHS
Sandwell and West Birmingham Hospitals
NHS Trust

PARTNERSHIPS WITH A PURPOSE

Integrated Annual Report and Accounts 2016/17

Incorporating the Quality Account and the Trust Charity Annual Review

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Front cover image

Gary Williamson, a patient at the regional Sickle Cell and Thalaessemia Centre at City Hospital.

Inside front cover image

Mohamed Elbanna, a Specialty Registrar in the Emergency Department.

1. Introduction

Thank you for taking the time to read our annual report. It provides information about the work of our dedicated teams. With candour the report explains where we are succeeding and where we have more work to do. Over the last three years we have seen improvements in quality and some of those are reflected in this report. Changes to sepsis care, improvements in end of life care, excellence in the care of children are all examples of work that we should be proud of in our local NHS.

This year the report focuses as well on partnerships. None of the improvements being delivered would be possible without the collaborations we have built, and continue to build with others. The Trust's Board made a very deliberate decision to emphasise and develop deep alliances with the local third and voluntary sector. That work is illustrated in the report. Our own Trust Charity has also aligned itself to that ambition and funded exciting projects with, for example, Sandwell Women's Aid (now Black Country Women's Aid), the African Caribbean Resource Centre and Agewell.

In the last year we did not meet our financial plans, although we did meet our statutory obligations and the auditors' opinion reflects strong grip and control exercised by the executive and our wider management teams. In the year ahead we intend to drastically reduce our reliance on agency staffing, and eliminate entirely the use of some especially expensive agencies. This will only be possible if we maintain strong recruitment and the last year has seen the launch of our 'Bringing Your Ambition to Life' campaign, with over 150 offers made and many new faces joining our organisation.

2017/18 is the organisation's "year of digital". We install our new Electronic Patient Record in autumn, and before that move to electronic case notes. It is difficult to overstate the scale or degree of change. We expect huge benefits for patients and staff from these changes. We will reduce duplication of effort, and the experience of patients being asked for the same information multiple times. We will be able to move care plans between sites and settings, consistent with our vision to become an outstanding provider of integrated care.

Last year we highlighted in the annual report our Quality Improvement Half Days (QIHDs). These provide a chance to learn and talk, and thereby improve standards. Over 1,500 staff participate each month, and in 2016/17 we expanded this programme to include all of our wards. The year ahead will see us qualitatively evaluate our QIHDs, and begin to celebrate very publicly the teams whose efforts to improve quality stand out. We are looking to build sustainable improvement based on collaboration and teamwork. This report shows how far we have come in that journey, and reflects confidence about the future as we move towards our new acute hospital opening in 2019.

Richard Samuda
Chairman

Toby Lewis
Chief Executive

About Sandwell and 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 7,200 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 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 in 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 2019. It is located on Grove Lane, on the Smethwick border with West Birmingham.

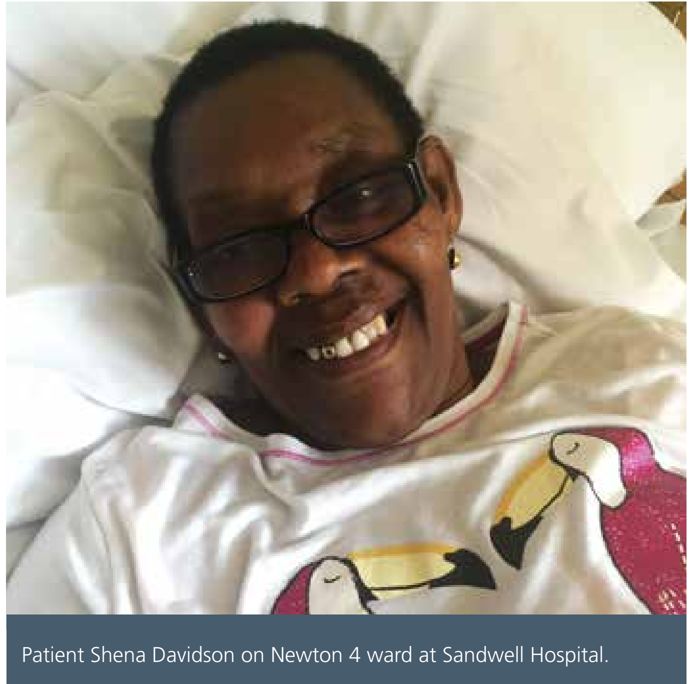
We are a key partner in efforts to change the shape of care in our area. Our intention is to provide substantially more care at home and rely less on acute hospitals. We aim to move 350,000 appointments out of traditional settings and close a further 20% of our hospital beds, as we have safely closed 25% over the last ten years. Whilst most of the programme involves investment in GP surgeries and health centres, our acute care will relocate into a single purpose built hospital – the Midland Met. The new hospital will act as a major employment opportunity for local people and is part of a wider scheme to develop the area adjacent to the site. Our training and education team are outward facing in sourcing the workforce we need for the long-term. We have a very active programme of apprentices and school experience joint working. We have a partnership with Sandwell University Technical College and more widely work closely with Birmingham City University, Wolverhampton University, Birmingham and Aston Universities. The Learning Works is our community-based recruitment and training resource. The Trust Board is committed to developing ever more consistent links into our local communities, working with voluntary sector, faith, and grassroots organisations. The Trust Charity also reinforces this work.

We are making investments in three areas: In the skills and training or our workforce; in the technology we use to both care for and communicate with patients and partners; and in our estate – in part through the developement of the Midland Met Hospital.

Over the last year:

- 5,954 babies were born at our Trust.
- There were 199,437 patient attendances plus 33,265 attendances seen under GP triage at our emergency departments with over 38,994 people admitted for a hospital stay.
- 45,950 day case procedures were carried out.
- 526,945 patients were seen in our outpatient departments.
- Over 650,000 patients were seen by community staff.

Baby Zachary Anderson with Maternity Manager Margaret Bradley.



Patient Shena Davidson on Newton 4 ward at Sandwell Hospital.

Partnerships with a purpose

Abuse Support Service launches

It's the partnership that will help to rebuild the lives of people who have experienced rape and sexual assault who work at the Trust.

Joining up with Warwick-based Safeline, colleagues who have been attacked, whether as a child or adult, can access help and advice. Safeline provides a wide range of emotional support, information and advice to survivors and their families. Director of Organisation Development Raffaela Goodby said: "As a caring employer, we recognise that the impact of rape and sexual abuse is devastating and long-lasting and that colleagues may not know where to go for help.. "One of the most difficult things is that this is such a personal and painful subject to talk about and share with others – which can make survivors hold back from asking for support, either from work colleagues or professionals. We want to break this cycle, which is why we've partnered with Safeline." The charity, which was established more than 20 years ago, has helped more than 25,000 people.

Liz Harrison and Anne Brookes from the Safeline team at the Trust's Staff Benefits and Winter Wellness Event in October.

2 Performance Report

During the year we confirmed our quality and safety plans, two of our five key plans that support our 2020 vision. The safety plan has been implemented within our surgical, community and paediatric wards, driving forward improvements in our safety standards. We call these our "always events" – checks we will do with every patient, every time. Our quality plan strives for improved outcomes for patients as we continue to deliver better care across our many and varied services.

We concluded our three year public health plan in 2017 and have reflected on the improvements made as we embrace our role as a healthcare provider, using every opportunity to support people's health and wellbeing, not just treat their health condition. We are setting the objectives for our next public health plan that will demonstrate our commitment to improving the health of those within the Sandwell and West Birmingham population.

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

Our 2020 vision and five key plans are supported by four enabling workstreams. This year we have invested in our digital schemes to drastically improve our IT infrastructure and enable smarter ways of working. The year ahead sees us implement a new electronic patient record plus embed digital dictation and speech recognition. The Trust's estate will change over the coming year as developments are made to release land on the City site and develop the Sandwell Treatment Centre in preparation for the opening of the new Midland Metropolitan Hospital.

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."

We recognise that we do not work alone, and to achieve our 2020 vision we need strong partnerships with a range of organisations and networks to deliver the best for the public

that we serve. Throughout the report you will see highlights of some of our key partnerships that aim to provide support for patients, carers, families and our communities, whatever people's needs or backgrounds.

Performance Overview

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

Top ten highlights

1. Seven-day access to care for end of life patients

Inspirational End of Life Care partnership sees beyond the NHS to ensure the Trust and our partners deliver joined up, co-ordinated care. The Connected Palliative Care Service is a collaborative work between John Taylor Hospice, Birmingham St Mary's Hospice, CrossRoads Care, Age Concern, and Sandwell and West Birmingham Hospitals NHS Trust. Commissioned by Sandwell and West Birmingham Clinical Commissioning Group to deliver end of life care services to people who are registered with a Sandwell and West Birmingham GP, the service provides 7 day access to a wide range of services for patients in their last year of life including hospice beds, domestic support and specialist palliative care. Speaking at the launch event Ms Helen Stephens, a member of the public said: "I am very impressed with this new model of care. As a patient who has complex needs and does not have family support, the new connected palliative care services would surely help me get the care that I need."

Dr Anna Lock speaks at the launch of the Connected Palliative Care service.

2. Plan aims to reduce avoidable harms

Implementation of our Safety Plan began during the year and sets out 10 safety commitment to patients and their carers. It concentrates on making sure we reduce patient avoidable harms, through must do safety-checks in our services. As a result we have ten standards to ensure that the plan is adhered to. Patients have their safety needs assessed, planned for, implemented and continuously reviewed as part of routine practice. We will in the future, make sure that patients and their carers are informed and included in care planning and will know what our safety standards are. It means they will know what to expect so they will be aware if something is not right, and how to alert the team looking after them to this so that it can be dealt with. During the year we rolled out the safety plan in our surgical, community and women's and children's wards.

3. Trust is working towards delay-free care

Safe and timely care is leading the way across our Trust as we adopted the Red to Green philosophy last winter. This is a belief that every single day a patient spends within our hospitals should be a day that progresses their care, avoiding any delays, helping them go home or to an alternative care facility as quickly as possible. Over the past winter and spring, staff throughout the Trust have been diligently keeping daily records detailing the delays and disruptions to patient care that have prevented patients progressing through their pathways. These metrics when combined with length of stay and 'home before lunch' figures help to identify key areas for development where performance gains could ultimately lead to patients receiving much more timely care. The teams have acted to overcome the delays that are within our control. Specific examples include the Newton 3 ward where staff have worked with imaging and portering to reduce the time it takes to have a diagnostic imaging procedure carried out, reducing the length of stay of patients on their ward by up to two days. By keeping a close eye on patient plans and reviews throughout the day, the team is able to work with imaging to ensure their patients are seen in a timely manner. Imaging have rolled out access to their CRIS radiology system to all wards, enabling ward teams to see schedules so that patients can be appropriately prepared and transferred ready for their procedure to take place. Most importantly, this means that patients are now much more informed about their scheduled tests.

Colleauges from the Community and therapies team are going from Red to Green.

4. Assessments for older patients mean more efficient care

Providing comprehensive geriatric care ‘nearer the front door’ was the reasoning behind the establishment of our Older Persons’ Assessment Unit (OPAU) last winter. The unit was set up using ten bed spaces from Sandwell’s former Coronary Care Unit, in response to the question of whether geriatric assessments are better carried out in a separate unit or in a ‘mainstream’ acute medical setting – something that has to be resolved before we move into the Midland Metropolitan Hospital. OPAU grew out of our ‘Frailsafe’ trial that emphasised the benefits of giving frail elderly people comprehensive geriatric assessments ‘nearer the front door’. The evidence we have suggests that the best way of delivering that is to put a multi-disciplinary team at the centre of the organisation. The OPAU team is made up of doctors, nurses, physiotherapists, pharmacists and – crucially – a social worker. Looking to the near future, one of our main objectives is to discharge our patients faster, ideally straight to their own homes or – if necessary – to a non-hospital care setting.

Staff from the Older Person’s Assessment Unit.

5. Digital developments will lead to paper-lite Trust

2017 is the year that SWBH ‘trusts in digital’ and lots of progress has already been made towards moving the majority of our paper processes online. For example, clinic letters can now be dictated, amended, signed and issued to patients and their GPs without printing a single piece of paper. Also, our clinicians are viewing the vast majority of their pathology results online. We must reduce our dependency on paper records to achieve our goal of providing multi-disciplinary access to more accurate, centralised and secure patient information. The benefits to patients of working digitally-by-default have been proven in other NHS Trusts and include:

- higher safety and quality standards
- reduced duplication of investigations
- less repetition of patient information
- optimised prescribing
- sustained, consistent best practice treatment approaches
- minimised unnecessary hospital stays

These benefits in turn will enable SWBH to realise its 2020 Vision and support the best patient experience at Midland Metropolitan Hospital. Put simply, if we all Trust in Digital: SWBH will deliver consistently high quality, integrated patient care and value that unites digital technology with clinical best practice. In readiness for the significant cultural and behavioural change the digital programme represents, all Trust departments are working to ensure their teams not only have access to technical devices and IT systems but can use them confidently. By the end of 2017, more than 5,000 of our patient-facing staff will be fully trained on the new electronic patient record and using it on a daily basis. We look forward to reporting on its successful implementation in the next Annual Report.

Cerner staff: (left to right) Simon Shanks , Global PMO Lead/Senior Project Manager, Ian Gibbons, Head of Customer Strategy and Colin Howman, Business Development Director.

6. Recruitment drive leads to job boost

The Trust has embarked on a recruitment drive to fill more than 200 nursing positions. Since this began in February, job offers have been accepted, with more than 150 of the vacancies to be filled by September. A jobs fair held in Birmingham saw 32 positions taken up, with 72 students being offered roles. The teams involved continue to focus on recruitment and retention. Meanwhile the Trust is reducing the amount that is spent on temporary staff. We are cutting out the use of high-cost agencies and changing the rates we pay for bank shifts to be more in line with neighbouring trusts.

Colleagues from SWBH mingle with prospective candidates at the RCNi Recruitment Fair held at the NEC, in Birmingham.

7. Research at Trust has ground breaking results

Over the last year over 300 research studies in various stages of activity were undertaken across the Trust, from actively recruiting participants into new studies to those in long term follow-up. In 2016/17, 60 new studies commenced with 95 National Institute for Heath Research (NIHR) portfolio studies recruiting research participants. Of these patient recruitment was highest in cardiovascular disease, ophthalmology and rheumatology although research activity has taken place across a full range of disciplines including cancer (Breast, Lung, Colorectal, and Haematological, Gynaecological, and Urological malignancies), stroke, diabetes, gastroenterology, surgery, dermatology, maternity, obstetrics & gynaecology, paediatrics, respiratory, orthopaedics and physiotherapy.

Over the last year we increased the internationally recognised excellence of our research portfolio and received major funding from sources including the Medical Research Council (MRC), Arthritis Research UK and the EU for research into a range of disease areas including corneal scarring, early arthritis, Bechet's disease and atrial fibrillation. We also increased the breadth of our clinical research portfolio with new research initiatives in a range of areas including clinical immunology, respiratory medicine and orthopaedics, and grew the range of health care professionals contributing to our research portfolio such as physiotherapists and speech and language therapists.

Dr Bob Ryder (third from left) with the Endobarrier Team.

8. New "first-class" benefits scheme impresses staff

In a bid to become the local employer of choice, last year we introduced a new first-class benefits scheme 'SWBH Benefits', launched in Oct 2016, with our biggest ever staff event. Held at Sandwell Hospital, over 1,000 staff attended, and by linking it to our annual flu vaccination campaign, we successfully vaccinated 300 staff – the most we've delivered on a single day. The event featured a variety of stalls to showcase our extensive benefits package. Whilst in the past we had offered various health and wellbeing benefits, they were fragmented resulting in limited staff engagement. However, with SWBH Benefits, all our existing benefits, along with a wealth of fantastic new ones, are now managed within a single platform for the first time. The new package offers smoking cessation, alcohol/drug support, weight management, exercise classes, eye tests, chiropody, immunisations, physiotherapy, counselling, finance/debt management, stress management, retirement planning, staff lottery, library services, will writing, nationwide discount scheme offering 6,500+ discounts, local discount scheme with 22 regional partners and salary sacrifice schemes for Cycle to work, car lease, childcare vouchers, car parking and Smartphones/home technology.

(Left to right) Emelye Westwood, from Ideal for All, with Kate Chester, Health and Wellbeing Support Officer from SWBH, offering healthy fresh produce for colleagues.

9. Staff networks promote respect and tolerance

In mid-November we launched our staff networks for lesbian, gay, bisexual and trans staff (LGBT), staff with disabilities, and our black and minority ethnic (BME) network. This came after the launch of our mutual respect and tolerance guidance, and introduction of our speak up guardians. Each network has a chair, vice chair and executive sponsor. The Board will endorse some very specific, numeric targets for our work in the next 12 months on inclusion and diversity.

L–R: Assistant Primary Care Liaison Manager Donna Mighty, Staff Nurse Leanne Burris and Security Officer Anser Khan – from our BME Network.

10. New Guardians appointed with vital roles

In 2016 the Trust appointed 10 Freedom to Speak Up Guardians – people who are committed to making sure that any colleagues who want to raise issues and concerns get their voices heard. In the wake of the Mid-Staffordshire inquiry, the Francis Report recommended that every NHS Trust should have at least one Freedom to Speak Up Guardian. SWBH's Guardians have been drawn from across the organisation and come from a wide range of occupational backgrounds. They have a vital role to play in helping to support staff who want to raise issues and concerns but may be worried about doing so. This is an additional route to supplement our whistleblowing policy. The Guardians are: Dermot Reilly, clinical practice coordinator, Harpal Tiwana, patient administration manager, Natasha Thompson, medical secretary, Rosie Auld, head orthoptist, Sandra Kennelly, clinical team leader and occupational therapist, Rachel Clarke, deputy anticoagulant services manager, Ian Galligan, technical supervisor medical engineering, Sue Whalen, consultant in sexual health, Robert Golding, junior doctor, and Anil Bhogal, security officer.

Freedom to speak up Guardian Natasha Thompson, Medical Secretary.

Partnerships with a purpose

Working with students to "Kiss it Better"

Patients continue to enjoy being pampered by beauty students thanks to a partnership between Sandwell College and Kissing It Better (KIT) which benefits the Trust. Students have been regularly visiting Sandwell Hospital, as part of the KIT service, to treat patients to hand massages and manicures. The initiative encourages organisations to work together to use their specialist skills in making a difference to the care of patients and their carers within hospitals and care homes.

Since the Trust joined forces with KIT and the college, patients have benefitted tremendously. Kissing it Better, which was founded by Jill Fraser and Nicola Matthews, is about sharing simple healthcare ideas, which make patients and staff feel truly appreciated. It also improves morale and motivation.

Liza Gill from the Trust volunteer service explained: "Being in hospital is not always a nice experience, so the idea of Kissing it Better is to brighten up the day for our patients by offering them these luxurious little treats. The students attended induction training (fire, health and safety and infection control) prior to visiting the wards. Their services were really well received by patients and staff and we have had some great feedback."

Visitor Sharmi Devia enjoyed being pampered by beauty students from Sandwell College.

Ajay Hira, Phlebotomist.

How we performed against our priorities

Strategic Objective	2016/17 Priority	Delivered?
Safe, High Quality Care	Reducing readmissions.	Partially
	Improving the experience of outpatients.	Partially
	Achieving the gains promised within our 10/10 programme.	Not yet
	Meeting the improvement requirements agreed with the Care Quality Commission.	Wholly
	Tackling caseload management in community teams.	Partially
Accessible and Responsive	Meet national wait time standards, and deliver a guaranteed maximum six week outpatient wait.	Partially
	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.	Not yet
	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.	Wholly
	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.	Not yet
Care Closer to Home	Ensure that we improve the ability of patients to die in a location of their choosing, including their own home.	Partially
	Respiratory medicine service sees material transfer into community setting, in support of GPs.	Not yet
Good Use of Resources	Create balanced financial plans for all directorates, and deliver Group level I&E balance on a full year basis.	Not yet
	Reform how corporate services support frontline care, ensuring information is readily available to teams from ward to Board.	Partially
	Reform how corporate services operate to create efficient transactional services that benchmark well against peers within the Black Country Alliance.	Partially
21st Century Infrastructure	Get NHSI approval for EPR full business case, award contract and begin implementation, whilst completing infrastructure investment programme.	Wholly
	Develop, agree and publicise our final location plans for services in the Sandwell Treatment Centre.	Wholly
	Finalise and begin to implement our plan for the current Sheldon block, as an intermediate care and rehabilitation centre for Ladywood and Perry Barr.	Partially
An Engaged and Effective Organisation	Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness.	Not yet
	Finalise our long term workforce plan, explaining how we will safely remove the pay-bill equivalent of 1000 posts between 2016 and 2019.	Wholly
	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	Partially

Partnerships with a purpose

Unique training opportunity through a collaboration with Aston Medical School

A new innovative training programme which sees the Trust working with Aston Medical School aims to encourage local students to stay within the area. The partnership scheme has led to the Trust linking with local schools, to offer the possibility of a career as a medical professional to children who may not have considered it in the past. The places are available at Aston Medical School, and not only focus on clinical skills, but also look at the interpersonal qualities essential for the delivery of excellent healthcare. Dr Shagaf Bakour, Obstetrics and Gynaecology consultant, also the Medical Director of Education for the new Aston Medical School, said: "The aim of the school is not just to educate students, but to encourage them to return to their communities and work in the primary care field. By doing that, they'll be directly improving health outcomes in some of the most deprived areas of the Midlands. We've received widespread support. Locally, it's come from the NHS Education and Training Council and Training Board, from the Deanery, from local NHS Trusts and GP practices – and nationally, from the British Medical Association.

Dr Shagaf Bakour, Obstetrics and Gynaecology consultant and medical director of education for the new Aston Medical School.

Priorities we did not fully deliver

- Achieving the gains promised within our 10/10 programme.

During the year we implemented our safety plan in community, surgical and women's / children's wards. This plan ensures that all patients receive their safety checks within the right time frame – our always events. In our medical wards we were not assured that the right standards of care were being consistently met so we implemented a new Consistency of Care programme. Ward teams are implementing 12 week improvement plans so that the standards of care are delivered consistently well.

- Meet national wait time standards, and deliver guaranteed maximum six week outpatient wait.

We have plans in place to improve A&E waiting times, which include increasing capacity at Sandwell Hospital by using more space and bringing about behavioural change. We continue to work closely with our social care partners to discharge patients more efficiently. Our Red/Green Day model is in place and it aims to eliminate delays in patients' stays and reduce our need for beds on that basis. Outpatient services have also been a focus and we have been reducing the scale of follow up care we provide in some key specialties. We are offering alternatives to clinic visits and working differently with primary care to offer shared care.

- 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.

We continue to work on cutting DNA rates, and cancelled clinic and operation numbers. Although some surgery postponements are unavoidable, we always prioritise rescheduling these procedures. Eliminating the use of high cost nursing agencies will also reduce our premium rate expenditure and this is a key priority for 2017. We are also changing the rates we pay for bank shifts to be more in line with neighbouring trusts. As always patient safety remains our top priority throughout this process.

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

The Trust did not achieve overall financial balance. The main drivers of this were unfunded capacity and consequent high levels of interim staffing and income levels below the target required to deliver financial balance.

- Reform how corporate services operate to create efficient transactional services that benchmark well against peers within the Black Country Alliance.

We have are worked with our partner NHS Trusts in the Black Country Alliance as well as Royal Wolverhampton to review corporate functions and see how we benchmark against others. We will review recommendations to see how we can get best value out of our back office services by working collaboratively.

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

Sickness absence reduced by 20% during 2016 – but did not meet the target of 3.5%. Reducing sickness absence and increasing wellbeing remains a key focus for the Trust for the coming year.

- Respiratory medicine service sees material transfer into community setting, in support of GPs.

So far, we have completed pilot studies and feasibility exercises to help us learn more about the impact of the project. The results from the work have suggested that there are opportunities for improved care. Patients and GPs involved in the studies have given positive feedback and we will continue working with our partners to deliver this objective.

Partnerships with a purpose

Pilot programme for trainee nurses means better quality care

The Trust and our neighbouring partners are one of only 11 trailblazers piloting a new Trainee Nursing Associate programme (TNA).
The new role, which sits alongside existing nursing care support workers and registered nurses, is part of a national programme run by Health Education England. As a result of this new role, nurses are able to spend more time using their specialist training to focus on clinical duties and take more of a lead in decisions about patient care. Staff trained through this two-year scheme, will learn on the job, leading to a foundation degree. Cath Greenway, Lead Nurse, from the Nurse Education Team, said: "Our TNAs attend Wolverhampton University one day each week and undertake learning in the workplace for the duration of the programme. They have a range of placements across the Trust which will enable them to experience care given to patients in their homes, close to home and in a hospital setting."

Trainee Nurse Associates Margaret Stephenson and Anne-Marie Hunt who are taking part in the Trainee Nursing Associate programme (TNA).

How our groups performed

Community & Therapies
Budget: £35 million
Headcount: 804

The Community & Therapies Clinical Group continues to thrive and develop. The group of predominantly therapists and nurses deliver over 30 different services across acute inpatients, intermediate care and re-ablement beds, outpatient clinics, emergency and assessment departments, outpatient clinics, patient's homes and a diverse range of community locations.

Key achievements:

- Consolidation of the Palliative & End of Life Care services delivering services across our acute sites, bed bases and Sandwell community. The Specialist Palliative Care Team, Macmillan Therapy Team and Urgent Response Team are co-located in the palliative care suite on the Sandwell site facilitating integrated working and establishing cohesive pathways of care. Our partnerships with John Taylor and St Mary's Hospices, Age Concern and Sandwell Crossroads continue to develop and the new Heart of Sandwell Day Hospice at Rowley Regis Hospital opened at the beginning of April, 2017.
- The new Rowley Regis Treatment Centre is the result of six months of building and investment which has transformed the community areas within Rowley Regis Hospital supporting all clinical groups. Services provided include outpatient physiotherapy, X-ray, consultant clinics, phlebotomy and children's therapies, in addition to themusculoskeletal physiotherapy specialties such as continence, IV therapy, DVT, general rehabilitation, respiratory and foot health that are provided.
- More District Nurse clinics have been established across the patch to support care closer to home for those patients able to get out and about, and later this year we will be supporting more patients to have a reduced length of stay in hospital by administering their IV therapy in a clinic or in their own home.
- The Integrated Care Service (iCares) continues to develop to particularly manage those adult patients with long term conditions. The service is available for all people with a Sandwell GP irrespective of where they live and includes those in care homes. For patients there are multiple treatment pathways including those requiring urgent multidisciplinary assessments avoiding admissions to the acute hospital by providing intensive interventions and life-long management to maximise independence.

Future plans:
Over half of the Trust's current activity is based in the community and this will grow in the coming years. In order to organise our business to deliver the full spectrum of integrated care, effectively take forward partnerships with primary care and prepare us to act as an accountable care organisation a moderate restructure has taken place in Community & Therapies and Medicine and Emergency Care Clinical Groups. From April 2017 co-locating some of the more community facing specialties aligning professional teams around patient pathways, not buildings, seems a sensible thing to do. A medical workforce including primary

care will strengthen our community services further and prepare us to deliver new models of care. The new group is called Primary Care, Community and Therapies.

Partnerships with a purpose

Inspirational End of Life Care partnership sees beyond the NHS

The Connected Palliative Care team based at Sandwell Hospital.

Our Connected Palliative Care service is a true partnership, providing a seven day service for patients in the last year of life through a new unique End of Life care hub. Located at Sandwell Hospital, the Connected Palliative Care service is run by the Trust and its partners John Taylor Hospice, Birmingham St Mary's Hospice, CrossRoads Care and Age Concern. It offers patients hospice beds, domestic support and specialist palliative care.

SWBH Nurse Manager & Service Lead for Palliative and End Of Life Care Tammy Davies said: "We have built a central hub which acts as a one-stop-shop for patients, carers and healthcare professionals." Professor Nick Harding, GP and Chair of Sandwell and West Birmingham Clinical Commissioning Group, said: "A great deal of work has taken us to this point in listening to patients, carers and providers; evaluating what was already on offer; developing a model with a co-ordination hub, urgent/crisis response team, and 24/7 access; and the appointment of the Trust as the main provider working with local hospices and voluntary organisations."

Patient Ronald Walker.

Imaging
Budget: £11 million
Headcount: 273

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.

Key achievements:

- We have become one of the first Trusts in the country to have state-of-the-art scanning equipment. These two new machines promise to cut waiting times whilst improving patient safety. The scanner automatically moves around and generates pictures in a second, allowing us to digitally share images with clinicians simultaneously so patients can be diagnosed immediately. This scanner also reduces the dose of radiation so it's safer for our patients without compromising the quality of the pictures. New Ultrasound kit has also been installed in antenatal and General Ultrasound.
- The Cardiology and Imaging team joined a national trial to provide a Computerised Tomography Coronary Angiography (CTCA) service to diagnose and assess medium-risk patients immediately. This new trial uses X-ray technology to create a detailed 3D picture of the heart and its blood vessels. Patients are treated as outpatients and once the scan is done, a cardiologist will review the results and be able to either give them immediate reassurance or get them started on the correct pathway to improving their wellbeing.
- Interventional Radiology was a finalist for the Health Service Journal's Value in Healthcare Awards. This achievement recognised the collaborative work with the Black Country Alliance in providing an out-of-hours service.

Future plans:
As part of the managed equipment service contract, we plan to refurbish all the imaging equipment across the Trust to prepare for the coming of the new Midland Metropolitan Hospital. We will continue to work with Siemens in preparation for the new hospital move, which means more access to leading technology in the new and retained environment. As well as maximising our relationship with Siemens, we will also work closely with Merge and Cerner to capitalise on the synergy of having all three major technology providers working together.

Partnerships with a purpose

State-of-the-art equipment at Trust thanks to deal with global firm

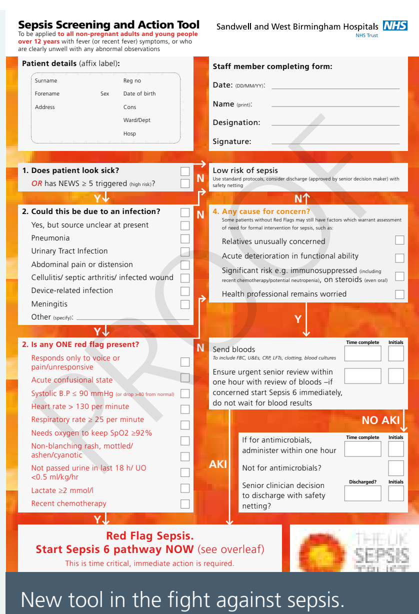
Trust officials sign the MES contract with Siemens they include (Left to right) Alan Kenny, Director of Estates and New Hospital Project, Tony Waite, Director of Finance & Performance, Dawn Webster, MMH Manager, Jonathan Walters, Group Director of Operations Pathology and Imaging, and Toby Lewis, Chief Executive.

Cutting edge equipment is now being used at the Trust after a 10-year deal was struck with technology firm Siemens. The Managed Equipment Service (MES) is an agreement which means the Trust can provide a leading medical imaging service for patients. One device includes a state-of-the-art robotic X-ray scanner which can produce an image in just one second. Already this is seeing a reduction in waiting times, whilst improving patient safety. Jonathan Walters, group director of operations for pathology and imaging at the Trust, said: "Our plan is to refurbish all the imaging equipment across the Trust over the next few years to prepare for the coming of the new Midland Metropolitan Hospital. We also plan to install new scanners at the Birmingham Treatment Centre and Neptune Health Park." The partnership enables both staff and patients to benefit from a well-designed clinical environment. The MES partnership also includes the provision, renewal and maintenance of imaging equipment for the next 10 years, underpinned by solutions to support operational and clinical efficiency.

Partnerships with a purpose

New screening tool will save lives

The number of deaths caused by blood poisoning could be drastically reduced thanks to a new Regional Sepsis Committee that has been formed by the Trust. Working with West Midlands Ambulance Service, Sandwell and West Birmingham Clinical Commissioning Group and community services, the committee has created a new Sepsis Action and Screening Tool, for all inpatients aged 12 and over. The tool has also been developed for use in GP practices.



Sepsis Screening and Action Tool

To be applied to all non-pregnant adults and young people over 12 years with fever (or recent fever) symptoms, or who are clearly unwell with any abnormal observations

Sandwell and West Birmingham Hospitals NHS Trust

Patient details (affix label):
Surname / Reg no
Forename / Sex / Date of birth
Address / Cons
Ward/Dept
Hosp

Staff member completing form:
Date: (DD/MM/YY):
Name (print):
Designation:
Signature:

1. Does patient look sick?
OR has NEWS ≥ 5 triggered (high risk)?
N → Low risk of sepsis
Use standard protocols, consider discharge (approved by senior decision maker) with safety netting
Y ↓

2. Could this be due to an infection?
Yes, but source unclear at present
Pneumonia
Urinary Tract Infection
Abdominal pain or distension
Cellulitis/ septic arthritis/ infected wound
Device-related infection
Meningitis
Other (specify):
N → Low risk of sepsis
Y ↓

2. Is any ONE red flag present?
Responds only to voice or pain/unresponsive
Acute confusional state
Systolic B.P ≤ 90 mmHg (or drop >40 from normal)
Heart rate > 130 per minute
Respiratory rate ≥ 25 per minute
Needs oxygen to keep SpO2 ≥92%
Non-blanching rash, mottled/ ashen/cyanotic
Not passed urine in last 18 h/ UO <0.5 ml/kg/hr
Lactate ≥2 mmol/l
Recent chemotherapy
N →

4. Any cause for concern?
Some patients without Red Flags may still have factors which warrant assessment of need for formal intervention for sepsis, such as:
Relatives unusually concerned
Acute deterioration in functional ability
Significant risk e.g. immunosuppressed (including recent chemotherapy/potential neutropenia), on steroids (even oral)
Health professional remains worried
N ↑ Low risk of sepsis
Y ↓

	Time complete	Initials
Send bloods To include FBC, U&Es, CRP, LFTs, clotting, blood cultures		
Ensure urgent senior review within one hour with review of bloods –if concerned start Sepsis 6 immediately, do not wait for blood results		

AKI → Red Flag Sepsis
NO AKI ↓

	Time complete	Initials
If for antimicrobials, administer within one hour		
Not for antimicrobials?		
	Discharged?	Initials
Senior clinician decision to discharge with safety netting?		

Y ↓

Red Flag Sepsis.
Start Sepsis 6 pathway NOW (see overleaf)
This is time critical, immediate action is required.

THE UK SEPSIS TRUST

New tool in the fight against sepsis.

Pathology
Budget: £18 million
Headcount: 344

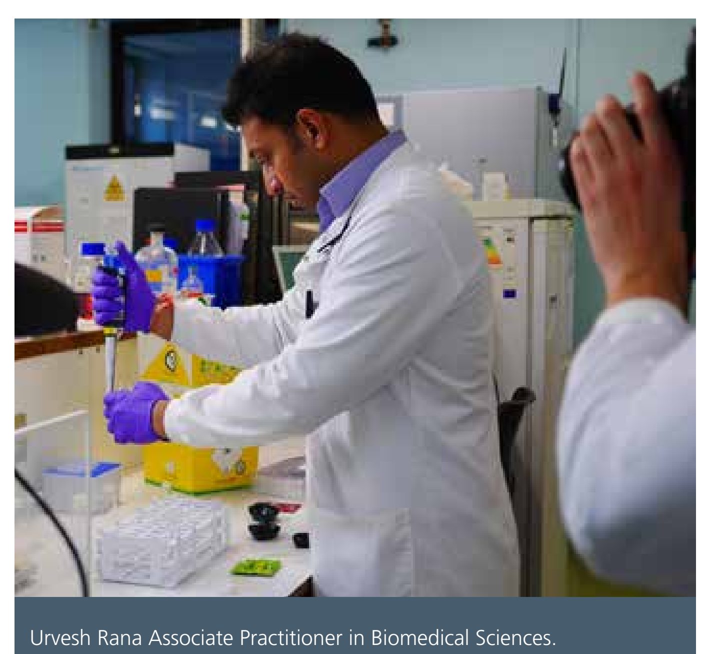
Pathology at SWBH covers comprehensive services that allow us to apply modern clinical science to the diagnosis, treatment, and monitoring of disease. We have facilities across our sites that allow speedy results, as well as services that go out to meet patients such as anticoagulation services and point of care testing. Our 2020 vision sees several changes that will be beneficial to the service, providing a faster and a more localised service for patients across the Trust. In 2018 we see our currently split-site services once again brought together at Sandwell. Alongside this, as we move towards a paper-free organisation. We have offered electronic results for many years and now more and more of our requests are made electronically as well.

Key achievements

- Community Phlebotomy delivers better and more integrated patient care with an emphasis on ensuring an efficient pathway for the samples from the patient's arm into the laboratory.
- The Pathology department is taking part in a trial funded by Sandwell Council to test all admissions to AMU A and AMU B for HIV, allowing earlier diagnosis of the condition. According to national and WHO guidelines, HIV testing should be considered in all general medical admissions. Figures show that 56 per cent of people are diagnosed late in Sandwell.
- The Pathology team have now planned the detail of the move of the rest of Pathology to the Sandwell Treatment Centre. This means that laboratories currently located on the City site will move in a phased way to Sandwell to support the new hospital, our community services including direct access from GPs and also specialist testing with samples coming to us from around the rest of the United Kingdom.
- Blood spot technology has been used effectively in the area of serology testing especially helping with work in the local prison and also mental health units.
- UKAS Inspections; All our laboratories have undergone their UKAS inspections which is similar to the wider CQC hospital inspection. The new ISO 15189 standard is now in place for Pathology and in Spring 2017 all our laboratories had inspections to ensure we comply to these new very rigorous standards. Indications are that the inspections were very successful.
- Our toxicology services have seen us pioneering the measurement of legal highs and this has created a degree of media attention on the work that we are doing in this area.

Future Plans

We have been working with the three other Black Country Pathology Departments on joint working initiatives as part of the NHSI drive to take forward the recommendations of the February 2016 report on unwarranted variation and operational productivity in the NHS. The Black Country Sustainability and Transformation Plan identifies pathology as an area that is moving forward. Working together at Pathology Director and Manager level the four Trusts, with the help of specialist consultants are appraising options to increase the efficiency and effectiveness of pathology services to ensure they are fit for purpose into the future.



Urvesh Rana Associate Practitioner in Biomedical Sciences.

Surgery
Budget: £113 million
Headcount: 1,355

In December 2016 Surgery A and B groups became one clinical team bringing huge benefits to the department. Now all services are under one umbrella, with one team working with the same systems and processes. Surgery includes trauma & orthopaedics, general surgery, breast surgery, plastic surgery, vascular surgery, urology, anaesthetics and critical care, as well as the Birmingham and Midland Eye Centre (BMEC). The group provides surgery and critical care for our patients. General surgery and orthopaedics is mainly delivered from Sandwell. Plastics, Urology, Vascular and Breast Surgery are mainly delivered from the City site and there are Critical Care Units at both main acute sites. We treat patients who present to our A&E departments with acute surgical or orthopaedic emergencies and perform a large number of elective operations.

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

- We have completed a successful merger of two clinical groups.
- We provide one of the largest hearing screening services for newborns, in the country and in the past year it has been accredited as an Awarding Centre for the Level 3 Diploma for Health Screeners (Newborn Hearing). Within the service, which provides screening for babies born in Birmingham, Sandwell and Solihull, we have dedicated trained screeners and offer an outpatient service for babies.
- We have been nationally recognised for our FINCH service. Accolades include Nurse of the Year.
- The Trust is now one of the few centres outside London approved to run the START (Systemic Training and Acute illness Recognition Treatment) course. It is an introduction to managing critically ill or potentially unwell patients on surgical wards for Foundation Year One Doctors. The course was developed by the Royal College of Surgeons.
- Pioneering work at the Trust on perioperative anaphylaxis screening is transforming patient safety. Some patients can suffer an extreme allergic reaction during surgery, with potentially severe consequences. But our team of immunologists and anaesthetists have investigated patients who have experienced a likely reaction during anaesthesia to identify the cause and to provide information about safe alternatives when an allergy to a drug or agent is found.
- Working with Health Education England, the Trust enrolled its first set of candidates on the Higher Specialist Scientific Training Scheme (HSST) for clinical scientists. The five-year programme gets people ready for a future career as a consultant clinical scientist. It also allows them to develop both their scientific expertise through a clinical doctorate, combining study and research, while maintaining their clinical practice and developing their leadership skills.

Future plans

We currently have an agreement in place to recruit a micro-vascular surgeon, which will add to the development of our hand and upper limb unit. With on going support from the Black Country Alliance board. We also will be undergoing a redesign of the plastics service, which will mean that it will be split into four different areas. As a result of the construction of the Midland Metropolitan Hospital, we will see the conversion of the Ophthalmology Emergency Department into an Urgent Care Centre. Our ongoing partnership with the Black Country Alliance will see our projects develop further.

Medicine & Emergency Care
Budget: £153 million
Headcount: 1,444

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 haematology/oncology. Some of these specialities moved to a new group with community and therapies at the start of 2017/18

Key achievements:

- Following their study in exploring new ways to treat diabetes, the Diabetes Research team successfully proved that a combined treatment can help patients control their diabetes effectively. Using an EndoBarrier device and medication, patients who struggle to lose weight and control diabetes can lose more than 12kg within a year and be able to manage their blood sugar levels. This study has received many awards and the treatment is now being considered within other NHS organisations.
- The Birmingham Rheumatology Group – which consists of the University of Birmingham, our Trust and University Hospitals Birmingham – has been designated a European League Against Rheumatism (EULAR) centre of excellence. EULAR is the organisation which represents people with arthritis or rheumatism, as well as the health professional and scientific societies of rheumatology in all the European nations. Its aims are to reduce the burden of rheumatic diseases on both the individual and society, by improving treatment, prevention and rehabilitation of musculoskeletal diseases.

- The Ambulatory Emergency Medical Care service has established 24 new pathways to improve patient experience. They range from chest pain and headache to syncope and upper GI bleeds. This new method aims to give patients a prompt review, assessments and scan. Patients receive their diagnostics, treatment and management plan at the Ambulatory Medical Assessment Area (AMAA) and they go home the same day without having to be admitted. Patients have rated the new services as exceptional. The average discharge rate at the department is 60 per cent compared to the national average of 40 per cent.
- The Cardiology team were awarded the Clinical Research Impact prize for their work on Atrial Fibrillation. The results of their research has been incorporated into NICE (the National Institute for Health and Care Excellence guidelines) and also both primary and secondary clinical pathways. They've also received accreditation by the British Society of Echocardiology. This recognition acknowledges the high standard across the department for echocardiology services, which is a type of non-invasive cardiac imaging using ultrasound.
- The Skin Centre, based at City Hospital, has recently been recognised as an NHS England assigned centre for the treatment of Hidradenitis Suppurativa (HS). This condition is a distressing, painful, long-term skin condition that causes abscesses and scarring on the skin. Having specialist status means that patients from a number of neighbouring hospitals will be referred to City to start a newly licensed biological treatment.

Future plans:
Our focus is to deliver the 'Fixing our Future' programme where we will re-design the specialties in scheduled care. With the Midland Metropolitan Hospital coming in 2019, the way we work to provide outpatient and day case provision will be changing to deliver services from multiple sites with a flexible seven day workforce model wherever feasible. The specialities in the scope of the programme are:

- o Diabetes/nephrology/endocrinology
- o Gastroenterology/endoscopy
- o Respiratory
- o Dermatology
- o Haematology/oncology
- o Rheumatology

Partnerships with a purpose

New Regional Haemoglobinopathy Centre at City Hospital

The Trust has become the first in the region to offer a new specialist service to treat sickle cell and thalassaemia sufferers. Working with NHS Blood and Transplant (NHSBT) and the West Midlands Specialist Commissioners, the regional specialist centre for haemoglobinopathy means that patients do not have to travel to London to receive pioneering treatment for blood conditions. Patients attending the new centre receive automated red cell exchange treatment – a complete blood transfusion – thanks to this state-of-the-art NHS service. This procedure removes all of the patient's abnormally shaped red blood cells and replaces them with donated blood, using a technique called apheresis. Patients have received more than 500 units of blood from NHSBT since the service started.

(Left to right) Ian Trenholm, chief executive at NHS Blood and Transplant, John James CEO The Sickle Cell Society, Councillor Paulette Hamilton, Birmingham Council's Cabinet Member for Health and Social Care, Catherine Howell, NHS Blood and Transplant's Chief Nurse for Diagnostic and Therapeutic Services, and Shivan Pancham, Lead Consultant for Sickle Cell and Thalassaemia.

Women's and Child Health
Budget: £78 million
Headcount: 932

The Women's and Child Health Clinical Group encompasses gynaecology services, ISHUS (Integrated Sexual Health Units in Sandwell), maternity and neonatal services, health visiting, family nurse partnership services and acute and community paediatric services.

Key achievements

- We became the first in the West Midlands to issue Baby Boxes to all new mothers who give birth at our Trust. The Baby Box promises to deliver a drastic reduction in infant mortality. The boxes are made from a special, durable cardboard and come with a firm mattress, waterproof mattress cover and 100 per cent cotton sheet. Statistics in Finland, where the idea originates from, has shown that the infant mortality rate has dropped by 75 per cent.
- Our health visiting team won the People's Award for a poster that described the complexities of the multi-agency Antenatal Changes Parenting Programme in a clear and easily accessible way. The award came from the Community Practitioners and Health Visitors Association.
- Kathryn Gutteridge won the Midwife of the Year Award from the prestigious Royal College of Midwives which has recognised the great work she has done over the years. Kathryn has been instrumental in the improvement to the maternity services at the Trust. Her ethos of creating calm and ensuring mothers from any background can experience the best birth possible is what drives a caring culture, which in turn attracts caring staff.
- Our Serenity Birth Unit won the Innovation in Practice Award, given to the service by the British Journal of Midwifery for the way it has developed a pathway for high risk expectant mothers. It offers continuity in care and one-to-one midwifery care for the whole of their labour so that there is no interruption.
- After successfully transforming the pathway for gynae-oncology patients requiring paracentesis (the draining of fluid from the abdomen), the team were given the 'Nurse led paracentesis service' Award, by MacMillan. Previously people having the procedure often complained about the length of their stay in hospital, and how it was carried out by a different consultant on every visit. In response to this feedback, the team created a nurse-led service that gives patients a single point of contact for all paracentesis enquiries. Nurses now perform the procedure and hospital stays have been reduced from three or four days to just one.
- Maternity services was successful in their bid to be in wave one of the national collaboration roll out towards achieving the maternity ambition to reduce still births and neonatal deaths by 30 per cent by 2020.
- GUM and CASH services are now delivered as an Integrated Sexual Health service (ISHUS) and provide a one stop, multi-site service to the borough of Sandwell.

Future Plans

We are 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 maternity services 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 are also working to our goal to appoint an Academic Professor of Obstetrics in partnership with Aston University. Meanwhile, our paediatric team plan to expand the development of our multidisciplinary allergy services, and we are working to ensure that the transition of care for our adolescents from a paediatrician to an adult service is seamless for both the patient and family. We are also looking at further developing a service of excellence for women experiencing problems in early pregnancy.

Partnerships with a purpose

Sandwell Women's Aid: New domestic violence project launch

Patients who turn up to the Trust's emergency departments after suffering abuse are getting the help they desperately need thanks to a joint project with Sandwell Women's Aid now known as Black Country Women's Aid. Advisors from the organisation are now placed within A&E at Sandwell and City Hospitals - which has led to a tenfold increase in identifying victims. As a result, 77 per cent of these individuals accepted ongoing specialist support from Women's Aid and other agencies. The project has contributed to a 91 per cent overall reduction in this vulnerable group's ongoing use of the Trust's A & E services, once targeted support was provided. The partnership

Sue Wilson, Domestic Abuse Lead Nurse at SWBH, Sue Lenton, from IDVA Sandwell Women's Aid, Wendy Simms, Operational Manager Sandwell Women's Aid, Sarah Ward, Executive Director Sandwell Women's Aid, and Jayne Clarke, Safeguarding Children Lead Nurse at SWBH.

was formed in late 2015 and has significantly improved the Trust's ability to identify and respond

Corporate
Budget: £16 million
Headcount: 1,796

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

Key achievements

- In the past year, our Live and Work Project has become a multi-award winning scheme, recognised by Sandwell and West Birmingham CCG Equality Awards, NHS Health Education England and the Sandwell Business Awards. The scheme is a successful partnership between our Trust and the West Midlands youth homelessness charity St Basils, with support from other organisations. The aim is to provide apprenticeship opportunities and living accommodation within the hospital to young people from St Basils.
- The Homeless Patient Pathway programme has now become an embedded Trust service and it is helping to reduce the re-admission rate. The team offers a holistic approach to patient care, starting from when they first present in hospital. While they are being looked after clinically, another member of the team will work with the patient and Sustain, our trusted housing provider, to find accommodation which is suitable for their individual needs. The team continue to work with the patient following their discharge from hospital.
- Our Trust partnered with the Kissing it Better campaign, which invites those in the community with specialist skills to make a difference to the care of patients and their carers within hospitals and care homes. Working with Kissing it Better, students from Sandwell College's beauty department have visited patients and their carers, offering them free massages and nail painting. This partnership will continue with more visits planned in the future, including hairdressing sessions, singing, and face painting for our younger patients.
- An expanded nursery at the Sandwell site means it is now able to provide care for up to 57 children a day. The purpose-built extension has a new baby room, for children aged between three months to 18 months. It's a bright and stimulating room, giving youngsters the space to explore and learn, with excellent support in their development.
- The Trust now has three fully established staff networks for lesbian, gay, bisexual and trans staff (LGBT), staff with disabilities, and black and minority ethnic (BME) network, which focus on colleagues becoming more involved. In particular the BME group sees a big part of their role as being able to support fellow BME staff who are facing significant challenges which may be because of their race. It provides a safe haven for staff and and offers a one-to-one basis for advice and sign posting to partner organisations as required.
- The Trust has been working with Black Country Women's Aid (SWA), and has now expanded its programme to help identify and respond to users of the domestic abuse service. The A&E Advocacy Project was first launched at Sandwell Hospital. In Summer, 2016 the Trust rolled out the scheme to City Hospital. Potential users of the service are identified and referred to Black Country Women's Aid for specialist support.
- Catering at our Trust has gone green, which means healthy eating pays off for staff and visitors. Anyone who uses their Healthy Eating Loyalty card when buying their meals from the green ranges gets their 10th green meal free. Not only that, but those purchasing their green meal on a Friday receive a free piece of fruit.

Future plans

We have exciting plans to transform our current medical education building at the Sandwell site. It will be our education hub, supported by refurbished facilities at Rowley Regis and the development of space for simulation and training in the new Midland Metropolitan Hospital. It will mean we have the space and facilities to develop everyone who works in the Trust.

We are looking to work with partners from the Modality Group of GPs. It is one of several GP federations with whom we are working. This initiative represents an effort to ensure that in around five years' time, there are high quality groups of GPs working in Sandwell and West Birmingham.

As Midland Metropolitian opens all SWBH Trust sites will be completely smoke free, both for patients and visitors, as well as staff. Nationally, smoking contributes to over 100,000 deaths each year through cancers, chronic obstructive pulmonary disease as well as heart disease. This is the key driving force behind the trust's plans to go smoke free. We are committed to helping our patients and staff, maintain a healthy lifestyle and our smoking cessation programme is key to this. Our smoking cessation plan for inpatients means we are able to provide them with nicotine patches, lozenges and sprays to reduce cravings. Staff have the opportunity to join a 12-week programme where they will be provided with free nicotine replacement therapy as well as the holistic support they need to quit.

Our intention within the Trust is to devote more consultant time to our wards, on a seven day basis. This will help drive care from red to green and provide a focal point of leadership alongside our ward managers. We are looking to be undertaking 75,000 fewer outpatient consultations in three years' time and that will create space for the remaining consultations to be longer and more rewarding and purposive, but also to release time to emergency care of our sickest patients.

The next stage of renovations are planned for Sandwell nursery, which will focus on the outdoor space, with the aim of providing a safe and stimulating garden with space for the children to run, climb and explore. There will be an area to grow wild flowers, encourage butterflies and bees and have bird houses and bug hotels. We are also going to build our own allotment so children can learn where food comes from and how to grow our own fruit and vegetables.

Partnerships with a purpose

Cerner engaged for provision of new electronic patient record

A partnership with technology giant Cerner means the Trust is well its way to implementing a new Electronic Patient Record (EPR) system. The collaboration will lead to better care as patient information, including medical history, allergies, and GP and community notes, will all be held in one place, which will allow clinicians to spend more time with their patients. Patients will also be able to gain access to their notes leading to better communication about appointments through secure online messaging. The EPR system will reduce the volume of paper records that are needed, enabling the Trust to move towards being paper-free. Cerner's offer includes EPR functionality for the Trust's Emergency Departments, Theatres, e-prescribing, clinical support, critical care, bed management and clinical documentation. Geoff Segal, Vice President & General Manager for Cerner UK and Ireland, said: "We're delighted that the Trust selected Cerner to support their digital journey to enable better and safer care for their patients and community. We share the vision that transformation must be clinically led in order to achieve the best outcomes for patients and staff. Together we will focus on improving outcomes and delivering the best possible care to the local community." Full roll-out will be completed by November 2017.

Signing the Cerner agreement (left to right, front row) Director of Finance and Performance Management Tony Waite, Chief Executive Toby Lewis, Director of Governance, Kam Dhami. (left to right back row) Director of Estates and New Hospital Project Alan Kenny, Chief Operating Officer Rachel Barlow, Chief Informatics Officer Mark Reynolds, Director of Organisation Development Raffaela Goodby, Medical Director Dr Roger Stedman, and Director of Communications Ruth Wilkin.

Quality and Performance Analysis Incorporating our Quality Account 2016/17

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 2016/17 in the eyes of our patients.
- How we performed in 2016/17 against our standards.
- How we performed against external measures.
- How well we performed when compared to other Trusts.
- Our priorities for 2017/18.

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
Date 01/06/2017

Signature

Toby Lewis
Chief Executive
Date 01/06/2017

Quality Plan

Our Vision for 2020 is to provide care with patient measureable outcomes that are equal to or exceed the best in the NHS, across all the services we provide. We will do this by doing the right things in the right way, by facilitating innovation and ensuring our teams base their practice on the best available evidence in a learning environment committed to continuous improvement.

This vision sees us delivering safe high quality care for all clinical services with a determined focus on the effectiveness of the care we provide for patients and the outcomes our services achieve for patients.

The aim of the Quality Plan is to produce measurable, patient meaningful outcomes, to improve on these continuously and to do so with an ambition that puts us amongst the best organisations in the NHS. The Quality Plan will be achieved over the period 2017/20 through the following objectives:

Quality Plan Objectives	
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	We will ensure the wellbeing of the children we care for, in particular reducing lost days of school as a result of hospital care; and ensuring the safe transition of care to adult services at the appropriate time.
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.

This quality plan focuses on clinical effectiveness and the patient's experience of care as the objectives are linked to patient measurable and meaningful outcomes.

Typically outcomes are collected through retrospective audit in many cases through large national audit programmes. These often publish many months after the audit period. Our aim is to get outcome data that is important to patients available as quickly as possible and have that information displayed in a visually appealing and meaningful way.

In the future all of our patients and carers, if asked, will describe their experience at Sandwell and West Birmingham Hospital (SWBH) as being of a good quality, regardless of the time, the location or the staff group that they received their care from. As a minimum each patient will be able to say that the quality of care they received at SWBH was the best that they could possibly want and the Trust ranking will be within the top 20% nationally for delivering good quality care.

Embedding the 10 Quality Objectives is fundamental to ensuring this future state. The assignment of objectives has been set through the Clinical Leadership Executive and while some of the objectives are specialty specific, some, such as management of sepsis, completion of mortality reviews and Venous Thromboembolism (VTE) assessment compliance are crosscutting.

The delivery of the quality plan has been split into four waves. Wave 1 is underway with five mortality initiatives included covering maternity, stroke, general surgery, trauma and orthopaedics and cardiology. Two of the plans covering maternity and general surgery are ready to commence in April 2017 with the other three undergoing modifications to their proposals.

The process for wave 2, which includes cancer, is in the planning stage and it is expected that plans will submitted for review / approval in June 2017.

Safety Plan

In 2016 SWBH published its Safety Plan. Roll out of the plan commenced in February 2017. This Safety Plan is the Trust's focused and organised commitment to patients and their carer(s) to significantly reduce or ambitiously remove patient avoidable harms, through formalising must do safety-checking actions across the trust. There are areas where this is done well, but there is more to do.

The Trust-wide Safety Plan embeds 10 multidisciplinary, evidenced-based clinical standards and ensures their compliance. The 10 standards will become part of current everyday clinical processes upon which the associated Quality Plan can build. Every patient will have their safety needs assessed, planned for, implemented and continuously reviewed in real time, as part of routine practice, thus significantly avoiding harms we call these our "always events".

The standards and outputs of the plan are summarised below:

	Standard	Output
1.	Ten out of Ten – The starting point for safety risk assessment of which care plans are then built upon	A safety checklist made up of 10 sub-standards that must be completed for every admitted patient within 24 hours.
2a.	Pressure Ulcer	A plan of care is in place for patients identified to be at a tissue viability risk.
2b.	Falls	A plan of care is in place for patients identified to be at a risk of a fall.
3.	Infection Control	A plan of care is in place for patients identified to be at a risk of a acquiring a Healthcare Acquired infection (HAI) or having a HAI on admission to be managed.
4.	Observations – Early Warning score (EWS) reporting and management	Monitoring vital signs as clinically required - taking in time appropriate action(s) to prevent an avoidable deterioration in a patient EWS are recorded (vital Pac or paper)– EWS were acted upon and this is evidenced in the patient's health care records.
5.	Care Plans and signed by Patients and Carers/Family	Nursing care plans are in place , individualised; reflecting risks identified (physical, social and psychological) through discussion with patient / carer.
6.	Focused care /Johns Campaign	A plan of care is in place for patients identified at risk from falls, absconding, self-harm, challenging behaviour or acutely unwell to ensure appropriate level of supervision with appropriately skilled Healthcare Professional and reflecting partnership working with carers..
7.	Antibiotic review every 72 hours	Reduction in inappropriate prescribing of antibiotics - An assessment has been done and the outcomes are documented of all patients on IV/ oral antibiotics after 72 hours that reflects appropriate or inappropriate use.
8.	Reduced Omissions	Patient's drugs are prescribed, correctly given and taken within a window that is deemed to be the right prescribed time. That a clinical omission for not giving the drug is recorded in the designated area.
9.	Informed Consent	All elective patients undergoing invasive procedures have been consented in accordance to policy.
10.	EDD and home care package	Accurate Expected Date of Discharge and 48hr follow up.

The 10 standards are fundamental to the patients' health and social care wellbeing. These are not new standards and processes and should be a core part of routine care. What we will achieve is a formalised approach to doing these routine activities to ensure that they are fully and always undertaken at the right time, consistent with recognised trust standard practice. Within the Trust there are 43 ward/ specialised areas; the Safety Plan is being rolled out to these wards incrementally during 2017.

In the future patients and their carers will be increasingly informed and included in care planning and will know what our safety standards are in layman terms. They will know what to expect, enabling them to identify when it is not quite right and how to bring it swiftly to our attention for corrective and preventative action.

The aim of the plan is to continually improve our safety culture and reduce harms to patients – this may include falls, pressure ulcers and infection. Each patient is assessed to determine any care needs they may have. The safety standards checklist ensures all standards are completed for all patients within 24hrs of admission. This is reviewed by the senior nurse and multi-disciplinary team (MDT) on a shift by shift basis and any non-compliance is rectified immediately. Subject experts and senior 'buddies' support areas to improve practice by coaching, supporting and problem solving.

How we measure quality

We review our performance against external frameworks and 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 (including the Quality and Safety Committee) as well as the Trust Board. Performance is managed through our Groups via our group performance review programme. We also audit the quality of clinical care we provide against a number of national standards that are published by external organisations for example the National Institute for Health and Care Excellence (NICE), National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) and specialty specific bodies for example the National Bowel Cancer Audit Programme (NBOCAP) and the National Hip Fracture Database (NHFD).

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. 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 have established a Data Quality Group whose scope will be to identify and implement data quality improvements and address data quality issues as they are found and monitor their improvement to a compliance standard.

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

During 2016/17 we provided data to secondary users for inclusion in Hospital Episode Statistics (HES) as follows:

April-December 2016

	Percentage with valid NHS number	Percentage with valid GP practice
Inpatients	98.8	100.0
Outpatients	99.5	100.0
Emergency Patients	97.1	99.0

NHS 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 NHS Foundation Trust (BTH)
- Kings College Hospital NHS Foundation Trust (KCH)
- Royal Liverpool and Broadgreen University NHS Foundation Trust (RLB)
- The Royal Wolverhampton Hospitals NHS Trust (RWH)
- University Hospital Bristol NHS Foundation Trust (UHB)
- Worcester Acute Hospital NHS Foundation Trust (WAH)
- Northumbria Healthcare NHS Foundation Trust (NHN)

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

The Care Quality Commission has not taken enforcement action against Sandwell & West Birmingham Hospitals NHS Trust during 2016/17 and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Medical Director Roger Stedman launching the Quality Plan.

Services provided / subcontracted

During 2016/17 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 2016/17 represents 100% of the total income generated from the provision of NHS services by the Trust.

(Left to right) Patient Dennis Hill, and Dr Chetan Varma.

How we performed in 2016/17:

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 important feedback regarding Trust services. Different methods are used to support patients including: electronic tablets, SMS texting, cards and more recently we now send messages via landlines.

Some of the improvements in 2016/17 have included the re-launch of sleep packs following a successful initial campaign, training of volunteers to support activity provision for patients with cognitive disorders, exploration of staff knowledge regarding sensory disability and provision of communication aids as a result of the survey and placing a flag on the records of patients with learning disabilities to support seamless care.

Family and Friends Test (FFT) – would recommend scores April 2016 – February 2017

SWBH Inpatient Score	National Average	National Lowest	National Highest
89.9%	96%	74%	100%

SWBH ED Score	National Average	National Lowest	National Highest
79.4%	86%	48%	100%

SWBH Outpatients Score	National Average	National Lowest	National Highest
88.2%	93%	73%	100%

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 patients, including listening to patients, the need for privacy, information and involving patients in decisions about their care.

Patient Stories

During 2016/17, 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.

The Board heard from the mother of a patient with a learning disability who had been admitted several times over the last year with artificial line feeding (PEG) complications resulting in breathing problems. The individual patient was reviewed and care actioned at the time but the executive team initiated a review of the PEG service and a review of caring for patients with learning disabilities within the hospital setting.

Complaints

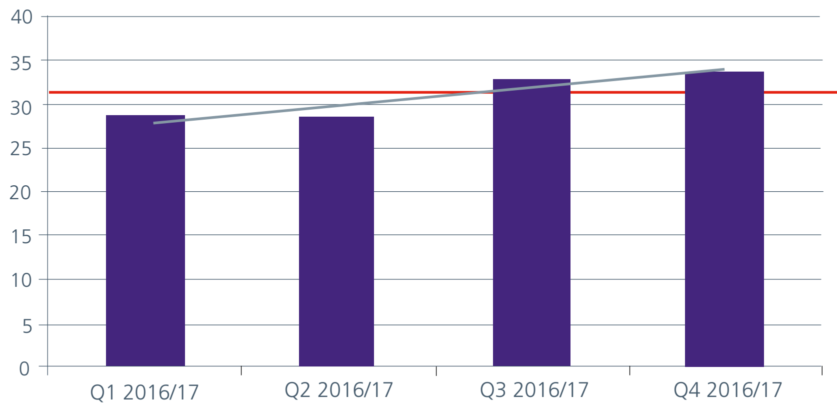
Complaints management remains effective and timely, focusing on the needs of complainants. Establishing the outcomes sought from complainants upfront, and offering resolution meetings alongside, or instead of written responses continues to be a focus of the complaints team.

Table showing this year's complaints vs last year

Patient experience	2015/2016	2016/2017
Complaints received - Formal%	871	1026

It was recognised that there was an opportunity to streamline the work that the PALS and Complaints do, and as such the team as a whole has been restructured. This restructure has coincided with other changes across the Trust and has had some impact on the KPI results. Complaints were still responded to by their target date, 81% of the time, and the average number of days they took to complete was 31 days.

Average number of days to respond to complaints by quarter



Most common themes of complaints comparing 2015/16 – 2016/17

The most common themes	2015/2016 %	2016/2017 %
All aspects of clinical treatment	53	48
Appointment delay/cancel (outpatient)	16	16
Attitude of staff	12	14
Communication/info to patient	6	7
Personal records	3	2
Appointments delay/cancel (in patient)	2	2
Admissions/ discharges, transfers	1	4
Transport services	1	1

Where learning can be evidenced, this is shown to the complainant even if this is sometime after the complaint is closed. The following are examples of learning that has taken place as a result of complaints.

- Communication between the District Nursing (DN) team, and patient's family improved through the use of a "Communication Sheet".
- New referral pathway established by a Professor in Neurology where all patients with a suspicion of a genetic diseases will now have access to counselling at the earliest opportunity.
- A change in clinical practice where it is now policy that arterial and venous cannulas are not placed too close together, and sharp scissors are no longer used to remove dressings.
- In light of the difficulties experienced by some, patient transport bookings can now be taken over the phone without the need to complete a form. This in turn has ensured equal access to appointments for all patients including those with disabilities.

PALS - Patient Advice and Liason Service

Local resolution is encouraged, on the basis that wards and outpatient 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, PALS provide an essential liaison service between the patient and service. They can 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. During 2016/17 we received 2592 queries into our PALS team

Themes of PALS enquiries

Theme	2015/2016 %	2016/2017 %
Appointment issues	25	28
Clinical issues	25	27
Complaints advice or referral	5	5
Communication	14	13

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.

NHS Digital publishes PROMs national-level headline data every month with additional organisation-level data made available each quarter. Data is provisional until a final annual publication is released each year.

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

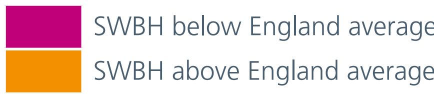
Patient Lakvinder Kaur Sangha tries out the new Cardiac Rehabilitation Gym at City Hospital.

Patient Reported Outcome Measures (PROMs)

	Health Status Questionnaire - Percentage improving			
	Finalised data for April 14– March 15 (Published 11/08/2016)		Provisional data for April 15– March 16 (Published 09/02/2017)	
	SWBH	National	SWBH	National
Hernia repairs	50.7%	43.7%	50.9 %	49.2%
Hip replacement	89.5%	89.3%	89.6%	90.6%
Knee replacement	81.0%	78.1%	81.6%	77.4%
Varicose vein surgery	52.0%	46.7%	52.6%	44.9%

Average adjusted heath gain

	Health Status Questionnaire - Average adjusted health gain							
	Finalised data for April 14– March 15 (Published 11/08/2016)				Provisional data for April 15– March 16 (Published 09/02/2017)			
	National	SWBH	Highest National	Lowest National	National	SWBH	Highest National	Lowest National
Hernia repairs	0.084	0.058	0.107	0.041	0.088	0.075	0.157	0.021
Hip replacement	0.436	0.414	0.495	0.348	0.438	0.435	0.510	0.320
Knee replacement	0.315	0.287	0.373	0.229	0.310	0.325	0.398	0.198
Varicose vein surgery	0.094	0.087	0.161	-0.021	0.095	0.077	0.149	0.018


SWBH below England average
SWBH above England average

The finalised data for 2014/15 and the provisional data for 2015/16 shows that there are areas where the reported outcome is below the average for England.

In response, the Trust has taken the following action:

Procedure	Action taken
Hip & Knee replacement	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. Patient information regarding the importance of completing PROMs will be displayed on waiting room TV screens in both fracture clinics cross site.
Varicose vein surgery	Most varicose veins are now done by radiofrequency ablation. Patients are offered another booklet if they forget to bring it with them on the day of surgery. All patients have a discussion regarding risk and benefits and information leaflets have been updated to include more information on PROMS and on what symptoms to expect post operatively and in what time frame.
Groin hernia repair	Patients are offered another booklet if they forget to bring it with them on the day of surgery. A PROMS lead within General Surgery is now in place, and PROMs Champions have been identified on both City and Sandwell Day Surgery Units. Patient information leaflets are to be revised to include post-operative expectations for patients. PROMs awareness is included in the training of all new staff on SDU / ASU as part of their induction programme.

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.

How we performed in 2016/17: Against our standards

Access Metrics	Measure	2016/17	Target
Cancer – 2 week GP referral to first outpatient	%	94.6	=>93.0
Cancer – 2 week GP referral to first outpatient (breast symptoms)	%	95.5	=>93.0
Cancer – 31 day diagnosis to treatment all cancers	%	98.0	=>96.0
Emergency care – 4 hour waits	%	87.23	=>95.0
Referral to treatment time – incomplete pathway < 18 weeks	%	93.08	=>92.0
Acute diagnostic waits < 6 weeks	%	1.32	<1.0
Cancelled operations	%	1.1	0.8
Cancelled operations (breach of 28 day guarantee)	Number	10	0
Delayed transfers of care	%	2.1	=<3.5
Outcome Metrics	**Measure**	**2016/17**	**Target**
MRSA Bacteraemia	Number	1	0
C Diff	Number	21	<30
Mortality reviews (complete within xx days)	%	66	=<90
Risk adjusted mortality index (RAMI)	RAMI	104.93	<100
Summary hospital level mortality index (SHMI)	SHMI	104	<100
Caesarean Section rate	%	26.3	<=25.0
Patient safety thermometer – harm free care	%	94.3	=<95
Never Events	Number	4	0
VTE risk assessment (adult IP)	%	95.4	=>95.0
WHO safer surgery checklist	%	99.9	=>100
Quality Governance Metrics	**Measure**	**2016/17**	**Target**
Mixed sex accommodation breaches	Number	51	0
Staff sickness absence (rolling 12 months)	%	4.48	=<2.5
Staff appraisal	%	97	=>95
Medical staff appraisal and revalidation	%	84.9	=>95
Mandatory training compliance	%	87.2	=>95
Clinical Quality and Outcomes	**Measure**	**2016/17**	**Target**
Stroke Care – patients who spend more than 90% stay on Stroke Unit	%	94.5	=>90
Stroke Care – Patients admitted to an Acute Stroke Unit within 4 hours	%	78.4	=>80
Stroke Care – patients receiving a CT scan within 1 hour of presentation	%	72.0	=>50.0
Stroke Care – Admission to thrombolysis time (% within 60 minutes)	%	67.4	=>85
TIA (High Risk) Treatment within 24 hours of presentation	%	98.0	=>70
TIA (Low Risk) Treatment within 7 days of presentation	%	97.2	=>75
MRSA screening elective	%	91.2	=>80
MRSA screening non-elective	%	93.0	=>80
Inpatient falls – Acute	Number	654	<804
Inpatient falls – Community	Number	340	
Hip Fractures – Operation within 36 hours	%	74.7	=>85
Patient Experience	**Measure**	**2016/17**	**Target**
Complaints received – Formal and link	Number	1176	N/A
Patient average length of stay	Days	3.56	N/A
Coronary Heart Disease - primary angioplasty (<150 mins)	%	96.1	=>80
Coronary Heart Disease – rapid access chest pain (<2weeks)	%	99.7	=>98

Children's Safeguarding

In order to safeguard children we continue to work closely with Sandwell and Birmingham Multi-Agency Safeguarding Hubs (MASH) and frontline staff to improve the quality of inter-agency referrals so that children and families receive the most appropriate support and intervention at the right time. We are an active and participatory partner in both Sandwell and Birmingham Safeguarding Children Boards and their sub-group meetings to provide assurance that we are meeting our statutory safeguarding children roles and responsibilities.

Our Safeguarding Children Training Strategy is in place to ensure our staff are appropriately trained to respond to safeguarding children concerns. 72% of staff have received face to face training and 74% of staff in key groups such as midwives, health visitors, sexual health services and emergency department practitioners have received more in depth training on how to recognise and refer safeguarding issues.

We have delivered a rolling programme of 'bite sized' training on Child Sexual Exploitation (CSE) jointly with Barnardo's to emergency department staff, midwives and health visitors so they can recognise risks/triggers and refer to children's social care appropriately. We are a member of both Sandwell's and Birmingham Safeguarding Children Board CSE Health Group to ensure the profile of CSE remains high on our agenda. We currently flag our electronic patient record when it is known a child/young person is at risk of CSE in order to support the practitioner's assessment and response when this vulnerable group accesses our services. We work closely with Sandwell and West Birmingham Clinical Commissioning Group who have hosted two CSE conferences which have been well attended by SWBH staff; the theme being the 'Voice of Survivor' and, following preparation for the first conference prompted the design of the 'CSE Superhero badge and logo' which the CCG has since received national recognition for.

The Safeguarding Team Domestic Abuse Nurses continue to deliver specific Domestic Abuse training across the organisation; the team has designed a domestic abuse leaflet that has been attached to wage slips to raise the profile of domestic abuse and give information on indicators and key contacts for all staff.

Your Trust Charity funded an Independent Domestic Violence Advocate (IDVA) Project to support victims and their children. This continues to prove to be a positive venture with over 181 victims being identified in Emergency Department receiving support and onward referral since the start of the project in November 2015. We have now extended the project into City ED from January 2017. Our Domestic Abuse Policy supports staff in routine enquiry of domestic abuse and the ED assessment paperwork has been amended to record this. We are currently seeking further funding to support the project post December 2017.

We have updated a number of policies against national and local guidance. These include female genital mutilation; paediatric liaison service policy, child death policy and the PREVENT agenda. We continually monitor findings from CQC inspections and review all action plans at our Safeguarding Children Operational Group.

The Child Protection Information Sharing (CP-IS) project went live in October 2016 with Birmingham City Council to share child protection information across unscheduled care settings. We have developed systems so that staff are able to access this information. It is anticipated that Sandwell MBC will go live with CP-IS in September 2017.

Priorities for 2017/18 will continue to focus on CP-IS integration across the local authority areas to inform our patient record, securing further funding for the IDVA project post December 2017, monitoring and delivering our safeguarding children training programme and continuing to raise CSE risk across key areas.

Children's safeguarding team (left to right) Glenn Bradnick, porter, Jayne Clarke, Safeguarding children lead nurse, Tanya Clarke, safeguarding administrator and Noreen Ahmed, specialist nurse for safeguarding children.

Adult safeguarding

A restructure has been carried out within the Adult Safeguarding team to ensure patients lacking in capacity are properly protected from any harms. This change means the team now consists of an Adult Safeguarding Nurse, Dementia lead, Tissue Viability Lead with Learning Disability Liaison Nurses, who are available at both Sandwell and City Hospitals.

The Trust has focused on Deprivation of Liberty applications for those patients, with training to senior nurses, consultants, senior therapists and managers within the organisation. In addition a tool for assessing capacity and prompt for raising a Deprivation of Liberty application which reinforces the Mental Capacity Act (2005) has been created. Whilst it is recognised that this work is required to continue within the organisation to ensure it is fully embedded to SWBH practice, initial data is encouraging. The organisation applied for more than double the Deprivation of Liberty safeguards when compared with the previous year.

We continue to work closely with Sandwell and Birmingham multi agency safeguarding board participating in work streams for both prevention and protection of shared strategies. We prioritise full cooperation with any identified cases meeting the criteria for public enquiries and we are committed to learning lessons and improving practices around patient/client safeguards. PREVENT duties within the Trust continue to develop with participation at multiagency meetings (Channel Panel) contributing to individual case management. The Trust participates in PREVENT forums chaired by NHS England.

All activities of the Safeguarding Nurse are recorded on a dashboard to ensure trends and themes can be identified to improve and maintain the safety of our patients.

The learning disability service has been expanded to include a specialist nurse based at both Sandwell and City Monday toFriday. An action plan for the Trust has been agreed and is in process and an operational policy is being formulated.

We have appointed two new activity co-ordinators and developed a training programme for volunteers who are attending the wards to provide therapeutic activity for patients with dementia, delirium and learning disabilities during their hospital admission.

Readmissions

Tackling readmissions remains a focus for the Trust as we strive to ensure we are in a position to provide good quality care that means ensuring patients are cared for in an appropriate environment. We will reduce our readmissions by a further 2% this year by coordinating care well across different services facilitating safe and timely discharges for our patients so that there is not a need for them to return for an unplanned stay in hospital.

We know that our frail patients are at the most risk of being readmitted so significant effort has been made in this area during the last 12 months.

Use of the LACE scoring tool identifies patients with a potential high risk of readmission against the criteria of length of stay, acuity of admission, case mix and the number of attendances to the emergency department in the last 6 months. Action planning is based on a threshold score of 11 which is automatically generated on the electronic bed management system to alert to ward clinical teams. Crucially the score is also auto-generated to the Community Contact Centre. The iCares community team call 100% of consented cases within 24 hours of hospital discharge and this in turn triggers the need for further intervention for a visit or a subsequent call. The coming months will also see the Frailty Early Supported Discharge Service to support continued rehabilitation at home.

We are currently trialing a Community-Acute Alert System where all over 65 year olds known to the Sandwell community teams within the last six months with one of 6 common conditions (asthma, heart failure, dementia, falls, COPD and UTI) are identified electronically and triaged by the Community Contact Centre. This can generate a proactive acute to community management plan to facilitate timely discharges.

The multi-disciplinary working in the Older Person's Assessment Unit at Sandwell includes a comprehensive geriatric assessment for all patients within 14 hours of admission and in development are personalised discharge information packs incorporating valuable information and contact numbers.

The multi disciplinary team working on our Older Person's Assessment Unit (OPAU) at Sandwell Hospital.

Readmission rates

The table below details our readmission rates. The information is collected during a financial year period and we now measure readmission within 30 days (previously 28 days).

Age 0 – 15 years

SWBH	Number of patients	Total number of re-admissions	Percentage of re-admissions
16/17	16257	985	6.1%
15/16	15867	1100	6.9%
14/15	15819	1360	8.6%
13/14	15331	1350	8.8%
12/13	15679	1463	9.3%
11/12	14533	1257	8.6%
10/11	15077	1219	8.1%

Age 16 and over

SWBH	Number of patients	Total number of re-admissions	Percentage of re-admissions
16/17	90621	6668	7.4%
15/16	92650	7738	8.4%
14/15	94349	7707	8.2%
13/14	96981	7530	7.8%
12/13	101647	7693	7.6%
11/12	102660	7235	7.0%
10/11	110729	7734	7.0%

All Ages

SWBH	Number of patients	Total number of re-admissions	Percentage of re-admissions
16/17	106875	7653	7.2%
15/16	108517	8838	8.1%
14/15	110168	9067	8.2%
13/14	112312	8880	7.9%
12/13	117326	9156	7.8%
11/12	117193	8492	7.2%
10/11	125806	8953	7.1%

Data April 2016 - February 2017

Outpatient Care

Outpatient care remains a key focus for improvement. We have halved the number of patients waiting over 18 weeks for treatment largely through improvements in our outpatient pathways and waiting time management. We have continued to roll out partial booking and text reminder services aiming to reduce the Do Not Attend (DNA) rate.

In the year ahead we anticipate there will be many more electronic referrals from primary care which will further enable us to improve the timeliness of our communication and booking processes with patients. This year we will embed electronic communications with our patients by email as well as implement the new electronic patient record in outpatients.

Community Caseloads

A key focus during the year has been to increase patient contact time by 10% amongst community staff. The adult community teams have introduced a number of new ways of working that benefit patients, are more cost effective and continue to deliver high quality care closer to home.

Working closely with our GP colleagues we have moved towards increased clinic based activity across District Nurse teams to improve productivity. We have introduced a number of new clinics since June 2016 with an intention to implement seven across Sandwell and West Birmingham in the coming months as facilities permit. Feedback from patients is positive and demonstrates that those patients who are not house bound are happy to attend clinics for their treatment and enjoy the social interaction and experience. The success of this clinical model has contributed to the District Nurse Service being able to deliver approximately 20% more activity than last year's baseline.

The introduction of mobile working across the whole adult community workforce provides real time access at the point of care to electronic records reducing the need for paper records. Clinicians do not need to return to base to complete their documentation giving them more time for direct patient contact. The gradual introduction of the lightweight laptops has facilitated live access to patient records in a patient's home resulting in optimal informed decision making, reduced risk and fewer attendances to the Emergency Department.

In the year ahead we will introduce clinicians to work within the Contact Centre who will undertake clinical triage at peak call times with the ability to divert calls to the most appropriate community services or simply advise over the phone.

Focussed Care

Last year we reported that we would adopt 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. This campaign has been implemented in all areas supported by the arrival of a Dementia Specialist Nurse. The nurse has worked in partnership with key wards to promote patient-centered care with the aim of reducing the need to provide extra supervision but to facilitate opportunities for activities and reminiscenc. This work will continue into 2017.

Quality Improvement Half Days

Following the successful launch of Quality Improvement Half Days (QIHDs) in April 2015, this year saw this unique approach to staff involvement develop and expand further across the organisation, with over 1000 colleagues regularly attending each time. The four hour QIHD sessions provide a chance for multi-disciplinary teams to take time away from their normal day-to-day duties to consider how to learn and develop new ideas. Though largely local, they also help tackle cross-organisational learning. On some occasions the learning might be very specific – an incident in one part of our Trust that has implications everywhere - or more general such as a change we need to put in place across our organisation. The synchronisation of ten half days a year and the involvement of all staff groups creates an opportunity for a sea change in approach to quality improvement. Our unique Quality Improvement Half Day (QIHD) process creates time to talk.

Looking ahead, in April 2017 our QIHD programmes feature, for the first time, ward QIHDs, making time for emergency teams to share lessons and learning. In May and June we roll out a voluntary accreditation scheme for teams to put their QIHD time forward for recognition as a role model in quality improvement. This is, above all, a mass movement. A bottom up effort to change results and culture, and the benefits are showing in both team morale and outcomes in our patients' experience of care.

Mortality

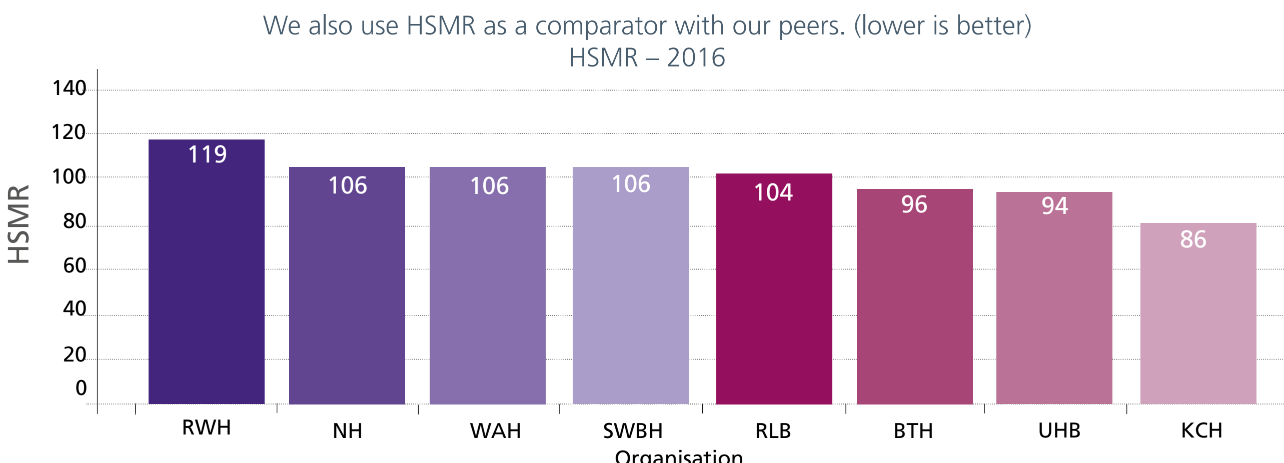
Mortality data is now extracted from the CHKS (Casper Healthcare Knowledge) System, which reports the Risk Adjusted Mortality Index (RAMI) as the principle measure of our organisation's mortality, and the HED (Healthcare Evaluation Database) System which reports the Hospital Standardised Mortality Ratio (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 2017) 106 for SWBH. This information is derived from the HED system, which is rebased monthly to provide the most up to date data.

We also use HSMR as a comparator with our peers. (lower is better)

HSMR – 2016



(Left to right) Community phlebotomist Jayne Burkinshaw, matron for community nursing services Denise Owen and Health Care Assistant Joel Williams.

RAMI (Risk Adjusted Mortality Index)

This is a methodology developed by Casper 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 is 104.93 and outside of statistical confidence limits which is above the National HES peer RAMI of 92. The aggregate RAMI for the City site is within statistical confidence limits with a RAMI of 96, and the Sandwell site with a RAMI of 119, which is outside of statistical confidence limits. This reflects a decreasing trend in hospital deaths with a palliative care code as a consequence of our drive for patients to receive such care in a place of their choosing other than in hospital. 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 104 for SWBH Trust.

Mortality comparisons against national results

	Lowest	Highest	SWBH
Observed	526	4514	2196
Expected	758	4674	2127
Score (SHMI)	0.6939	0.9658	1.0322

The data above compares our mortality figures against all other Trusts nationally. A Trust would only get a SHMI value of one if the number of patients who died following treatment was exactly the same as the expected number using the SHMI methodology.

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

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

Trust Mortality Review System

For the year 2016/17 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. Mortality Review compliance has been set as a local CQUIN for 2016/2017. Although there has been an improvement in the number of deaths reviewed within 42 days, achievement of this target has been sporadic and we will continue to keep this as a priority for 2017/2018.

2016/17

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD
Death	140	115	124	379	121	100	86	307	103	128	134	365	168	134	96	398	1449
Reviewed	84	87	85	256	84	60	47	191	79	96	109	284	103	71	62	236	967
% Reviewed	60	75	68	67	69	60	54	62	76	75	81	77	61	52	64	59	66
% Cumulative Reviewed	60	67	67	67	68	66	65	65	66	67	69	69	68	66	66	66	66

Deaths of patients with involvement from specialist palliative care services

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

Total number of deaths	Palliative Care	%
2196	571	26

Diagnostic care coding= Z5.15.
End of life (Palliative) care

What we are doing to reduce avoidable deaths:

- We will review 90% of deaths within 42 days.
- Top 3 learning points
  1. 100% compliance with the Sepsis Bundle
  2. Timely management of Acute Kidney Injury (AKI)
  3. Early implementation of the Supportive Care Plan
- Enhanced revision of the current mortality review system in readiness for migration to the new EPR.
- Incentive for reviewers who complete 100% reviews.
- Participation in the National Mortality Retrospective Case Record Review (NMRCRR) commissioned by HQUIP as an early implementer site.
- Participation as a Tier 1 training site for the NMRCRR.
- Participation in the National Learning Disability Mortality Review Programme (LeDeR) managed by the University of Bristol.
- Working with the Black Country Alliance and NHS England West Midlands Mortality Concordat to collaborate, share good practice and quality improvement based around Learning From Deaths in our region.
- Corporate work streams identifying Group and Specialty Quality Improvement of End of Life Care and Specialist Palliative Care.

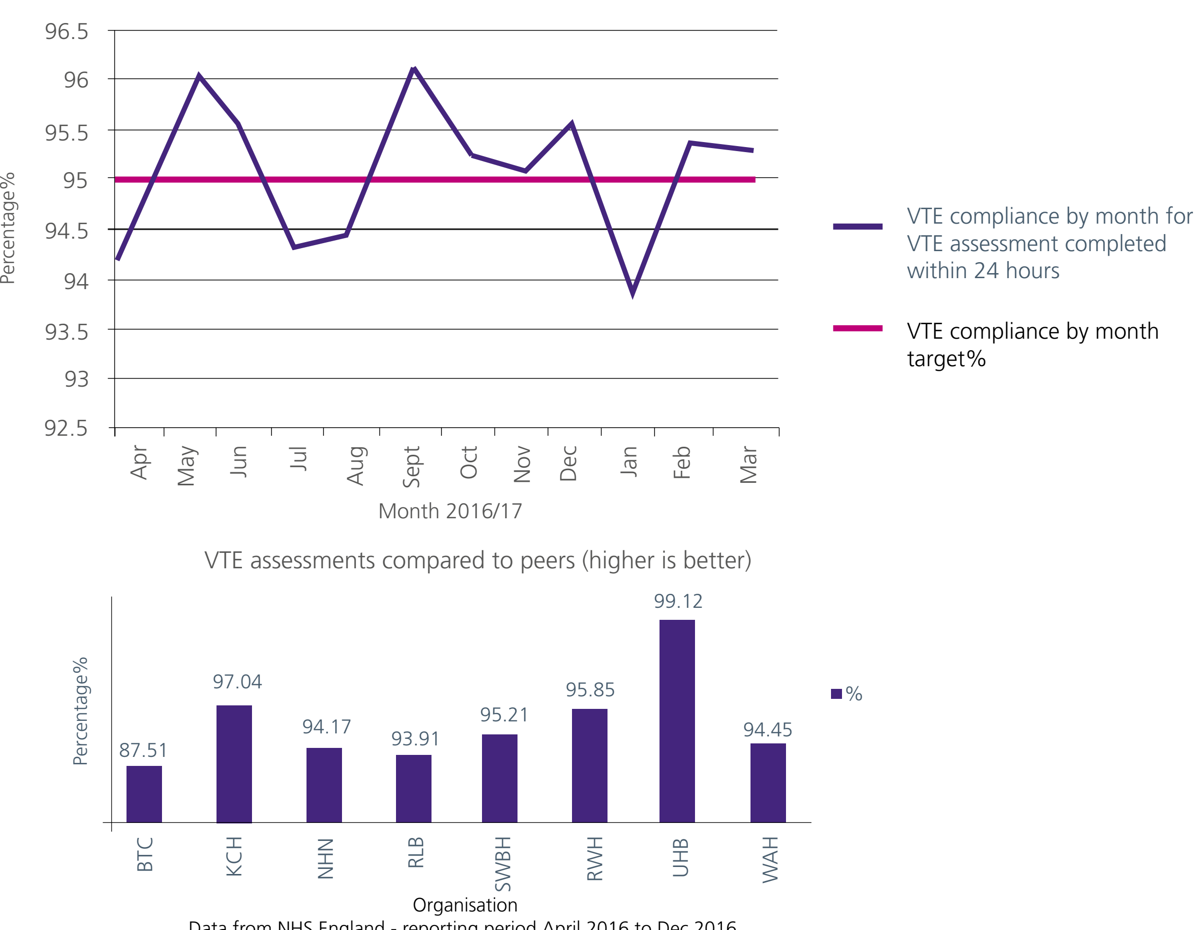
Connected Palliative care team (left to right) Aimee Hughes, end of life care facilitator, and Zoe Chappell, specialist palliative care nurse.

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. Our year end position is 95.4%.

VTE assessments completed within 24 hours 2016/17



Data from NHS England - reporting period April 2016 to Dec 2016.

VTE Assessments

Lowest/highest average - Data from NHS England - reporting period April 2016 to Dec 2016

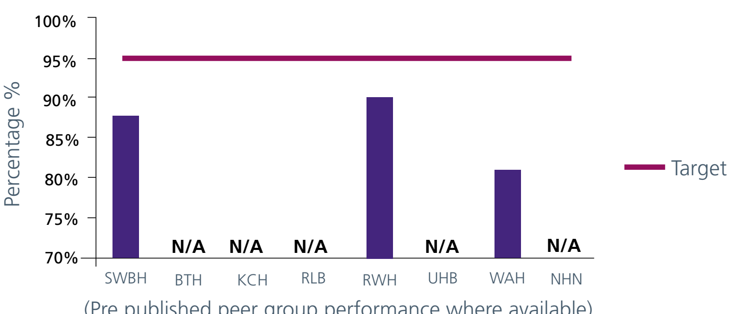
Lowest	Highest	Average
82%	100%	95.55%

Emergency four hour waits

In line with the national standard we aim to ensure that 95% of patients will wait for no more than 4 hours within our Emergency Departments (ED). Although the majority of patients were seen in 4 hours on average we achieved 87.22%.

We continue to see good results in ambulance handover time, meaning that ambulance crews can get back on the road more quickly. We remain committed to improving our performance and have implemented Rapid, Treatment & Assessment (RAT) this year which has shown an improvement in time to treatment.

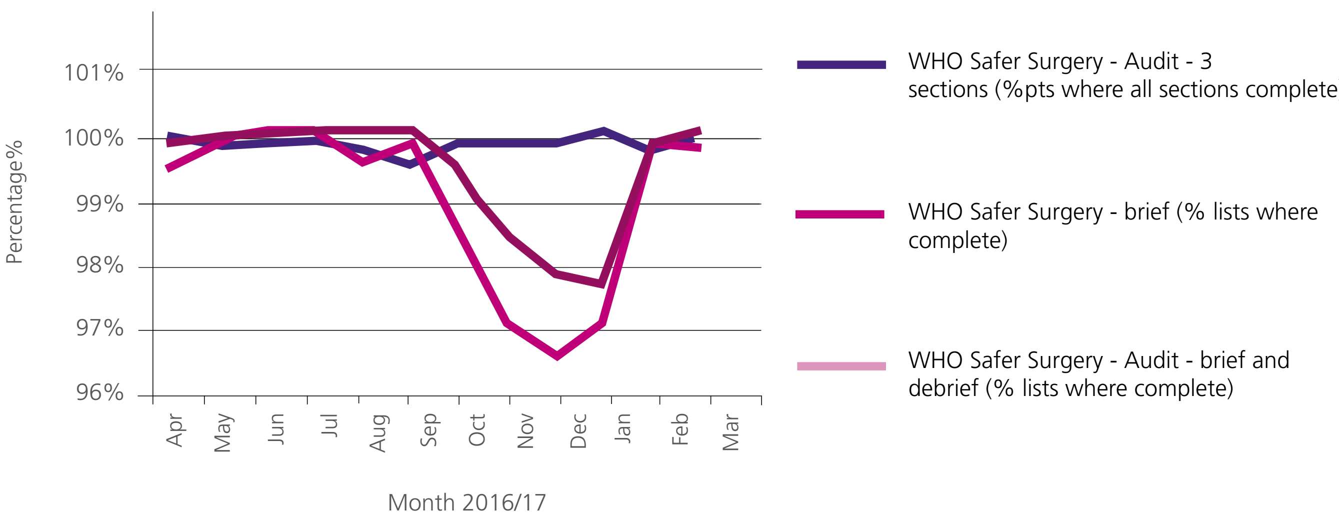
Percentage of patients waiting 4 hours or less in Emergency Departments 2016/17
(Higher is better – target 95%)



(Pre published peer group performance where available)

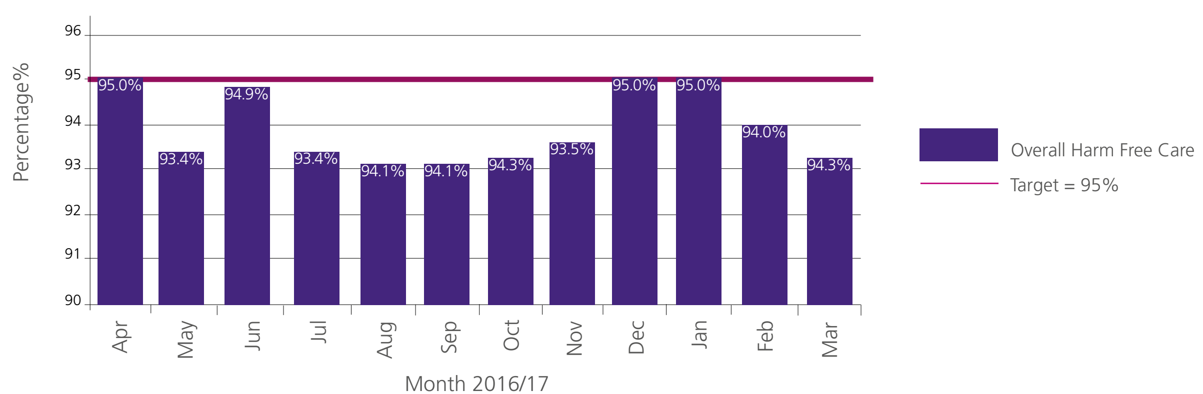
WHO Safer Surgery Checklist

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



Harm free care

We continue to undertake monthly prevalence audits looking at four harms – pressure ulcers, falls, catheter related UTIs and DVT. We review harms via the incident reporting framework with lessons learned shared locally and across the organisation.



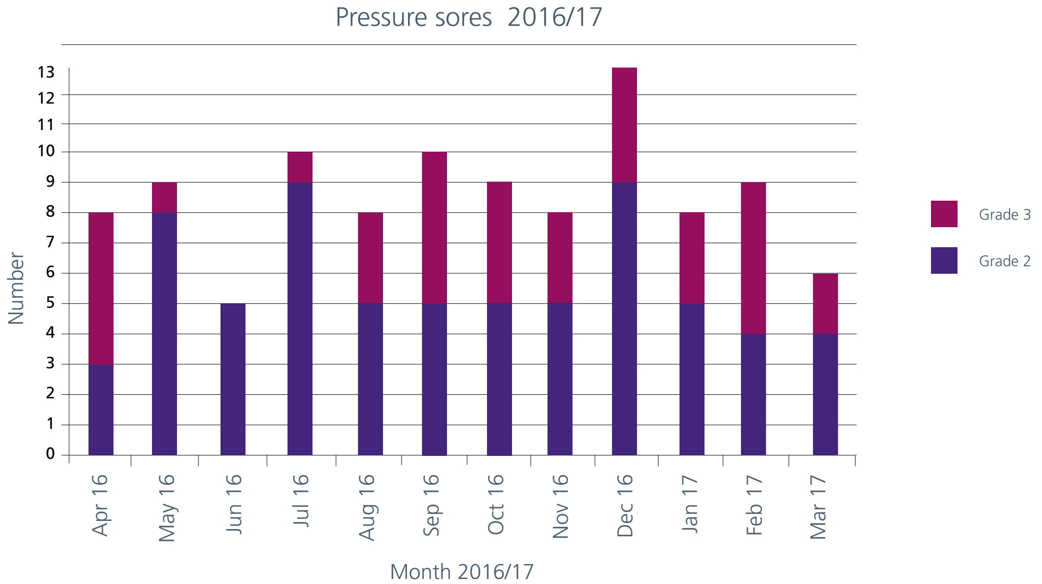
Pressure ulcers

Pressure ulcer prevention remains one of the key priorities within the Trust and is incorporated within the Trust Safety Plan for 2017 which focuses on ensuring consistency in identifying when our patients are at risk of developing pressure damage and ensuring they have all the preventative strategies in place to reduce the risk of our patients going on to develop pressure damage.

In line with our vision to provide patients the safest care possible the Trust continues to promote being open with the reporting of pressure damage incidences in order to learn from mistakes and improve future care for patients. With continued ongoing monitoring and review of grade 3 pressure ulcers the Trust strives to keep our safety promises by learning from incidents, changing care when required and reducing harm to our patients.

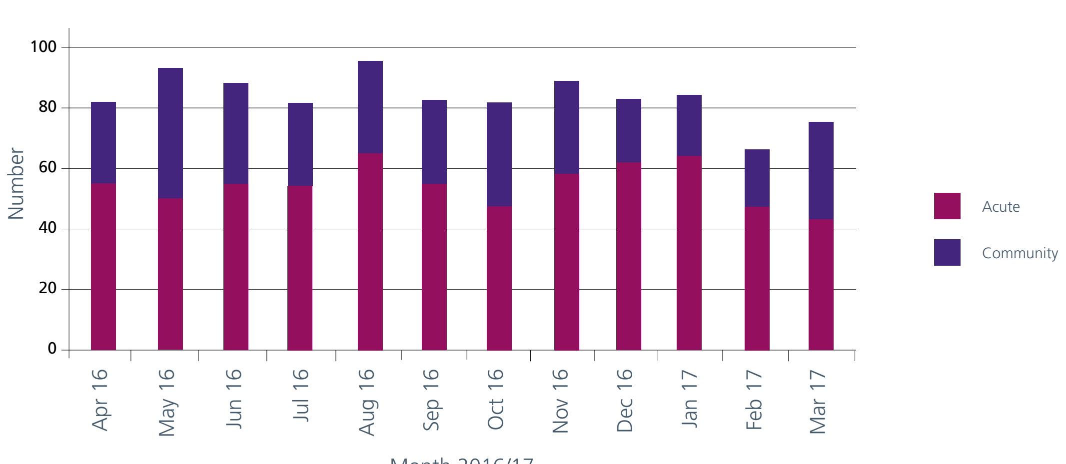
The Trust has sustained our previous improvements in the reduction of avoidable pressure damage; however pressure damage still occurs in low levels. In the coming year the Tissue Viability service will be engaged in the National NHS Improvement Stop the Pressure Campaign to eliminate avoidable pressure ulcers within the Trust. The campaign will focus on the early identification of at risk patients and reacting quickly to the early warning signs and preventing pressure damage occurring. This initiative will support the Trust Safety Plan with a huge focus on preventing harm occurring to our patients.

During 2016 our focus on community pressure ulcer prevention has continued with a new initiative working in partnership with West Midlands Fire Service as part of their Safe and Well project, offering fire safety advice to patients in their own homes using pressure relieving air flow mattresses. The first event in April 2017 included raising awareness within our District Nursing teams of the need to consider the risk of fire and to offer patients a referral for advice from the West Midlands Fire Service.



Falls

The number of falls in 2016/17 was 994. All incidents with a slip, trip or fall indicated are automatically highlighted and collated on a monthly basis to provide a monthly / quarterly and annual report. We review this information to try to reduce the risk to our patients.



The aim of the Infection Prevention and Control Service (IPCS) is to develop, utilise and promote infection prevention and control practices that are cost effective, safe and efficient, minimising the risk of patients acquiring infections, during or as a result of their stay in hospital. Working in partnership with health care professionals across the health economy, the Trust is committed to a zero tolerance ambition to eliminate all avoidable HCAIs.

To comply with current legislation and meet the National demands from professional bodies such as the Department of Health (DH), the Care Quality Commission (CQC) and NHS Improvement (NHSI), the IPCS adopt a proactive approach to the identification, management and monitoring through education, training, surveillance, and monitoring of clinical and non-clinical practices in line with national standards such as National Institute for Health and Care Excellence (NICE) guidance, Patient Lead Assessment in the Clinical Environment (PLACE), national standards of cleaning and guidance and recommendations from professional bodies.

Organisational structures continue to work well both within our own organisation and across the wider healthcare economy. The IPCS is a fully integrated service incorporating the acute, community and intermediate care. Partnership working with the Clinical Commissioning Groups (CCG), NHS Improvement (NHSI), Health Protection Unit (HPU) and Public Health England (PHE) through the Health Economy Groups for Infection Prevention and Control continues to thrive.

Infection Performance for 2016/17

Target	Agreed target/rate [Year end]	Trust rate [End Mar 2016]	Compliant	Comments	
MRSA bacteraemia	0	2 (1 attributed to SWBH on HCAI data base)	No	Pre 48hrs [laboratory identified] 1= Sandwell * 1 = City	Post 48hrs [laboratory identified] 1= Sandwell 1 = City
				All bacteraemia's identified in the laboratory have had a post infection review as per PHE guidance to identify issues and lesson learnt. Of the cases identified 1* has been attributed to SWBH.	
C.difficile acquisition toxin positive	30	21 attributed to SWBH	Yes	12 =Sandwell site 9 =City site	
MRSA Screening - Elective [YTD]	85% (locally agreed)	91.2%	Yes		
MRSA Screening - Non Elective [YTD]	85% (locally agreed)	93.0%	Yes		
Post 48hrs MSSA Bacteraemia (rate per 100,000 bed days)	N/A	15 (7.18 per 100,000 bed days)		All Post 48 hrs bacteraemias 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 (Target = 3% by Ward, dept. and site.)	City	2.5%	3.0%	2.7%	3.9%	3.2%	2.5%	3.0%	2.3%	2.1%	1.5%	2.5%	3.3%
	SGH	3.7%	3.8%	3.9%	4.1%	8.0%	3.3%	4.6%	4.6%	1.9%	1.8%	0.9%	6.1%
	It needs to be recognised that due to the clinical condition of some patients there is a risk of obtaining an unavoidable blood contaminant. However, any clinician identified as taking a contaminated blood culture is required to attend for further training to reiterate practices. In addition to this, since Aug 2014 the IPCS have introduced a training programme for all new doctors to the Trust.												

During the period April 2016 – March 2017 two wards closed (Leasowes and Rowley Regis) due to Norovirus which was confirmed and five bay closures (Sandwell 3, Rowley Regis 2) with Norovirus confirmed in two of these. There were four outbreaks of flu at Sandwell resulting in one ward closure and bay closures in the other areas. Two wards at City were closed with flu during February.

In addition to outbreaks of D&V, due to the emergence of multi resistant organisms, national guidance, increased surveillance and microbiological screening of patients the Trust has identified an increasing number of periods of increased incidence and outbreak attributed to a variety of micro-organisms to include: - Clostridium difficile [CDI] two PIIs one confirmed as an outbreak, Extended Spectrum βeta lactamase organisms [ESBL], one PII, Carbapenamase resistant organisms [CRO]; Vancomycin resistant enterococci [VRE] one PII confirmed as an outbreak at Sandwell, MDR Acinetobacter one PII confirmed as an outbreak at Sandwell. In all incidents post infection reviews have been undertaken and multi-disciplinary and agency meetings held to identify lessons learnt and outcome of lessons learnt.

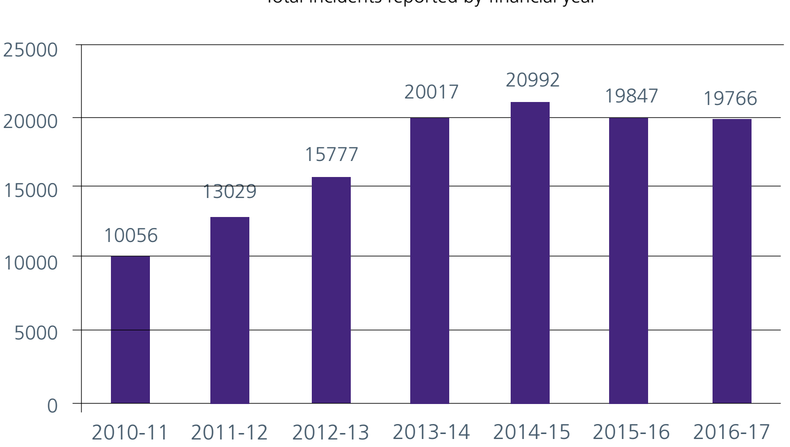
Key to maintaining standards is continued commitment and compliance with infection prevention and control policies by clinical and non-clinical groups and healthcare personnel. Audit and training continues to be prioritised as a means of monitoring and delivering continuous improvements.

Information Governance Toolkit (IGT) attainment levels
We are compliant across the Information Governance Toolkit requirements for 2016/17. We successfully achieved 91%, which is a "Satisfactory" (GREEN) level, according to the NHS Digital IG Toolkit grading scheme. "Satisfactory" means that a minimum Level 2 was achieved for all requirements. We will continue to build on this to strengthen our IG practices and processes and work towards attaining Level 3 compliance.

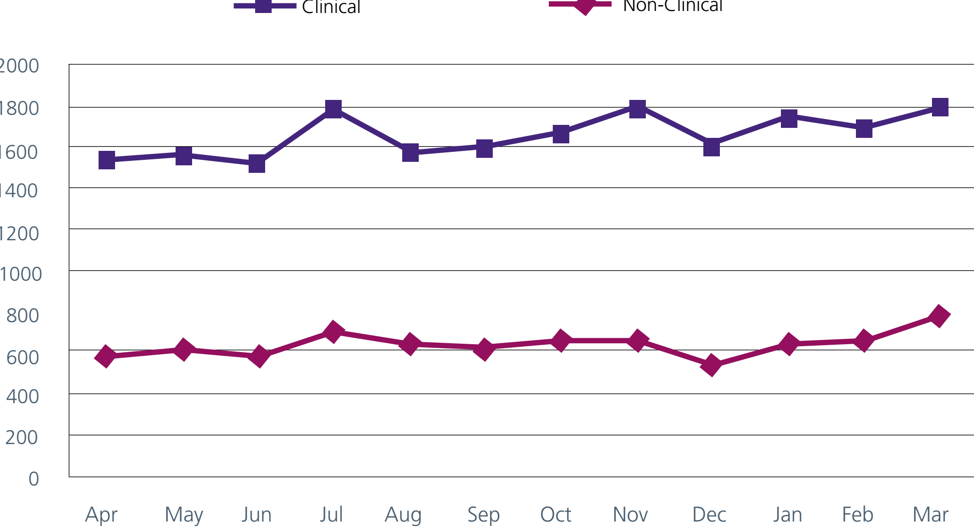
Incident reporting
A positive safety culture remains essential for the delivery of high quality care. We continue to submit our incident data to the National Reporting & Learning System (NRLS) which is publically available and provides comparative data with like-sized Trusts. This data shows that as at the September 2016 report we are in the middle 50% of reporters of Trusts with a reporting rate of 44.48 per 1000 bed days.

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	84	7	28	0.32	7	0.1
2015/16	50.1	76	16.5	20	0.2	6	0.1
2016/17 (up to Sep 2016)	44.48	73	22	8	0.2	1	0.0

The latest data (April to September) shows an overall position of reduced incidents resulting in severe harm or death.



Incidents reported during 2016-17 split by 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 2016/17 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.

Serious incidents reported in 2016/17

2016/17	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of SIs	1	2	3	2	1	0	3	1	1	1	4	5

Dr Jonha Rizkalla, Emergency Department Consultant.

Never Events

During 2016/17 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 robust controls are in place to prevent them from happening.

Incident	What Happened	Where it happened	What we learned
Maternity (June 2016)	Retained item at surgery	Failure in documenting the correct number of packs left in situ. Failure of handover.	Developed a SOP for sign out and introduced wrist band per pack in situ process. Amended practice (packs must be tied together). SBAR handover now in place.
T&O (June 2016)	Retained item at surgery	Failure to identify that the drill device was left in the operation site due to an incorrect instrument count.	Introduced a surgical pause for operations that take place under xray control. Procedure changed re. counting of instruments. Visual and verbal instrument count by scrub nurse. MHRA contacted about making the drill guide a different colour. Tray standardisation is ongoing.
Ophthalmology (November 2016)	Wrong site surgery	The root cause was identified as a failure to correctly follow positive patient identification procedure.	Reinforce positive patient identification and strengthen consent process. Review and implement where feasible changes to clinic waiting areas. Introduce wristbands for patients attending for an invasive procedure. Review IT system to incorporate ability to flag up patients attending on the same day with same/similar names. Updated SOP.
Gynaecology (February 2017)	Retained item at surgery	The root cause was identified as variance in practice due to inadequate awareness of updated policy.	Ensure the updated policy is made available electronically and all staff to be made aware the changes. Permit use of ribbon gauze as clinically indicated but stop use of Jelonet and blue gauze. Stop removal of packs overnight. Reinforce completion of "Sign out" part of Safe Surgery Checklist.

How we performed against external measures: Our Care Quality Commission Improvement Plan

Positive progress has been made this year in delivering the outstanding actions for improvement identified by the CQC as part of their inspection in October 2014. Of the 67 areas requiring attention the majority have now been addressed with positive results for patients, relatives and staff. Some of the improvements include: medicines trolleys widely installed to improve security and safety, outpatient clinic templates comprehensively re-set to what patients need, ward night staff changed qualified ratios and an increased number of patients dying in their preferred place.

The balance of unresolved actions are associated with our medical wards where unreliable practices exist in relation to, for example, ward nursing care plans, fluid balance monitoring and patient agreements with care and treatment remain. An Executive-led 12-week improvement plan is in place to achieve consistency of care on our medical wards by June 2017.

The Trust's in-house inspections continued throughout the year with up to 30 colleagues and external partners at a time visiting wards, theatres, outpatients and services across our sites to observe practices, review clinical records, interview staff and speak to patients and relatives. The key aim of the inspections is to validate that the improvements made have actually taken place. Valuable insight is gained from this approach so the visits will continue in 2017/18.

CQUINs (Commissioning for Quality and Innovation)
The Trust is contracted to deliver a total of 22 CQUIN schemes during 2016/17. Seven schemes are nationally mandated, a further seven have been agreed locally, three identified by the West Midlands Specialised Commissioners, four by Public Health and one in Secondary Care Dental. The table below details the contracted schemes and indicator of whether the scheme has been achieved during this period of time. A proportion of Sandwell and West Birmingham Hospitals NHS Trust income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between Sandwell and West Birmingham CCG, Specialised Commissioners and Public Health.

CQUINs for 2016/17			
1	National	Staff Health & Wellbeing - Introduction of health & wellbeing initiatives	Partially met
2	National	Staff Health & Wellbeing - Healthy food for NHS staff, visitors and patients	✓
3	National	Staff Health & Wellbeing - Improving uptake of flu vaccination	✓
4	National	Sepsis - A&E Screening & Review	Partially met
5	National	Sepsis - Inpatient Screening & Review	Partially met
6	National	Antimicrobial Resistance and Antimicrobial Stewardship - Reduction of antibiotic consumption	✓
7	National	Antimicrobial Resistance and Antimicrobial Stewardship - Review of antibiotic prescribing	✓
8	Local	Cancer - Audit of 2ww cancellations	✓
9	Local	Cancer - Cancer Treatment Summary Record in Discharge Care Plans	✓
10	Local	Cancer - Cancer VTE Advice	✓
11	Local	Safeguarding CSE - Production of a CSE awareness video that is used in staff training sessions	✓
12	Local	Mortality - Achieve an improvement in the % of avoidable and unavoidable death reviews within 42 days	Partially met
13	Local	Discharges - Implementation of transfer of care plans	✓
14	Local	Discharges - Reduction in Readmission Rate (Adults)	✓
15	Spec.	Preventing term admissions to NIC	X
16	Spec.	Haemoglobinopathy improving pathways	✓
17	Spec.	Activation systems for patients with long term conditions	X
18	Public Health	Breast Screening - improvement in uptake - Local information collection on reasons for non-participation in screening amongst the general population	✓
19	Public Health	Breast Screening - improvement in uptake - Promotion of screening programme	✓
20	Public Health	Bowel Screening - improvement in uptake - Local information collection on reasons for non-participation in screening amongst the general population	✓
21	Public Health	Bowel Screening - improvement in uptake - Promotion of screening programme	✓
22	Secondary care Dental	Sugar Free Medicines Audit	✓

External Visits

Care Quality Commission Inspection

The Care Quality Commission visited the Trust at the end of March 2017 to carry out a routine re-inspection following their previous visit in October 2014. Not all, or even most, of our services were re-inspected. Community services were largely excluded, given a rating of good or outstanding from the last review, as were children's services. But adult acute services in both hospitals, end of life care and our community inpatient areas were visited by around fifty professionals and expert patients. In the verbal feedback we were advised that since the last inspection in 2014 the CQC saw significant improvements to the overall service provision. Across all of our 3 sites (City, Sandwell and Rowley Regis Hospitals) and in the community they saw care delivered by kind and caring staff. Some practices in need of attention were found but nothing that was reported as a patient safety concern requiring immediate action. The final report is expected in the summer.

Pathology - UKAS 21-24 February, 13-17th March, 3-4th April

A comprehensive quality assurance visit for Pathology at both City and Sandwell took place recently. At the end of the second week of inspections (with Toxicology still to be inspected) feedback was received from the UKAS inspectors. The overwhelming theme was that this has been a good experience for both the lab and the inspectors and "there are no alarm bells" and "no show stoppers". Most of the findings and recommendations were typical of a lab transitioning from CPA to ISO15189 namely some aspects of verification, traceability and measurement of uncertainty.

The final feedback session took place following two days of inspection in Toxicology. Once again the feedback was positive with all of the assessors stating their willingness to return for future surveillance visits. Two recommendations were made:

1. That the laboratory maintains CPA accreditation until March 2018 when this standard ceases to exist.
2. That accreditation to ISO15189 (2102) is awarded subject to validation of the report by an independent assessor.

In order to be accredited the Trust will have 12 weeks from 4th April 2017 to evidence that the findings have been cleared.

Birmingham and Midland Eye Centre

As a part of the on-going assurance for the Birmingham and Midland Eye Centre based within Sandwell and West Birmingham footprint a planned unannounced visit was agreed by Sandwell & West Birmingham Clinical Commissioning Group (CCG). The purpose of the visit was to gain assurance across the elements of a range of quality and safety measures. The visit took place on 24th November 2016. Overall the visit was a very positive experience.

In the Emergency Department/Urgent Care Centre, feedback to the inspectors from patients regarding their experience of past and present experiences within the department was extremely positive and praise was extended to the staff for their care delivery and expertise. The visitors spoke to patients and their families, some of whom had been attending for many years and therefore were a good barometer of the consistency of the care delivered. It was noted all patients gave positive feedback of their experience of the department and the treatment that they had received.

In outpatients, the team encountered exemplary care for patients in both the reception area and in the treatment room with a patient that had been shadowed from 'self-check in' to treatment. Excellent knowledge and skills were observed in the treatment room regarding procedures and checklists and overall the inspectors were very impressed with the level of professionalism and expertise displayed by the nurses throughout the procedure.

The visiting team highlighted some recommendations for improvements including the location of the triage function and records management, however there were no serious concerns identified during the visit.

Health Education West Midlands visits

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

Training undergraduate and post graduate staff plays a big part in ensuring safe, high quality care for our patients provided by caring and compassionate clinicians. HEWM visited the trust once within the last year in November, looking at the Medical training provided in Medicine. The visiting panel noted that there is a 'strong education ethos' within the Trust which is providing trainees with a good training environment and supported by supervisors who were engaged in education and training and described by trainees as friendly and supportive. It was reported that there is strong educational governance within the Trust and board level engagement, support for education and training and a positive and proactive approach to quality improvement with both trainees and trainers engaged in the process. There were some areas highlighted for improvement which included improved simulated procedural skills training for core medical trainees.

All trainees who met the visiting panel recommended their training post and recommended the Trust as part of the friends and family test.

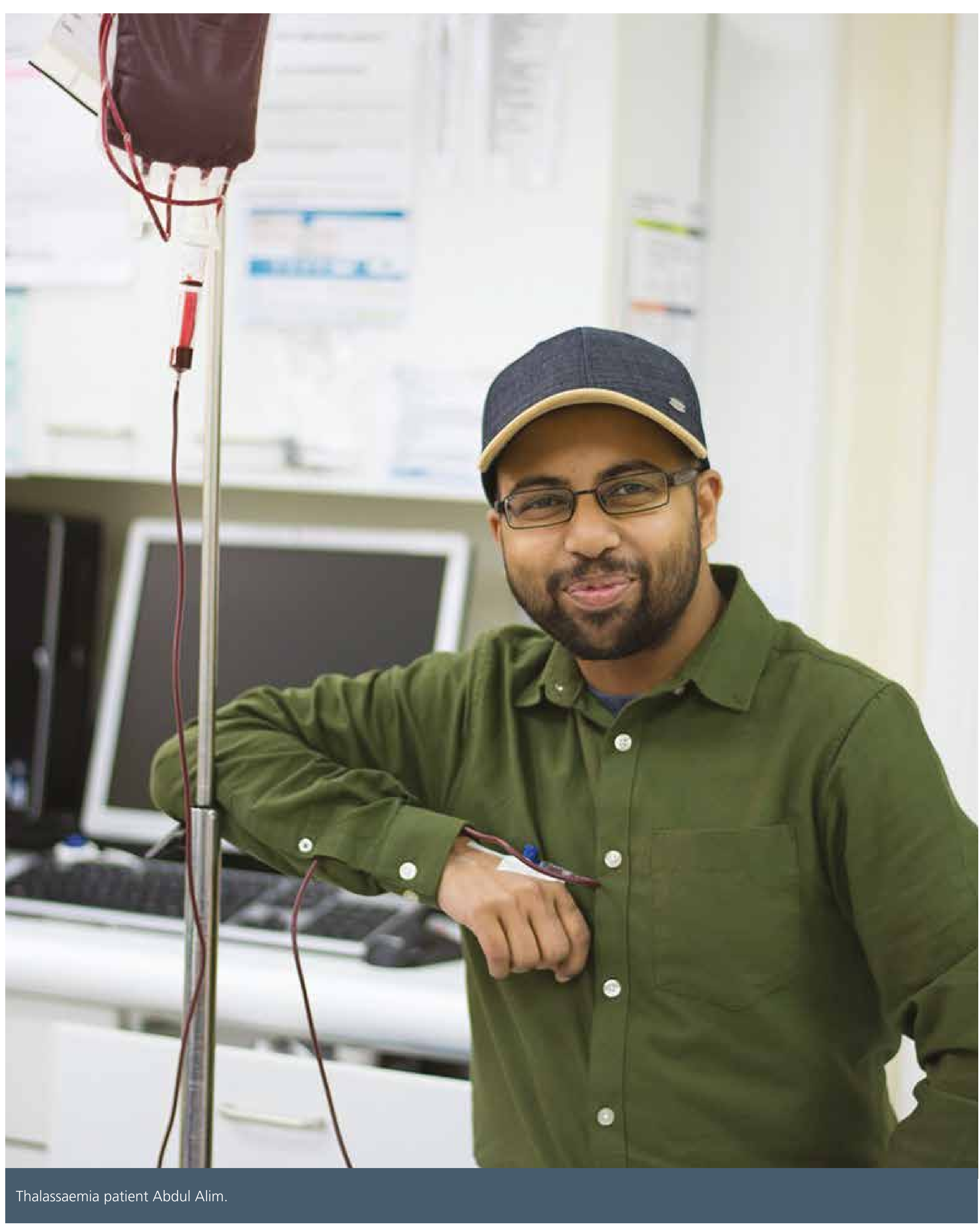
Revalidation – NHS England Revalidation Assurance

In 2016 NHS England visited SWBH for a quality assurance inspection of our appraisal and revalidation process for doctors. The visiting team met with the Responsible Officer, Appraisal Lead, Head of Medical Staffing and Revalidation Lead for the Trust and reviewed revalidation associated documentation prior to the visit.

The team were content that Sandwell & West Birmingham Hospitals NHS Trust's existing policies, processes and procedures for appraisal and revalidation were adequate and met requirements of the current processes. It was noted that the Responsible Officer had a good team in

place that complied with obligations for the completion and timely submission of quarterly reports to NHS England along with the Annual Organisational Audit and Statement of Compliance. The Responsible Officer is a member of the board and presents an annual report prepared by the Head of Medical Staffing which also includes their Statement of Compliance for approval.

It was noted that some of the documentation was due for review and the visiting team suggested the review would be an opportunity to strengthen policy documents in terms of process and consequences. The recommendations included documenting the escalation process and consequences of non-engagement, the responsibilities of both the appraiser and the appraisee. It was also recommended that a scheme of delegation put in place to make it clear who has delegated responsibility to process recommendations on GMC Connect on behalf of the Responsible Officer.



Thalassaemia patient Abdul Alim.

Participation in clinical audits

During 2016/17, Sandwell & West Birmingham NHS Hospitals Trust has participated in 40 national clinical audits and 3 national confidential enquiries (Clinical Outcome Review Programmes) 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 100% 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 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	Participated Yes /No	Percentage of eligible cases submitted
Women's & Child Health		
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Diabetes (National Paediatric Diabetes Audit)	Yes	100%
Paediatric pneumonia	Yes	Ongoing
Cystic Fibrosis Registry	Yes	100%
Acute care		
Hip, knee and ankle replacements (National Joint Registry)	Yes	96%
Severe trauma (Trauma Audit & Research Network)	Yes	50%
Adult Critical Care (Case Mix Programme)	Yes	100%
National COPD Audit (Secondary Care) - Pulmonary rehabilitation - Secondary care	 Yes Yes	 100% 63%
National Emergency Laparotomy Audit (NELA)	Yes	62%
Asthma (paediatric and adult) care in emergency departments	Yes	100%
Severe Sepsis and Septic Shock – care in emergency departments	Yes	100%
Consultant sign off (Not included in list/ spreadsheet)	Yes	100%
Long term conditions		
Diabetes (National Diabetes Audit) Adult - Diabetes (National Foot Care Audit) - National Diabetes Inpatient Audit - National Pregnancy in Diabetes Audit - National Core Diabetes Audit	 Yes Yes Yes Yes	 100% 100% 100% 100%
Adult asthma (British Thoracic Society)	Yes	96%
Inflammatory Bowel Disease (IBD) programme/IBD Registry	Yes	Ongoing
Heart		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	100%
Heart Failure (Heart Failure Audit)	Yes	90%
Cardiac Rhythm Management Audit	Yes	100%
Acute stroke (SSNAP)	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%
Head & Neck Cancer Audit	Yes	100%

National Audits	Participated Yes /No	Percentage of eligible cases submitted
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 - Fracture Liaison Service Database	 Yes Yes	 100% 100%
National Audit of dementia	Yes	61%
British Association of Urological Surgeons Audits (BAUS) - Nephrectomy Audit - Percutaneous Nephrolithotomy - Stress Urinary Incontinence Audit	Yes	Ongoing
Other people		
Elective Surgery (National PROMs Programme)	Yes	71%
National Ophthalmology Audit	Yes	100%
Endocrine and Thyroid National Audit	Yes	100%
Breast & Cosmetic Implant Registry	Yes	100%
National Confidential Enquiries (Clinical Outcome Review Programmes)		
Medical & surgical programme - National Confidential Enquiry into Patient Out-come & Death (NCEPOD) The Trust participated in the following studies in 2016/17 - Physical and mental health patient in acute hospital - Non-invasive ventilation - Cancer in children, teens & young adults	 Yes Yes Yes	 90% 100% 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 Yes	 Ongoing Ongoing

Participation in clinical research

Approximately 3200 patients receiving NHS services provided or sub-contracted by SWBHT in 2016-2017 were recruited during that period to participate in research approved by a research ethics committee and/or the Health Research Authority. Of these, in excess of 2,750 were recruited into National Institute for Health Research (NIHR) portfolio studies whilst 450 were recruited into 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 remain abreast of the latest treatment possibilities.

There are over 300 research studies being undertaken across the Trust in various stages of activity, from actively recruiting participants into new studies to those in long term follow-up. In 2016/17, 60 new studies have been given Trust approval to commence (42 NIHR portfolio studies and 18 non NIHR portfolio studies). 95 NIHR portfolio studies have actively recruited research participants in 2016/17.

During 2016/17, patient recruitment was highest in cardiovascular disease, ophthalmology and rheumatology although research activity has taken place across a full range of disciplines including cancer (breast, lung, colorectal, and haematological, gynaecological, and urological malignancies), stroke, diabetes, gastroenterology, surgery, dermatology, maternity, obstetrics & gynaecology, paediatrics, respiratory, orthopaedics and physiotherapy.

Important new developments in 2016/17 include:

- Increasing the internationally recognised excellent of our research portfolio: we have received major funding from sources including the MRC, Arthritis Research UK and the EU for research into a range of disease areas including corneal scarring, early arthritis, Bechet's disease and atrial fibrillation.
- Increasing the breadth of our of clinical research portfolio with new research initiatives in a range of areas including clinical immunology, respiratory medicine and orthopaedics.
- Increasing the range of health care professionals contributing to our research portfolio: physiotherapists and speech and language therapists have made major contributions to our research and we have seen important developments in the involvement of clinical nurse specialists contributing to research delivery.
- Translating research into better and safer care: SWBH researchers have been involved with or led the development of national / international clinical guidelines for a range of diseases including Parkinson's disease, Early arthritis, Rheumatoid arthritis, Atrial fibrillation, Gynaecological cancers and pregnancy and rheumatic diseases.
- We have integrated research into a number of our community based clinics.
- We have continued our efforts to make R&D more visible within the organisation and to its patients for example through patient representation on the R&D committee and the use of social medial channels to promote R&D activities.

Duty of Candour

The statutory Duty of Candour requires the Trust's commitment to put systems in place to ensure that communication between healthcare staff and patients, and/or their carers, is open and honest when a patient has suffered harm as a result of healthcare treatment, and that this is documented. The regulations apply to incidents which result in moderate or severe harm to the patient, patient deaths as a result of the patient safety incident and where an incident has resulted in prolonged psychological harm (28 days or more). A duty of candour has always existed as part of the code of conduct for registered healthcare professionals but became legal in 2014. The Trust has in place robust arrangements to recognise incidents applicable to the duty of candour, informing and caring for the patient and initiating an investigation.

Every incident reported and confirmed as moderate, severe harm or where the incident has led to death of the patient, must have a duty of candour discussion documented on the Duty of Candour Proforma. Results for February and March 2017 show 100% compliance (32 and 38 incidents

Thalassaemia patient Harsha Ladva.

Our Priorities for 2017/18

Strategic Plan	Priorities
Quality	• Review our Care Quality Commission report that is due during the year and implement our action plan to continue improving safety standards and quality of care. • Implement the improvement plans to reduce avoidable mortality in surgery, cardiology, deaths due to sepsis and perinatal mortality.
Safety	• Improve care in medicine by comprehensive implementation of consistency of care in all of our inpatient wards. • Implement the safety plan in all inpatient areas (including community wards) so that patients have all safety checks as standard. • Complete targeted recruitment for our hard to fill nurse roles that will create fully staffed teams reducing reliance on temporary workers.
Service performance	• Meet our four hour A&E waiting time commitment to patients sustainably in Q4. • Reduce length of stay by increasing the number of morning discharges and cutting delayed transfers of care • Deliver reductions in wait time and improved productivity through successful execution of our annual production plan for elective care.
Our people	• Cut sickness absence to below 3%. • Create a more engaged workforce through promoting opportunities to speak up, make suggestions and listen to colleagues. • Implement the changes needed to meet our workforce plans for 2018 – 2020. Deliver our Aspiring for Excellence: New PDR process.
Digital workstream	• Successfully implement our new electronic patient record during the Autumn supporting our journey towards a paper-free environment. • Fully embed digital dictation and speech recognition, reducing time taken for patients and healthcare professionals to receive Trust correspondence. • Ensure robust, improved infrastructure for our technology.
Our places	• Finalise and publish our final location plans for services in the Sandwell Treatment Centre. • Exit 2017/18 with delivery plan for Midland Met on track and seven day service model developed, costed and agreed.
Long-term financial plan	• Reduce agency spend by £10m during the year. • Meet financial commitments to generate a surplus by year end with all groups meeting their income and expenditure budgets. • Work with the Black Country Alliance and STP partners to deliver efficiency savings including across corporate back office functions and in procurement of supplies and services.

CQUINs (Commissioning for Quality and Innovation (CQUINs) 2017-18

The following CQUIN (commissioning for quality innovation) targets are agreed with our NHS commissioners. We assign CQUIN leads on clinical and operational levels to appropriately support each CQUIN. We publish monthly data on how we are doing against milestones and this is published in the Trust's Integrated Quality & Performance Report, which is discussed in our public board meetings. The NHS Commissioners are informed of progress on a quarterly basis.

Strategic Objective	Goal Name	Description of Goal
Goal Number	NHS Staff Health & Well Being	Achieving an improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress
	Reducing the Impact of Serious Infections	Antimicrobial Resistance and Sepsis
	Improving services for people with Mental Health needs	Improving services for people with Mental Health needs who present to A&E
	Offering advice and Guidance (A&G)	Set up and operate A&G services for non-urgent GP referrals
	NHS e-Referrals CQUIN	GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service
	Proactive and Safe Discharge	Improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS)
	Preventing ill Health	Preventing ill Health by risky behaviours (alcohol and tobacco)
	Improving the assessment of wounds	Increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment
	Personalised Care / support planning	Embedding personalised care and support planning for people with long-term conditions
Specialised Services	Inpatient Paediatric Services	Improve Paediatric Intensive Care (PIC) capacity utilisation. In some cases children could be better managed by providing high dependency care closer to home but more needs to be done to understand demand particularly in relation to care delivered in acute hospitals.
	Activation System for Patients with Long Term Conditions – HIV	Activate patients (the knowledge, skills and capacity to manage their own condition) to enable better outcomes including reduced frequency of exacerbations and associated high cost interventions.
	Improving Haemoglobinopathy Pathways through ODN Networks	Organising Haemoglobinopathy care be organised on a clearly defined network basis. This is set out in published standards produced by specialist societies for sickle cell disease and thalassaemia.
Public Health and Dental	Breast Cancer Screening	Improving access and uptake through patient and public engagement.
	Bowel Cancer	Improving access and uptake through patient and public engagement.
	Secondary Care Dental	Sugar Free Medicines Audit.

Partner statements

Healthwatch Sandwell

Thank you for asking us to comment on the 2016/7 Quality Accounts of Sandwell and West Birmingham Hospitals NHS Trust.

The report contains the ambitious plans for improvements in a number of areas of great importance to local people. These include improvements in cancer treatment, reduction in rates of stillbirth and improvements in management of young adults moving from children's to adult services. These are all important areas where the Trust has to work with other provider organisations or deal with difficult socioeconomic conditions. There are clear plans for improving processes. Later in the report they show the difficulties in assessing outcome measures where Patient Reported Outcomes may indicate very different outcomes from measurements of health gains.

The Trust has had visits by the Care Quality Commission this year to Sandwell, City and Rowley Regis Hospitals and the Birmingham Medical Eye Centre. The initial reports were all good. The thorough investigation of a Never Event at Birmingham Medical Eye Centre showed the Trust's commitment to investigate such events and improve processes even when the Care Quality Commission does not identify any problems.

The Trust has continued to monitor the development of a number of multi-resistant organisms, which pose potential major problems of untreatable infections in the future. Screening of patients for colonisation by MRSA was carried out on 85% of patients, which is at a lower rate than the target.

The Trust continued to carry out research and 3200 patients were enrolled into research projects carried out by clinicians, specialist nurses and other allied health professionals. A large number of audits were carried out and improvements in management were instituted as a result. These included improved care of the elderly requiring abdominal surgery, restricting use of antibiotics in acute pancreatitis, earlier use of orthotics in management of diabetic foot ulcers and venous thromboprophylaxis following lower limb injuries. The Trust is also planning to become increasingly digitised. It plans to increase the number of electronic referrals despite some initial teething problems. They also plan to go paperless, presumably when they are confident of not being at risk of disruption by international hacking!

The report identifies two areas of great concern, namely high readmission and mortality rates. A plan to reduce readmissions by using the LACE scoring toolkit to identify elderly patients at risk of readmission ensures that staff are aware of the risk and also arrange improved care in the comminity by iCares after discharge. Addressing the high mortality rates requires in-depth investigations of the causes of death so that these can be analysed and improvements made. At present only 60% of deaths are followed by mortality reviews and until this figure increases analysis and improved care is unlikely to occur.

The Trust understands that the patient is at the centre of all their plans for improved care and states that "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". Unfortunately the facts that the Friends and Family test is filled in by fewer patients than the national average and that patient engagement shows that many people find the complaint process daunting, fear that their complaint will not produce improvements in the service and may jeopardise their own care suggest that the Trust's laudable aim in this area is not being realised. Corresponding issues with the complaints process were also reported by Healthwatch Sandwell in their recent investigation into care at Sandwell Hospital, a follow-up to an earlier similar investigation, leading to the following recommendation: '...that the entire complaints experience from a patient perspective be reviewed. We are sure that SWBHT have made efforts to improve the process, but this remains a difficult area to change for patients.' It is also of concern that the number of incidents reported by staff has fallen during the last two years. Such reports are a valuable source of plans for improved care and are also a sign of an open culture happy to accept constructive criticism.

Trust response

We are currently reforming our process of learning from deaths. Our revised process will include a Medical Examiner function who will be responsible for initial review of all deaths on notification to the bereavement office and then triage appropriately to the appropriate investigation stream. This will improve learning from deaths and ensure that families and carers are included in the process.

Healthwatch Birmingham

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for Sandwell and West Birmingham Hospitals NHS Trust 2016/17. In line with our role, we have focused on the following:

- The use of patient and public insight, experience and involvement in decision-making
- The quality of care patients, the public, service users and carers access and how this aligns with their needs
- Variability in the provision of care and the impact it has on patient outcomes.
- Patient Experience and Feedback

Healthwatch Birmingham agrees that improving patient experience should be a key objective as it is linked to meaningful outcomes. That patients and carers should be informed and included in care planning. We note the various ways in which the Trust collects patient feedback, including the Friends and Family Test, surveys and complaints. However, our review of the Quality Account shows no evidence of triangulation of the various methods and of an agreement across the Trust on how and why patients, the public and carers will be engaged in order to improve health outcomes and reduce health inequality. Whilst we acknowledge that there is mention of the use of feedback, in terms of FFT scores and patient stories, the idea of patient experience, insight and feedback does not appear to be embedded in the many decision-making activities the Trust makes. For instance you mention the following in the report:

- Mortality reviews – two plans covering maternity and general surgery are ready to commence in April 2017 with three others undergoing modification to their proposals;
- Wave 2 (Cancer) – this is in the planning stages and it is expected that the plans will be submitted for review/ approval in June 2017.
- An executive-led 12-week improvement plan is in place to achieve consistency of care on the trust's medical wards by June 2017 especially concerning patient agreement with care and treatment.
- The Trusts' in house inspections conducted throughout the year.

In these plans, the Trust does not mention how service users, carers and the public will be involved both in the reviews and the development of future plans. In order to make improvements, the Trust needs to ensure that service users are involved from the point of identifying the barrier to improvement in health outcomes including increasing independence and preventing worsening ill-health; and mapping out possible solutions to evaluating options and selecting the optimum solution. To do this effectively, the Trust should consider developing a strategy for involving patients and the public in decision-making. Such a strategy will clearly outline how and why patients, the public and carers will be engaged in order to improve health outcomes and reduce health inequality. This will ensure that there is commitment across the Trust to using patient and public insight, experience and involvement. It will also make clear arrangements for collating feedback and experience.

We also ask the Trust to not only use service user and carer's insight and experience to identify barriers to improved health outcomes but also to identify and understand health inequality. Therefore the Trust should commit to increasing the number and diversity of people it's hearing from. We therefore welcome the Trusts' work on Children's safeguarding and domestic abuse and on safeguarding adults to ensure patients lacking in capacity are protected from harm. This will help identify any gaps in service provision, the needs of different groups and improve health outcomes, particularly for those that seldom give feedback. Healthwatch Birmingham would like to see the following in next year's report:

- A demonstration of how patient feedback and experiences have been used to develop priorities for the 2018/19 Quality Account in the 2017/18 Quality Account;
- Changes in practice or improvement to services that have been made as a result of patient feedback and experience in the 2017/18 Quality Account. We welcome that there is a widening use of patient stories for learning and we hope to see more examples of this across the Trust;
- An introduction of qualitative questions and demographic questions to the FFT survey that will complement the statistical data the Trust collects and offer greater insight to barriers different patients face to receiving good quality of care;
- A demonstration of how the Trust uses patient insight and experience to understand the barriers different groups face and the impact on health outcomes. Consequently, how this data is used to implement change or improvement that addresses the needs of these groups.

The Friends and Family Test (FFT)
We welcome the use of different methods (tablets, sms texting, cards) to ensure that patients are able to give their feedback. We note the improvements that have been made as a result of this survey, for instance re-launch of sleep packs; training volunteers to support patients with cognitive disorders, and placing a flag on the records of patients with learning disabilities to support seamless care. However, we observe that the positive recommender score for 2016/17 is below the national average, although not lower than the lowest Trust. The FFT inpatient score is 89.9% (96% national average); Emergency Department score is 79.4% (86% National Average), and for Outpatients it is 88.2% (93% National Average). A comparison of the positive responder rate indicates that this is higher for inpatients, seconded by outpatients and lower for the Emergency department. This shows variability in care based on how patients access services or the location of access to services. Consequently, the report shows that the Trust failed to meet its target of 50 patients expressing satisfaction (FFT) with IP wards and emergency care. Only 15 patients expressed satisfaction.

Complaints
There was an increase in the number of formal complaints received by the Trust from 871 in 2015/16 to 1026 in 2016/17. Although, complainants were responded to within the target date 81% of the time, the average number of days the Trust takes to respond to complaints steadily increased over the four quarters. The most common themes people complained about remain similar for 2015/16 and 2016/17, with complaints on attitude of staff and admissions/discharges/transfer increasing. Similarly, 2,592 people contacted PALS during the 2016/17 and the top three issues were communication, clinical issues and appointments. We welcome examples of actions taken as a result of learning that has occurred from complaints. We hope to see the impact learning from complaints has had on services and patient experience in the 2017/18 Quality Account.

Pre- and post-operative surveys
Provisional data for April 2015 to March 2016 indicates that the Trust has performed above the national average for patients reporting an improvement in their health status following a procedure. However, the Trusts' is performance is below the national average for hip replacement. We welcome the actions taken to make improvements, particularly, the joint club where patients are given advice and information so that they understand the risk and benefits as well as expected outcome.

Trusts performance against standards and CQUIN
Our review of the Quality report shows that the Trust has failed to meet standards in a number of areas that have the potential to lead to variability in the quality of care leading to poor health outcomes. It is therefore positive that some of these areas are still a priority for the Trust in 2017/18 and we hope to see improvements after the Trust implements the various actions agreed.

Incident reporting
The report states that the Trust reported 19,766 incidents in 2016/17; 8 of which resulted in serious harm and one in death. The number of serious incidents increased during 2016/17 from 1 in April 2016 to 5 in March 2017. The trust also reported four never events against target of zero. We commend the Trust for ensuring that learning is taking place and actions have been taken to rectify the causes. We hope the Trust meets its target of zero never events in the 2017/18 Quality Account and that lessons learned will become embedded in Trust practice.

Mortality reviews
The Trust only carried out 68.3% mortality reviews against a target of 90%. Mortality is an indicator of problems with the quality of care, therefore reviews are an important tool for ensuring learning occurs. Equally, learning improves health outcomes, we therefore welcome the Trust's plan to keep this as a priority for 2017/18.

Other Comments
Generally, we are concerned that the Trust has failed to meet standards for delayed transfers of care; and the number of patients offered another date for operation in 28 days following a cancelled operation. Most concerning is the Trust reporting 51 breaches for mixed sex accommodation against a target of zero. Equally the Trust has not managed to deliver against five of the agreed Commissioning for Quality and Innovation (CQUINs) schemes. Namely, Sepsis A & E/inpatient screening and review; Mortality reviews; preventing term admissions to NIC; and activation systems for patients with long term conditions. These have the potential to lead to poor patient experience and outcomes. We look forward to reading how you have made improvements in the 2017/18 Quality Account.

Although we have highlighted different areas in this report where the Trust can make improvement, we recognise the Trust's achievements. We congratulate the Trust for introducing the Connected Palliative Care Service which has improved the quality of care for patients at the end of life. Thank you for giving us the opportunity to review the Trust's Quality Account.

Trust response

We welcome the comments from our partners relating to our Quality Account.

Understanding and improving the experience of our patients and their carers and families is really important to us. As Healthwatch Birmingham identify, we have a number of different ways to gain feedback on our services. We use this feedback to put in place improvements such as the consistency of care programme in our medical wards.

We recognise that performance on certain measures has fallen below our expectations and the standards we wish for our patients and these areas are recognised as priorities for the year ahead.

We would be keen to work with all our partners to see what support they can provide as we continue to improve the service for our patients.

Sandwell and West Birmingham Clinical Commissioning Group

This Quality Account, prepared by Sandwell and West Birmingham Hospitals Trust (SWBH), is a true reflection of the work undertaken by the trust during the 2016/17 contract year.

SWBH engages fully and openly with its CCG commissioners, providing opportunity for dialogue at both a contract and locality level, via CQRM, and CRM meetings.

SWBH has demonstrated its commitment to quality by the introduction of a number of quality improvements schemes during year, including: The appointment of Dementia Specialist Nurses and implementation of the John's Campaign, The End of Life Care Connected Palliative Care Service, Changes to the District Nursing service to deliver 20% more activity via use of the Clinic, the development of Child Safeguarding policies and introduction of the Child Protection Information Sharing project (CP-IS), and the setting up of a steering group to support improvements to Data Quality.

During the 2016/17 contract year, the CCG wishes to acknowledge and congratulate SWBH on their continued reduction of patients experiencing pressure damage and pressure damage resulting in significant harm; their continued progress on reducing hospital acquired infections (with low numbers of C-Diff and MRSA infections acquired by patients in 2016/17; the good result achieved by the Trust in terms of Patient Reported Outcome Measure (PROMs) for Hernia Repairs, Hip Replacement, Knee Replacement and Varicose Vein Surgery, and their performance in relation to VTE assessment completed with 24 hours. The CCG also wish to acknowledge the Trust's moderate success in achieving most Local Quality Indicator targets and National and Local CQUIN schemes for 2016/17. In addition, the CCG also acknowledges the learning and actions taken by the Trust in regard to complaints but acknowledges that more needs to be done to improve the average time taken to respond to complaints.

The CCG also wishes to recognise and acknowledge the challenges faced by SWBH to: improve Mortality Index scores and the number of mortality reviews taken; to achieve the emergency care 4 hour wait target, to consistently achieve the 95% target for Harm Free Care; to continue to address workforce issues - notably sickness absence and numbers of agency staff; improving safety in relation to patient falls, and to improve average adjusted health gain scores against PROMs indicators. The CCG also wishes to acknowledge that while the Trust have experienced difficulties in achieving their commitments to reduce instances of Mixed Sex Accommodation (MSA), that in the instances where targets have been missed, the reasons why have all been justified by clinical need.

Looking forward, the CCG welcome the Trust's Quality Plan Objectives for 2017-20, its aspiration to reduce readmissions by 2% by coordinating care across organisations and facilitating safe and timely discharges, and its support of the continuation of the SWBH Safety Plan.

Trust response

We thank the CCG for their engagement in our Quality and Safety agenda and look forward to working with them over the next 12 months to deliver our ambitions in the Quality and Safety plans.

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of Sandwell and West Birmingham Hospitals NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period; and
- Percentage of reported patient safety incidents resulting in severe harm or death.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and the auditor

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 Regulations).

In preparing the Quality Account, the 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, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2016 to May 2017;
- papers relating to quality reported to the Board over the period April 2016 to May 2017;
- feedback from the Commissioners dated 30 May 2017;
- feedback from Local Healthwatch (Birmingham) dated 23 May 2017;
- feedback from Local Healthwatch (Sandwell) dated 16 May 2017;
- the 2015 national patient survey published June 2016;
- the latest national staff survey dated March 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017;
- the annual governance statement dated 1 June 2017; and
- the Care Quality Commission's Inspection report dated March 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Sandwell and West Birmingham Hospitals NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Sandwell and West Birmingham Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sandwell and West Birmingham Hospitals NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP

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

1 June 2017

Partnerships with a purpose

Hospital shop is a hit with staff and patients

An exciting new partnership with social enterprise Agewell has led to the opening of a new shop at Sandwell Hospital. Patients and staff have been flocking to the new business which stocks a range of sandwiches, snacks, drinks, toiletries, gifts and newspapers. The shop helps Agewell generate revenue to support older people over 50 who are in need. The organisation has been working closely with our 'Icares' team in providing sessions to help patients with their posture, in the aim of preventing falls and increase patients' confidence when they are at home. The group has been offering their 'Befriending' services at the Trust for a while, also known as "Edna's Army", which sees Agewell volunteers visit the wards and spend time with patients who feel lonely and need more support from the community.

Pauline Withey, Agewell Service manager, and Deborah Harrold, Chief Executive of Agewell.

Your Trust Charity

Your Trust Charity is the new re-branded name for Sandwell & West Birmingham Hospitals NHS Trust Charities. The team was set up in July 2016 and the mission of the charity is: *"To enhance the experience of all people using our hospitals including staff, patients and their families. We will do this by providing additional facilities and supporting innovative projects that create a comfortable and secure environment."*

SWBH moments

Your Trust Charity has created 'SWBH Moments' as part of this re-branding. The idea is simple - it celebrates the 'moments' of patients and their families - which would not have been possible without funding or charitable grants from Your Trust Charity. This could be a time where an intervention saved a life, made a real difference to someone, or resulted in some positive changes that our care can create.

New appeals and themes

The team have also engaged with staff across the Trust to help create some new exciting appeals and themes, which cover many aspects of the Trust's work, and will help to raise more money for Your Trust Charity. The following eight appeals and themes have been developed and are currently being promoted - more themes will be created in the future:

Raffaela Goodby, Director of Organisation Development supporting the Your Trust Charity at an event.

Fundraising and working within our community

Your Trust Charity has had a very successful year for donations and in-kind gifts, and very gratefully thanks individuals, companies, community groups and schools, as well as legacies, that made this all possible. Thanks go to the continuing partnership with New Square Shopping

Centre in West Bromwich, who raised over £4,000 for Your Trust Charity in the last year. This included a Summer Fun Event, and an appearance by Zog, the much loved children's character created by Julia Donaldson, at the launch of the charity's brand new appeals.

Your Trust Charity is also very grateful for the donations of Christmas gifts, decorations and time for a number of Trust departments from the following: ACT Ministry, Bristnall Hall Academy, Tesco, Santander, Stuart Bathurst School, West Bromwich Albion Football Club, West Bromwich Building Society, and Westminster School.

Looking Ahead

A five year fundraising strategy to 2020/21 has been developed, which aims to position Your Trust Charity as one of the leading healthcare charities in the region. It plans to diversify income streams, focusing on 6 key areas which involve: individual (one-off, regular and lottery), corporate, legacy and trusts/foundations. It also aims to increase total income year-on-year, supported by the new brand which will act as a focal point to re-engage with members, supporters and donors. Your Trust Charity will shortly be dissolving the linked and associated charities, becoming established as a single entity.

The Midland Metropolitan Hospital Appeal

In November 2016, a fundraising appeal to raise a minimum £2m for enhanced benefits from the new Midland Metropolitan Hospital was launched with senior business leaders and key Trust stakeholders. The campaign focuses on five main themes, identifying the added value that supporters can bring, to make a real difference to those using and delivering services. These themes include: Arts, Education & Heritage, Research & Development, Furnishings & Equipment, and Community Regeneration.

2016/17 Grants Programme and Partnerships

Thanks to a generous legacy donation, Your Trust Charity has been able to run another large and small grants programme, building on the success of the 2014/15 programme. The Charitable Funds Committee received 49 bids in total, and assessed them against the following four themes:

1. Infrastructure - Improvements to SWBH environment and facilities including support of integrated care.
2. Education - Supporting the educational development of clinical and non-clinical staff, to secure the long term future of health and social care in Sandwell and West Birmingham.
3. Innovation - Helping the trust to be a leader of innovation through pump priming activities, running pilots and testing out new ideas and technologies for care that enhance outcomes for local people.
4. Community resilience - Supporting communities to improve their health outcomes.

A particular focus was applied to partnership working, and on this basis the committee approved in principle the grants of 13 new projects of almost £400,000, which includes the following large grants:

- The Sapphire Project: Agewell CIC and West Bromwich African Caribbean Care Centre - this grant of £109,080 has created an innovative partnership with these two organisations. They will both work with the Trust over 12 months to bridge the gap from hospital to home and into self-management for older and vulnerable people, ensuring they get home and build resilience to stay at home safely.
- Parenting Young People Programme: St Basil's and the University of Birmingham - this grant of £48,750 will develop, deliver, and evaluate a 2 year programme for Trust staff that will help them increase their confidence in their parenting and caring roles. By improving their staff wellbeing and engagement, the programme will aim to reduce their stress and ensuing staff absenteeism.
- New Day Hospice: this grant of £29,308 will provide a number of added-value activities for patients, their families and carers in the new Day Hospice. These include a well-resourced and inviting new arts and crafts area, a wellbeing room, complimentary therapy provision, and the training of staff on M Tech massage and FABS exercise.

Small grants projects approved included the following:

- Growing for Health: Ideal For All - this project will deliver taster 'hands on' gardening, food growing, cooking, health eating awareness sessions for staff, patients and the wider public at the Trust and Ideal For All's market garden in Oldbury.
- Cape Community Care Day Centre - to provide a health advice and advocacy service for clients at the day centre. This volunteer-led service will deliver a number of health communication sessions and home visits, focusing on clients with dementia.
- Taking Sandwell Hospital Into The Digital Age - to provide the radio station (a registered charity) with digital equipment for broadcasting their service through the internet. This will develop their service and engage with more listeners, greatly enlarging the reach of the station.

2014/15 Grants Programme

In addition to the large grant awarded to Black Country Women's Aid mentioned earlier in this Annual Report, another large grant awardee from 2014/15 continues to improve the experience of the Trust's patients and families.

Neonatal jaundice is a common condition in babies, especially those born pre-term. Baby Jai was born five weeks early. Thanks to a £60,000 charitable grant, the Neo-Natal Department was able to purchase 10 bilipads, which provide therapy through UV lights. These bilipads have enabled Jai's parents, and many other parents, to hold their babies during those precious early days whilst they recover. This is their SWBH Moment.

Saul Wilkin Mzobe pictured at the 'Zog and the Flying Doctors' Your Trust Charity public reading event.

Partnerships with a purpose

Phantom bus stop is creating a sense of security for dementia patients

Ward Sister Hayley Griffiths at the Lyndon 4 Bus stop.

The Trust and the charity Better Understanding of Dementia (BUDS) are the driving force behind a new way to help patients suffering from the disease – by creating a "bus stop" on a ward. It has been installed on Lyndon 4, at Sandwell Hospital, to create a feeling of love and security for dementia patients as well a distraction. Ward Sister, Hayley Griffiths, who worked with BUDS on the project, said: "Patients with dementia will repeatedly ask to go home and they will often try to leave the ward. Staff will be able to take patients to sit in the bus stop for a short while which will calm them down and making them feel more in control.

We hope that this will reduce the amount of time patients try to leave the ward, and a better approach to calm and reassure dementia patients." BUDS Training and Development Officer Claire Mahmood, said: "Being in hospital can be very stressful for people with dementia who often want to go home. The bus stop is a proven way of calming and reassuring people and also gives a great space for staff to spend time with patients."
from the community.

3 Accountability Report

Corporate Governance Report

Director's Report

The Trust Board meets monthly. The Chair of the Board is Richard Samuda and the Vice-Chair is Olwen Dutton. During the year, two Non-Executive Directors completed their term of office. Marie Perry, a new Non-Executive Director filled one of these posts. At the time of writing, recruitment is underway for a new Non-Executive Director from the University of Birmingham to fill the remaining vacancy.

Non-Executive Directors: Board and Committee attendance
The Trust did not hold any Remuneration Committee meetings during 2016/17.

Non-Executive Directors: Board and committee attendance	Trust Board	Audit and Risk Management	Quality and Safety	Finance and Investment	Charitable Funds	Workforce & Organisational Development	Major Projects Authority	Public Health, Equality & Community Development
Richard Samuda, Chair	12/12		9/11	10/10	3/4	4/4	5/5	3/4
Olwen Dutton, Vice-Chair	11/12	2/4	9/11					
Dr Paramjit Gill, Non-Exec Director*	10/11					3/3		3/3
Mike Hoare, Non-Exec Director	11/12		7/11				5/5	
Harjinder Kang, Non-Exec Director	9/12	2/4		9/10		4/4	3/3	
Waseem Zaffar, Non-Exec Director	10/12	0/1			4/4			3/4
Robin Russell, Non-Exec Director**	1/4	2/2		2/2				
Marie Perry, Non-Exec Director***	5/6	2/2		4/5				
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	Major Projects Authority	Public Health, Equality & Community Development
Toby Lewis, Chief Executive	11/12			2/4	3/4	5/5	4/4
Rachel Barlow, Chief Operating Officer	12/12	5/11	5/10		1/4	3/5	
Kam Dhami, Director of Governance	12/12	7/11					
Raffaela Goodby, Director of Organisation Development	12/12		7/10		4/4	4/5	4/4
Colin Ovington, Chief Nurse+	7/9	7/7		2/3	2/4		0/2
Elaine Newell, Interim Chief Nurse++	3/3	3/4		0/1	0/2		2/2
Dr Roger Stedman, Medical Director	12/12	7/11				2/5	4/4
Tony Waite, Director of Finance and Performance	11/12	6/11	10/10	2/4		5/5	

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 his position as Non-Executive Director in February 2017
**	Stepped down from his position as Non-Executive Director in July 2016
***	Appointed as full NED from 1 Oct 2016
+	Left the Trust in December 2016
++	Joined the Trust Board in December 2016
^	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)
- Dr Roger Stedman, Medical Director (Board Member)
- Colin Ovington, Chief Nurse (Board Member) – until December 2016
- Elaine Newell, Interim Chief Nurse (Board Member) – from December 2016
- Tony Waite, Finance Director (Board Member)
- Raffaela Goodby, Director of Organisational Development (Board Member)
- Kam Dhami, Director of Governance (Board Member)
- Ruth Wilkin, Director of Communications
- Alan Kenny, Director of Estates and New Hospital Project
- Mark Reynolds, Chief Informatics Officer

The members of the Audit and Risk Management Committee at 31 March 2017 were Marie Perry (Chair), Olwen Dutton, Harjinder Kang and Waseem Zaffar.

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 & Risk Management Committee	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 five times a year.
Quality and Safety Committee	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 Committee	The Committee provides oversight and assurance in respect of 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 accordance with the wishes of donors. 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. The Committee meets quarterly.
Major Projects Authority	The Committee provides the Board with assurance concerning the strategic direction to support the project to establish the Midland Metropolitan Hospital (MMH) and that the programme of interim reconfigurations is consistent with the long term direction towards the new hospital. The Committee focuses specifically on the delivery of the MMH business case.
Public Health, Community Development and Equality Committee	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. No Remuneration Committee meetings were held in 2016/17.

Name	Interests Declared
Chairman	
Richard Samuda	• Director – 'Kissing It Better' • Non Executive Director – Warwick Racecourse
Non-Executive Directors	
Olwen Dutton	• Partner – Anthony Collins LLP • Fellow – Royal Society of Arts • Member – Lunar Society • Member – Council of the Birmingham Law Society • Member – Labour Party • Trustee – Writing West Midlands
Michael Hoare	• Director-Metech Consulting • Director CCL Group • Director of Nobu Ltd
Harjinder Kang	• Management Consultant – Chiesi Pharmaceutica S.p.A. • Management Consultant – Galbraith Wight Ltd • Trustee – Birmingham Botanical Gardens • Director – Abnasia Ltd
Marie Perry	• Head of Finance & Procurement at the Consumer Council for Water
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
Executive Directors	
Toby Lewis (Chief Executive)	• Board member – Sandwell University Technical College • Independent member - Council of Aston University
Rachel Barlow (Chief Operating Officer)	• None
Elaine Newell (Chief Nurse)	• None
Roger Stedman (Medical Director)	• Partner – Excel Anaesthesia (private anaesthesia services)
Tony Waite (Director of Finance & Performance Management)	• None
Raffaela Goodby (Director of Organisation Development)	• None
Kam Dhami (Director of Governance)	• None

Director of Governance Kam Dhami at a staff quetion time.

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.

I confirm that, as far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the trust's auditors are aware of that information. I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Toby Lewis
(Chief Executive)
1st June 2017

Partnerships with a purpose

The Sapphire Project: Supporting older adults and carers in hospital and at home

Sapphire Service volunteers pictured with Jessie John, Ambulatory Assessment Nurse.

A new project is set to improve the experience of older people and their carers while they are in hospital.

Funded through Your Trust Charity, The Sapphire Service is jointly run by Agewell and the West Bromwich African Caribbean Resource Centre. The funding will enable the service to work with the wards from the moment patients are admitted up to when they are discharged and back at home. Some of the support to be provided by The Sapphire Service includes befriending patients and helping with eating and hydration. While Agewell will be providing a wider service, the role of the West Bromwich African Caribbean Resource Centre will be to target African Caribbean and dual heritage older adults and carers.

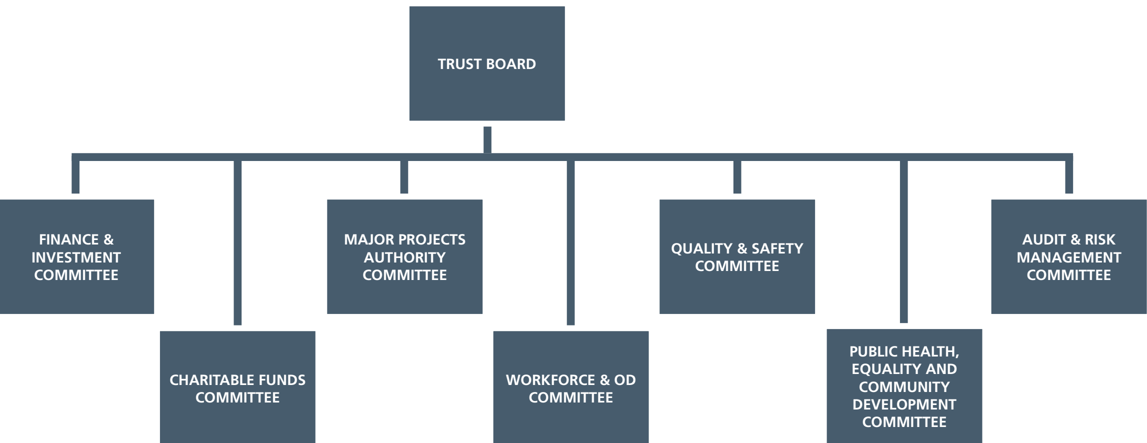
Deska Howe, Older People and Health Divisional Manager, West Bromwich African Caribbean Resource Centre said: "We aim to reduce any isolation suffered by patients and improve their hospital experience." Agewell CEO, Deborah Harrold added: "The Sapphire Service will support the discharge planning process, by advocating for patients." Patients will receive a visit within seven days of their discharge after which the Sapphire Service will provide community intervention from the two organisations for up to six weeks.

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.

The Governance Framework of the Organisation

The Trust is led strategically by the Trust Board. The Board sets out the strategic direction of the Trust, which is embodied in our 2020 vision, published in 2015 after a year's consultation. Below the Board there are 8 Board committees (figure 1) which serve 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. The MPA is a new committee for 2016-17 and an assessment of its effectiveness is included in the external audit report into the Trust. The Board has completed, via its March and April private meetings, a review by the Director of Governance of the functioning of the Board and its committees. This has produced a short list of recommendations which are being tracked via the Board's usual follow through system. The Chief Executive and Chairman have agreed new 'attendance rules' for the 2017-18 Board committee system, which are intended to achieve greater consistency of attendance at key committees. During the year we made changes to the quoracy of the ARM to ensure that is operated effectively. All committees report in full into the Board's meeting and these non-executive led reports are taken at the outset of the meeting to allow the full Board to scrutinise whether the committees are achieving their objectives. The focus of the committees remains on the delivery of the 2020 vision, and whether day to day operational delivery is consistent with that medium term vision.



The Right Care, Right Here project was abolished in 2015-16 and replaced by the STP. The Trust has played a key role in the Black Country STP, whilst receiving papers for the Birmingham STP. The BCA work that the Trust is instrumental within is the heart of that STP plan, both through pathology and back office services, and delivery of the Midland Met hospital is a part of the STP plan. Governance of the STP continues to evolve and due scrutiny of that evolution will form part of the work of the Trust Board in 2017-18. STP matters form one fifth of the monthly Chief Executive's report to the public Trust Board – ensuring that the STP is at the centre of the Board's thinking and debates. The RCRH abolition has not been replaced by visible SWB structures for place based collaboration. Two board to board meetings have been called by the Trust with the CCG to seek to address local relationship deficits, and chair level discussions on a new shared governance model for the area continue.

The decision making role of the Clinical Leadership Executive continues to evolve, and become both more visible and increasingly interactive. One of the recommendations of the Board's governance review is designed to give greater visibility at Board level for the working of the executive function. This will help to avoid duplication at Board level. In 2017-18 we will review how our Groups work with their directorate functions, as part of the continued journey of the Trust to being directorate based in its operational function.

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.

During 2016-17 11 risks were removed from the corporate risk register. Three major risks were added, relating to paediatric ophthalmology, 'unsubstantiated' beds (unfunded pop up wards), and the vaccination issues which have impacted the NHS as a whole. A review of risk 'velocity' at local level is in train and changes will be made in Safeguard to ensure that teams with no risks on the risk register are routinely challenged to confirm that this is a positive choice. The risk registers for the Trust are available to all employees in the organisation as part of our culture of openness. In Q1 2017-18 we will work to ensure that major project risks are assimilated into the broader risk culture of the Trust, whilst recognising that these delivery risks are often best managed at project level.

I am satisfied that, distinctively, the risk system plays a key role in the functioning of the Board and wider executive. We will continue to develop our approach, and ensure that our QIHD system for learning Trust-wide is informed by the key risks identified within our risk register.

Risk and control framework

The Trust completed a review of our performance and the relevant key performance indicators as part of preparing for the Single Oversight Model. The SOM rated the Trust at a 3, in common with most major hospital providers. This reflected three indicators in particular:

- agency expenditure
- four hour standard performance on emergency care
- a requires improvement rating from the CQC (2014-15)

Work continues to tackle these issues, and a further report from the CQC is expected in public by Q3 2017-18. Detailed, Board overseen plans for both agency reduction (-£10m) and ED delivery (90% from July 2017) have been developed.

The Trust has a clearly developed forward plan. Given the detail of our long term planning behind the 2020 vision, our focus is not on total annual refreshing of plans, but on multi-year consistency and delivery by quarter. This is being embedded via our Group Programme Offices (GPOs), which provide the basis and toolkit for teams to balance the competing priorities of various stakeholders as well as to ensure that patient priorities within their teams are expedited. 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.

Our audit plans continue to reflect corporate priorities as well as identified risks. In 2016-17 there has been a focus on the CQC improvement plan, as well as on financial due diligence given the deteriorating cash and budget compliance position. 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 others via the HSCIC SUS Data Quality Dashboards which is used to monitor compliance with mandatory fields and commissioning sets.

Accounts, including our Quality Account

We will complete to time our relevant statutory accounts, both quality and financial. They reflect accurately the very challenging environment of the local health system. The Trust in effect delivered our third financial plan, but was not able to meet our initial control total, nor a revised breakeven position which was agreed prior to submission at a senior level with NHS Improvement. The underlying financial position has been reported in public throughout the year.

The Quality Account reflects strong delivery on some key improvement objectives including falls and C-diff. VTE performance meets the national standard but falls short of our stated aim of 100% coverage. The Board has given due scrutiny throughout the year to changes in our SHMI and RAMI positions, and to alterations in method around the recording of expected deaths. The Trust benchmarks well against others in how we review mortality, including end of life care, and has completed analysis of deaths in our care of patients who have learning disabilities.

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 (Medial Director). Breaches and near miss issues are identified, acted upon and drawn as required to the attention of the relevant Board committee. During 2016-17 we have not had to pursue extended action on any matters reported to the ICO. All such reports are scrutinised at a senior level within the Trust for learning.

The Trust's latest Information Governance Toolkit self-assessment declaration has led to another improvement on the previous year's score with the self-assessment score now at 91%. During 2016/17 there was 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 implanted 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.

During 2016-17 we have not made as much progress as we would wish with improving the scores within our kite mark system. The Audit and Risk Management Committee have requested some additional work be undertaken to change this during the first six months of 2017-18. Resource is being provided to do this, notwithstanding the improvements which are a by-product of our EPR deployment in November 2017. Our 18 week RTT data quality has been specifically reviewed in year, and a further internal audit is currently being undertaken.

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. During 2016-17 a number of investigations have led to action. Awareness of fraud issues is high within the Trust.

In April 2016 we asked all employees to complete a staff declaration, across a range of issues, including conflicts of interest. At the time of writing, this is 72% complete.

Whistleblowing and duty of candour

Our efforts to create an open culture are extensive. We have in place all of the statutory arrangements. Our system includes an independently run anonymous helpline. During 2016-17 we appointed 10 Freedom to Speak Up Guardians, as well as our junior doctor's hours' guardian. Data on staff awareness and confidence to report provides reassurance that our systems are understood and respected. We monitor the timeliness and quality of our duty of candour delivery at patient level. Our revised SI process incorporates clear guidance and instruction on the role of patients and their families.

In year we have raised one 'organisational' duty of candour concern with NHSI owing to continuing concerns about the sufficiency and quality of adolescent mental health liaison support in Birmingham. Adolescent mental health provision remains red rated within our Board's Risk Register and has been in place for over twelve months. There is no evidence of a systematic location solution being put in place. Devolved or delegated commissioning arrangements under which providers will have more discretion to set service scale and scope offer some grounds for optimism.

Safeguarding and DOL

The Trust has worked to improve the comprehensiveness of our safeguarding and DOL procedures during 2016-17. In year we received a regulation 28 notice in relation to the latter, and subsequently instigated materially changed clinical procedures and revised Trust governance. Initial review suggests that this has been effective. Throughout the year we have worked to ensure good safeguarding training coverage and to develop better peer training and learning at team level. This work continues and the Board's Safeguarding scorecard remains in place.

Equality and diversity

In April 2017 we will have completed implementation of the nine diversity pledges we instituted in 2015. These have seen a focus on celebrating the range of backgrounds among employees in the Trust, as well as meeting statutory commitments such as the WRES analysis. Our 2017-2020 People Plan contains further commitments on the nature of our workforce and leadership – with our drive to 50-50 at Board level (it is achieved at executive level) and planned changes in BME representation in senior band 8a+ roles across the organisation.

REVIEW OF EFFECTIVENESS OR RISK MANAGEMENT AND INTERNAL CONTROL

Our systems for exercising suitable control over safe clinical, research and educational practice are extensive and we continue to deliver care with low infection and good outcomes. The Board has been active, and so have its committees in tracking outcome outliers. A culture of quality improvement is beginning to be embedded through our QIHD framework, and we expect that step change from 2014 to be reflected in our CQC report.

Our financial performance has been accurately and transparently reported throughout the year. We set a deficit budget and were migrated to a surplus position with the aid of STF. Income deviation, STF surcharging, and some expenditure failure then led to an in year deficit. Undelivered CIP is a feature of our underlying deficit, as our income positions below our LTFM. These deviations have been tackled, and Q4 shows income improvement and the closure of unfunded beds. Notwithstanding that our scale of challenge in 2017-18 and 2018-19 is substantial.

We have made major strides in a number of facets of 'counting and coding' during 2016-17. A transformation in our capture of overseas visitors has seen revenues rise, and the Trust make investments in teams who are achieving good 'question' coverage. We have overhauled how we account for research and development income, and resolved between ourselves and our Charity how some matters are best accounted for. This chasing of discipline, and capturing smaller items well, is part of a wider 'clean

and capturing smaller items well, is part of a wider 'clean up' of our approach.

External review has found that our Midland Met and EPR programmes are, within normal confidence limits, well managed and effective. Our forward challenge is juggling not just these two programmes, but others within our 2020 portfolio, as well as a changing external policy and organisational landscape. The Board's risk mitigation for this position is to focus hard on middle management capacity and capability.

Controls over agency expenditure, off framework and above cap spend are all clear. Many exceptional items require executive, or even my own approval. Despite this our expenditure continued to exceed our own plans and the NHSI cap. Adjusted arrangements are being put in place for 2017-18 consistent with an even steeper plan to reduce utilisation. Tackling our nursing vacancy position is the biggest single delivery dependency, as it better rota management among nurses, doctors and radiographers. Further reduction in sickness will be important in some fields.

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. The CQC re-inspected some services in late March 2017, and a report is due in Q2 2017-18. Our own controls and analysis told us that:

- 62 of 67 actions had not only been implemented but had shown improvement;
- Ward care within medicine was a potential improvement outlier meriting special attention;
- Care documentation was an ongoing issue for us, notwithstanding a new EPR in 2017;
- Our always events culture had yet to deliver its potential; and
- Shared learning was improving, aided in particular by our QIHD work.

I highlighted in 2015/16 a series of four ongoing control concerns:

- Do Not Resuscitate documentation has been a continued focus of attention in 2016-17, with the rollout of our Supportive Care Plans. Audit suggests that there remains variable practice in documenting some conversations, albeit our overall End Of Life care service is remarkably improved – with a 10% jump in patients dying in their chosen location. The implementation of our EPR represents an opportunity to manage deviation in practice more rapidly, and the next phase of our mortality review system's development will focus attention on expected deaths not known to the specialist palliative care team.
- We have a strong Trust level business continuity plan. By July 2017 the Board has insisted that local plans also pass scrutiny. There are any number of reasons for this, but this list includes our greater reliance on IT, and the heightened risk of either cyber or terrorist attack. The Trust has restructured our specialist team in year to support this wider deployment. Accountability for this work rests with the Chief Operating Officer.
- The resilience of our IT infrastructure has come into sharp focus both in 2015 and 2016. Whilst there is improvement, no lack of effort, and no lack of investment, delivery falls short of what we need. No single system failure has hit us in 2016 but persistent crashes and system slowness has wearied teams. Changes in IT responsiveness have helped mitigate this, and technical background changes have too. The work will be completed by the end of July 2017.
- HR data quality is still an issue for us. 2016-17 ends with another staff in post to ESR reconciliation, cross checked against budgets. We have an ambitious people plan for 2017-2020 and it will not succeed unless we accurately know who we employ, their appraisal and development status, their training needs, and who their line manager is. Major exercises on data cleansing have occurred, but we have work to do to make 'tending to' the ESR data everyone's job.

With regret I am adding two other areas of weakness to our 'worry list'. Both are longstanding problems, whose impact is in focus within our work presently:

- Deprivation of Liberty assessments have markedly improved since the coroner wrote to me in early 2016-17. The Board has tracked this closely and our IPR shows quantified growth in external referrals. However, our own data and informal CQC feedback still shows signs of limited coverage in some parts of the Trust. Whilst we have no adverse findings for individual patients arising from this, we have work to do to ensure that our best practice is embedded everywhere.
- Results acknowledgement features on our risk register, and has done for some time. We are working to put in place the changes in clinical workflow to support changed performance in 2017-18 via EPR. Importantly under the new system inpatients will not be able to be discharged with unacknowledged but reported results pending. This is a key change arising from some errors highlighted within our care. As at today not all results are acknowledged or are capable of acknowledgement. Even under EPR this will remain true of some disciplines. Though far from uncommon in the NHS, the position is not optimal practice and we will consider how best we understand and track the potential harms from this.

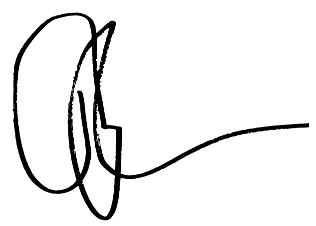
I have chosen not to include in this AGS section areas of clinical performance where we fall short of our ambitions, but meet or exceed NHS norms. We will consider in 2017-18, and the relevant AGS, how best to report controls assurance in always areas or targeted 100% delivery aims. In doing so we will highlight areas, such as VTE assessment or medication reconciliation, where there is a material risk of harm from omission or delay.

Concluding remarks

It is only reasonable to add to this statement that during 2016-17 some elements of externally driven control have not operated with the pace that is consistent with my statutory duties. Most saliently a Capital Resource Limit for the Trust was confirmed in writing in month 11. The process for contract arbitration did not operate to timetable nor process, making some financial forecasting more hedged than is intended. I understand that these challenges are not unique to SWBH but they nonetheless impact on our local control regime.

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. The external audit report demonstrates that there is no loss of control behind the performance outcomes we have delivered. We face a challenging environment and have work to do with partners to improve results in the face of those difficulties. The strong leadership system we have in place around our 2020 vision, and the devolution underpinned by our GPO approach, provides a basis for confidence that we can achieve improvement in 2017-18.

Signed



Toby Lewis Chief Executive (On behalf of the Board)
Date 01/06/2017

A key part of our contingency planning is ensuring we have trained media spokespeople. Pictured above is Dr Nick Sherwood who took part in training for 12 delegates in June this year.

Emergency Preparedness, Resilience and Response (EPRR) Statement of Compliance

As a Category 1 responder under the Civil Contingency Act 2004 the Trust is required to be ready to respond to any critical or major incidents. As part of the national NHS assurance process, acute health providers alongside other responding organisations need to submit a self-assessment. This year we were substantively compliant against the NHS England Core Emergency Preparedness Response & Recovery (EPRR) standards. Out of 104 questions there were six areas where we were not fully compliant but had plans in progress to become so. There were no areas for which we were 'red' uncompliant. We were able to demonstrate the training and exercises delivered to key groups of staff to ensure we could respond to any event. With the recent appointment of our Emergency Planner, Phil Sterling we anticipate that we will be fully compliant 2017/18.

We confirm that our level of compliance with the EPRR core standards 2016/17 has been confirmed to Sandwell and West Birmingham Hospitals NHS Trust's Board of Directors.

Mother Alisha Edwards with son Logan Edmunds at the launch of Baby Box initiative.

Remuneration and Staff 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 2017, these were:

- Richard Samuda (Chair)
- Olwen Dutton (Vice Chair)
- Harjinder Kang
- Paramjit Gill
- Waseem Zaffar
- Marie Perry
- Michael Hoare

During 2016/17, the composition of the Committee changed, Robin Russell (Non-Executive Director) left the Trust on 31/8/16 and was replaced with Marie Perry on 01/10/16.

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 2016-2017 no inflationary rises were approved. The Remuneration Committee in February 2016 approved salary increases for Toby Lewis (Chief Executive) and Rachel Barlow (Chief Operating Officer) that were payable with effect from 1st April 2016.

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.

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

SALARIES AND ALLOWANCES OF SENIOR MANAGERS

	2016-17				2015-16			
Name and Tile	(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 £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
Richard Samuda, Chair	20-25	1	0	25-30	20-25	32	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 (1/6/15 to 31/8/16)	0-5	0	0	0-5	5-10	0	0	5-10
Marie Perry, Non-Executive Director (from 1/10/16)	0-5	0	0	0-5	0	0	0	0
Waseem Zaffar, Non-Executive Director (from 1/6/15)	5-10	0	0	5-10	5-10	0	0	5-10
Gianjeet Hunjan, Non-Executive Director (until 16/8/15)	0	0	0	0	0-5	0	0	0-5
Sarinder Singh Sahota, Non-Executive Director (until 1/8/15)	0	0	0	0	0-5	0	0	0-5
Harjinder Kang, Non-Executive Director	5-10	0	0	5-10	5-10	0	0	5-10
Paramjit Gill Non-Executive Director	5-10	0	0	5-10	5-10	0	0	5-10
Michael Hoare, Non-Executive Director	5-10	0	0	5-10	5-10	0	0	5-10
Toby Lewis, Chief Executive	190-195	2	72.5-75	265-270	175-180	0	62.5-65.0	240-245
Antony Waite, Director of Finance & Performance Management	150-155	0	120.0-122.5	270-275	135-140	0	32.5-35.0	170-175
Colin Ovington, Chief Nurse (until 31/12/16)	85-90	0	17.5-20.0	100-105	110-115	0	17.5-20.0	130-135
Elaine Newell, Chief Nurse (from 19/12/16)	35-40	0	60.0-62.5	95-100	0	0	0	0
Roger Stedman, Medical Director	165-170		137.5-140.0	305-310	165-170		17.5-20.0	185-190
Rachel Barlow, Chief Operating Officer	120-125	0	125.0-127.5	250-255	105-110	0	30.0-32.5	140-145
Kam Dhami, Director of Governance	95-100	0	22.5-25.0	120-125	95-100	0	25.0-27.5	125-130
Raffaela Goodby Director of Organisation Development (from 11/2/15) - (See Note 1)	95-100	0	22.5-25.0	120-125	95-100	0	10.0-12.5	110-115

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. Elaine Newell was Acting Chief Nurse from 19/12/16 to 28/2/17. From 1/3/17 the appointment was on a substantive basis
3. The salary quoted for Antony Waite for 2016/17 includes a payment of £14,000 in respect of additional responsibilities undertaken outside of the trust on behalf of NHSi as Finance Improvement Director
4. Non-Executive Directors - do not receive pensionable remuneration and therefore do not accrue any pension related benefits.
5. Pension Related Benefits are not a paid remuneration. They are a nationally determined calculation designed to show the in-year increase in total pension benefits which have accrued to the individual. This is determined on a basis excluding employee contributions and over a notional 20 year period. Changes in benefits will be dependent on the particular circumstances of each individual.
6. 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 2017	Lump sum at pension age related to accrued pension at 31st March 2017	Cash Equivalent Transfer Value at 31st March 2017	Cash Equivalent Transfer Value at 31st March 2016	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 £0
Toby Lewis, Chief Executive	2.5-5.0	2.5-5.0	45-50	120-125	703	609	94	0
Antony Waite, Director of Finance & Performance Management	5.0-7.5	10-12.5	50-55	145-150	950	844	106	0
Elaine Newell , Chief Nurse (from 31/12/16)	0-2.5	2.5-5.0	30-35	100-105	640	580	17	0
Colin Ovington, Chief Nurse (until 18/12/16)	0-2.5	2.5-5.0	50-55	160-165	1142	1080	47	0
Roger Stedman, Medical Director	7.5-10.0	12.5-15.0	50-55	130-135	830	675	155	0
Rachel Barlow, Chief Operating Officer	5.0-7.5	12.5-15.0	35-40	100-105	592	491	101	0
Kam Dhami, Director of Governance	0-2.5	0	35-40	95-100	562	529	33	0
Raffaela Goodby Director of Organisation Development (from 11/2/15)	0-2.5	0	0	0	18	4	14	0

Pay Multiples

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

The banded remuneration of the highest paid director/Member in the Trust in the financial year 2016-17 was £192,500 (2015-16, £180,000). This was 7 times (2015-16 7) the median remuneration of the workforce, which was £26,302 (2015-16, £25,298). The Trust has calculated the pay multiple based on permanent staff, and excludes temporary or agency staff.

In 2016-17, 3 (2015-16, 6) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £195,000 to £275,000 (2015-16 £180,000-£275,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The Trust's average workforce numbers totalled 6897, and the change in average number of WTE employed across year was an increase of 18. The change in WTE employed from March 2016 to March 2017 was an increase of 40. 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 reduced between 2015-16 and 2016-17 by 3.5% (from £272,256 to £262,594). 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 consolidated inflationary increase in pay in 2016-17 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.

Staff Numbers - average Number of Employees under contract of service

	2016-17			2015-16
	Total	**Permanently employed**	**Other**	Total
	Number	**Number**	**Number**	Number
Average Staff Numbers				
Medical and dental	**821**	727	94	799
Ambulance staff	**0**	0	0	0
Administration and estates	**1,302**	1,166	136	1,341
Healthcare assistants and other support staff	**1,788**	1,514	274	1,775
Nursing, midwifery and health visiting staff	**2,248**	1,922	326	2,250
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**737**	693	44	714
Social Care Staff	**0**	0	0	0
Healthcare Science Staff	**0**	0	0	0
Other	**0**	0	0	0
TOTAL	**6,896**	**6,022**	**874**	6,879

Staff Costs - Cost of Employees under contract of service

	2016-17			2015-16
Staff Costs	**Total**	**Permanently employed**	**Other**	**Total**
	£'000s	**£'000s**	**£'000s**	**£'000s**
Medical and dental	**85,787**	**71,735**	14,052	**81,321**
Ambulance staff	**0**	**0**	0	**0**
Administration and estates	**36,264**	**32,153**	4,111	**35,967**
Healthcare assistants and other support staff	**52,414**	**42,254**	10,160	**48,735**
Nursing, midwifery and health visiting staff	**100,101**	**80,322**	19,779	**93,948**
Nursing, midwifery and health visiting learners	**0**	**0**	0	**0**
Scientific, therapeutic and technical staff	**36,311**	**33,480**	2,831	**35,337**
Social Care Staff	**0**	**0**	0	**0**
Healthcare Science Staff	**0**	**0**	0	**0**
Other	**166**	**166**	0	**209**
	311,043	**260,110**	**50,933**	295,516

Staff sickness absence and ill health retirements

	Number	Number
Total Days Lost	63,069	69,941
Total Staff Years	6,140	6,201
Average working Days Lost	10.27	11.28

*The data presented above represents information for the 2016 calendar year which the Trust considers to be a reasonable proxy for financial year equivalents.

	2016-17	2015-16
	Number	Number
Number of persons retired early on ill health grounds	9	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	323	201

Exit Packages

Exit package cost band (including any special payment element)	2016-17 *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	1,997	0	0	**1**	**1,997**	0	0
£10,000-£25,000	0	0	0	0	**0**	**0**	0	0
£25,001-£50,000	4	130,714	0	0	**4**	**130,714**	0	0
£50,001-£100,000	0	0	0	0	**0**	**0**	0	0
£100,001 - £150,000	1	136,458	0	0	**1**	**136,458**	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	**6**	**269,169**	**0**	**0**	**6**	**269,169**	**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.

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

Single exit packages can be made up of several components each of which will be counted separately in this note.

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

Off Payroll Engagements

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as at 31 March 2016	5
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	0
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.

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months there are no new engagements between 01 April 2016 and 31 March 2017.

There are no off payroll engagements of Board members or senior officials with significant financial responsibility between 01 April 2016 and 31 March 2017.

The Trust continues to make progress to reduce the number of non-substantive (agency, bank and other off payroll engagements) staff it uses from 6 in 2015/16 to 5 in 2016/17, i.e. a reduction of 17%.

Consultancy Services

During 2015-16 the NHS Trust Development Authority introduced controls over expenditure on consultancy services which included the requirement for NHS Bodies to seek approval before signing contracts for consultancy projects over £50,000.

During 2016-17 the Trust complied with these controls and engaged with suppliers for Consultancy Services (as defined in Chapter 5, Annex 1 of the Department of Health Group Accounting Manual 2016-17), the total expenditure incurred was £0.93m (2015/16 £0.85m).

Partnerships with a purpose

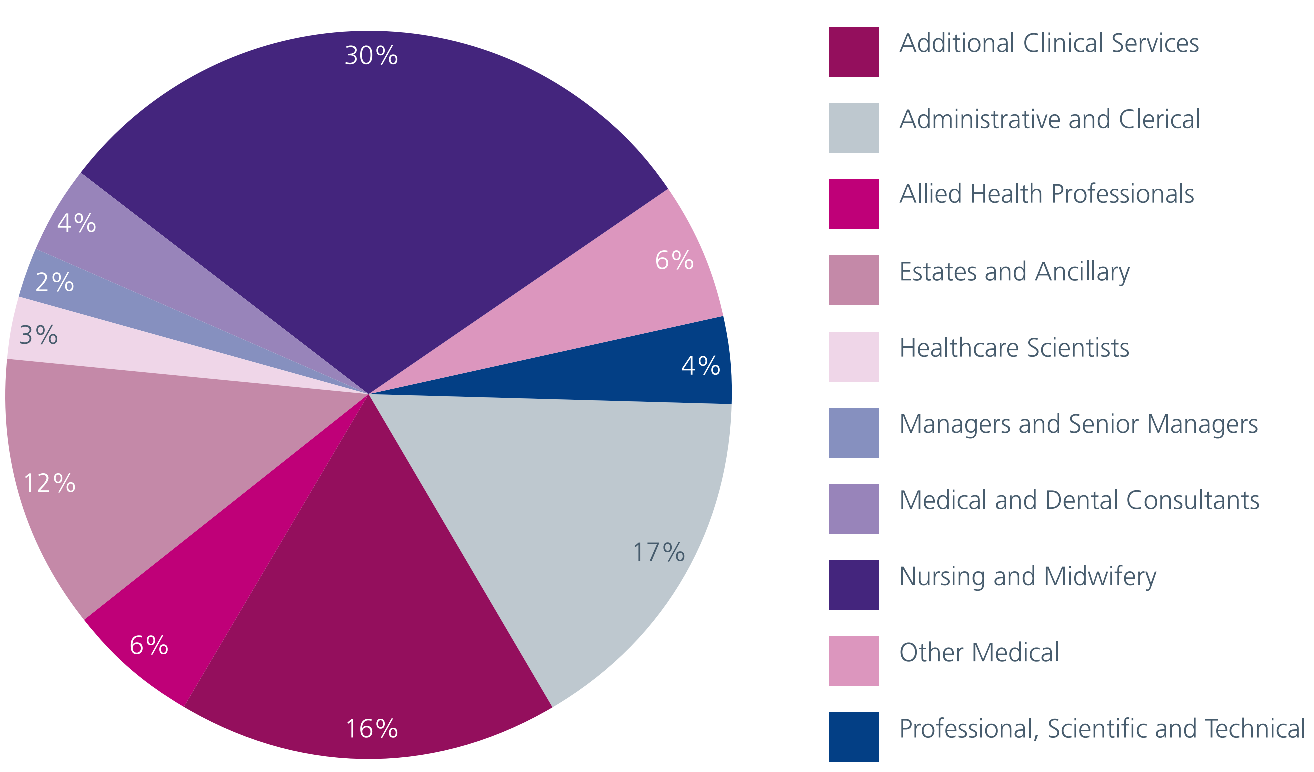
Live and Work transforms lives

It's a multi-award winning scheme which has transformed the lives of many homeless people. The Live and Work project has seen the Trust work with the charity St Basil's to provide apprenticeship opportunities to young people, while providing those who were previously homeless or at risk of homelessness a safe place to live. Jim Pollitt, who helped set up the scheme, said "It's brilliant to get recognition for a scheme that promotes diversity, equality and inclusion."

The Live & Work team (Left to right) Jevon Johnson, apprentice, Jamie Gillen, Supervisor, Ann Garrity, Manager, Helen Colbourne, Project Coordinator, Sarah Short – trainer/Assessor, Julie Smith, Trainer/Assessor and Maxine Griffiths, Widening Participation Manager.

Sporting the results of our kids 'flu' design competition are Mark Lee, Security Officer and Geraldine DeVall Occupational Health Specialist Nurse with children Chloe Beswick (centre rear) and front left to right Thomas Beswick, Ethan Barnard and Ruby-Ann Field.

Workforce Profile 2016/17



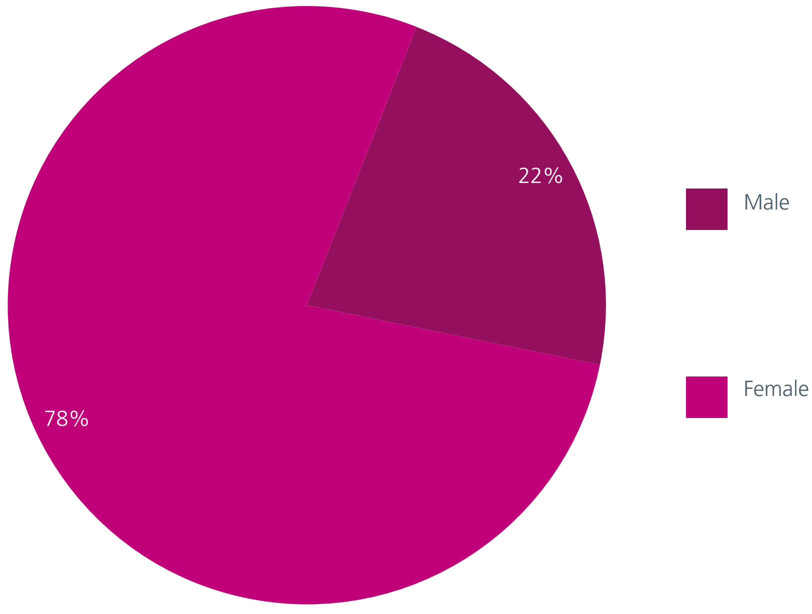
Partnerships with a purpose

Trust duo land apprenticeships with leading charity

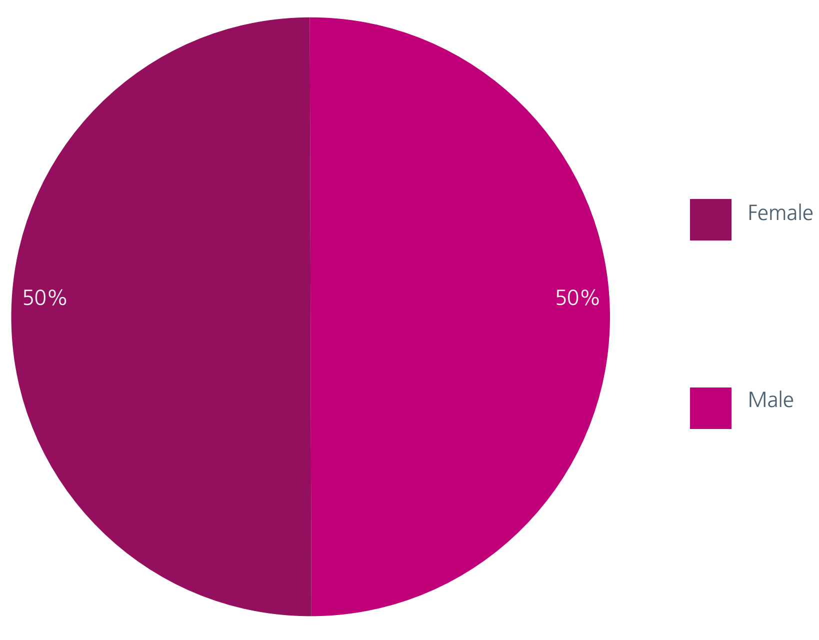
(left to right) Apprentice Darren Showell, Estates operational manager Nick Lane, and Apprentice Mike Williams.

Two employees are proof that if you're ready to take the opportunity, you can make a career change at any time in life. Both Darren Showell and Mike Williams, have joined the Trust's Estates team and are working as adult apprentices whilst being trained by the independent charity JTL. Darren is now a mechanical craftsperson, whilst Mike is an electrical craftsperson. JTL offers training courses and NVQs across the building services sector. Estates Operational Manager, Nick Lane, said: "It's natural to think that apprenticeships are only for the young, but the fact is that older people are just as eager to learn new skills – and they bring a huge amount of life experience into the workplace. When we advertised our two adult apprenticeships, we had a massive response. Darren and Mike were the stand-out candidates – and they've proved that again by being accepted on to the JTL course. JTL are notoriously choosy – they take only one in every 10 people who apply."

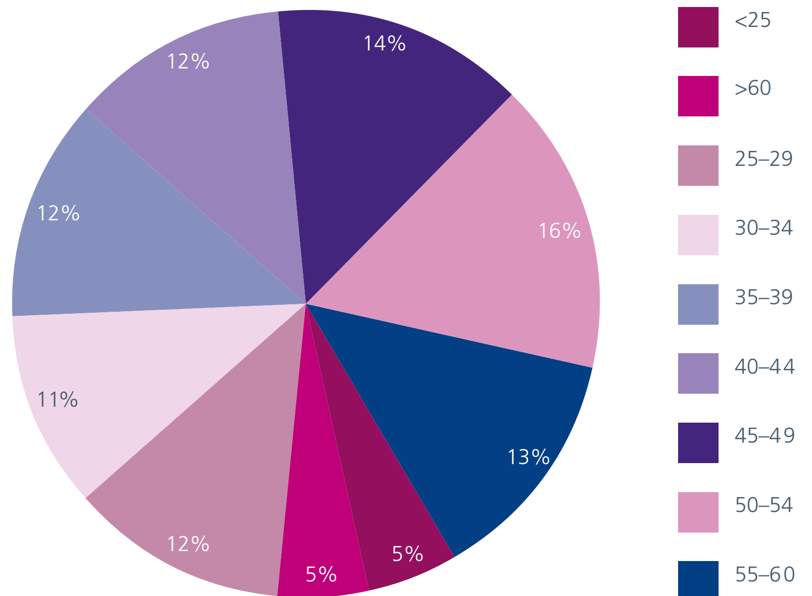
All Employees Gender Profile 2016/17



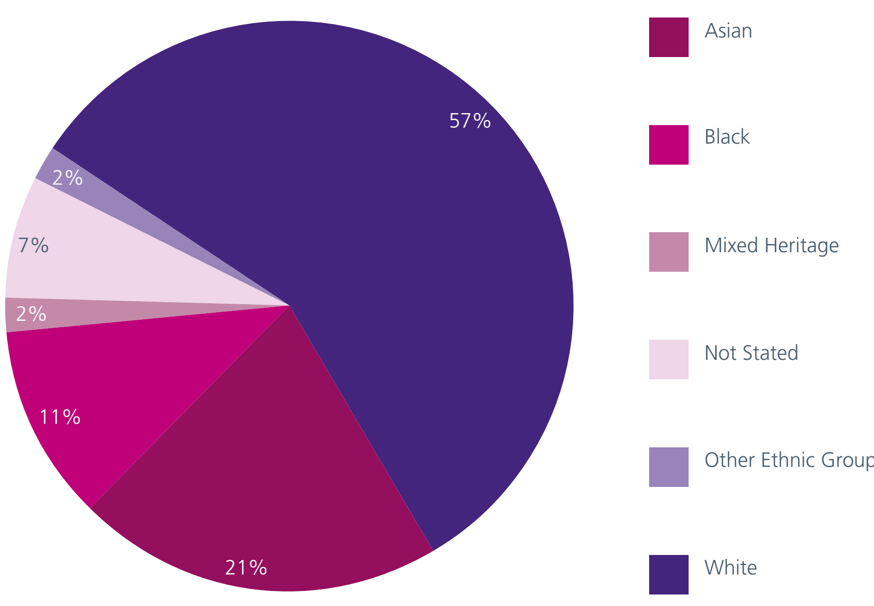
Executive Directors Gender Profile 2016/17



Age Profile 2016/17



Ethnicity Profile 2016 / 17



Workforce profile: Senior Management by Band

Band 8 - Range A	42
Band 8 - Range B	19
Band 8 - Range C	18
Band 8 - Range D	11
Band 9	8
Directors & Chief Executive	9
Chair	1

Pictured at a Wellbeing event are Raffaela Goodby, Director of OrganisationDevelopment, Stuart Young, Nurse and Elaine Newell, Chief Nurse.

Health and Wellbeing

The Flu Jab Campaign was the most successful in the region with 73% of our staff taking up the free flu jab, against a national average of 49%. The campaign has won national awards and been featured as a positive case study on the NHS Employers Website. The work of the Occupational Health Team and the peer vaccinator programme was recognised and celebrated.

Recruitment activity

We have had a really successful year in recruitment which enabled us to recruit 737 new starters with our highlights including the launch of a new SWBH brand which showcases the Trust's plans together with the opportunities and benefits available to employees. We have used targeted social media as a recruitment aid to great effect. Our guaranteed jobs for students who completed their training with us, recruitment fairs and 'One Stop' recruitment days where candidates are interviewed, complete numeracy and literacy tests and undertake pre-employment checks on the same day have resulted in over 125 new staff nurses starting with the Trust. We have also continued to increase the number of apprentices by working with local colleges and offering accommodation to young people at risk of homelessness as part of our Live and Work Project.

Sickness

Sickness absence remains a focus for us and absence has reduced from 4.83% at the end of March 2016 to 4.48% in March 2017. We have 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 phone 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.

This year we have launched our new SWBH Benefits portal, a one-stop online location for colleagues to access all their benefits in one place. We have also run a number of wellbeing activities that have taken place to support colleagues in increasing their wellbeing including walking clubs, holistic therapies, and a rapid access Musculoskeletal (MSK) service to offer fast advice and support to our staff. 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. 186 employees have a recorded disability.

Listening to our staff

The organisation is widely acknowledged for its long term commitment to improve employee engagement and know we act on colleauge feedback. We take a thorough approach to engagement through the biggest NHS survey in the country – Your Voice. Your Voice polls every member of staff every six months and asks them questions that generate a score of engagement. The score is generated through questions we ask about motivation, involvement and advocacy. As well as the engagement score, Your Voice provides us with rich data in the form of staff comments. Many teams report that reading people's comments is incredibly informative and helps them identify how to make improvements.

Key highlights from the latest Your Voice survey November – December 2016:

- Response rate was 16% from 1,024 individuals and 171 teams.
- Group response rate varied from 8% (Medicine) to 29% (Community).
- Directorates are asked to generate two or three actions that aim to make a difference to the engagement scores, response rate and importantly how results of Your Voice and action taken is communicated.

NHS Staff Survey

A sample of 1,250 colleagues are asked to complete the NHS Staff Survey and this year our response rate improved by 9% on last year. We are currently developing our action plan with leaders from our clinical and corporate groups.

- We score well on reporting incidents of violence and bullying / harassment and lower than other Trusts in the number of times people have experienced such abuse.
- 91% of staff reported having an appraisal in the last 12 months (Trust average 86%).

Partnerships with a purpose

Hand-in-hand with our partners to promote health and wellbeing

A community partnership project has seen the Trust working with different local organisations to 'make a difference' to our patients and employees' health and wellbeing. One successful collaboration includes working with 'Ideal for All', a local horticultural growing and engagement project, that regularly sells, and promotes locally grown fresh fruit and vegetables within the hospital. This project also supports those vulnerable or isolated individuals that benefit from meeting other people and they also get to 'grow' their own produce. The group also support those suffering from cancer related illnesses and this extends to families and carers too, with open coffee mornings, set in a quiet and tranquil garden.

Sandwell College has also joined the project, with its sports and physical activity team supporting our employees with inductions at the inhouse gym based at sandwell hospital. Jenny Wright, Health and Wellbeing manager, said: "We have strengthened partnerships and extended our acute hospital services to include programmes and benefits for both patients and employees. This has also given opportunities for local community projects to develop and flourish, within a safe environment that reflects the health needs of our local population."

Gym Intern Josh Bingham and Sports Lecturer Scott Thomas from Sandwell College at the new gym at Sandwell Hospital.

Staff Friends and Family Test

We are required to poll staff once a quarter with the staff friends and family test questions (would I recommend this organisation as a place to receive care / would I recommend my organisation as a place to work). We do this through each Your Voice survey, the national staff survey and an additional poll sample of 1250 colleagues.

Partnerships with a purpose

Health visiting team join forces with Sandwell Council

A partnership between our Health Visiting Team and Sandwell Metropolitan Borough Council means that the two teams are working closely together to give the community better support. Our Trust and the local authority have joined forces to deliver key public health messages and health visiting services across the Sandwell area. The partnership is not only helping to deliver excellent care, it is also giving the health visiting team and council a better understanding of the specific services offered by each other to benefit Sandwell residents.

Some paediatric and gynaecology services are available in GP practices to ensure seamless and cost effective care for patients. Sarah Farmer, Sandwell Metropolitan Borough Council Early Years Programme Manager 0-19, said: "We want to give health visitors the chance to articulate how they want to see the services working and also looking at how we can promote council services such as our healthy lifestyle and welfare rights services through health visiting. There are a lot of opportunities such as multi-agency training and also working with other parts of the council, for example children's services."

There is also a partnership with Sandwell Council and our maternity and health visiting teams to develop an enhanced pathway for women with more complex needs for support with parenting.

(Left to right) Professional lead Randeep Kaur, health visitor Gaynor Roberts and Nikki Ingram, health visiting team leader.

Partnerships with a purpose

New era in district nursing starts at Rowley

The way district nursing is delivered at Rowley Regis Hospital has been transformed after the Trust joined forces with GPs in the area. A new clinic has been set up at the site and sees patients from the 'Your Health Partnership' – the four practice GP federation that SWBH is working with on a range of innovative projects.

Group Director of Nursing, Sarah Shingler, told Heartbeat: "The clinic grew out of district nurses' commitment to explore new ways of improving our productivity. We also wanted to make a contribution to meeting SWBH's vision of offering patients the right treatment in the right place at the right time. Key to that is freeing up capacity – and that starts with understanding what patients actually need." In the coming year work will continue with all GP Practices across the area to improve care. The Trust will carry on strengthening its commitment to deliver integrated care by agreeing more formal partnership arrangements with some groups of primary care provider organisations in our catchment area.

Kenneth Ruston (seated centre) tried out the new district nursing clinic at Rowley Regis Hospital.

Equality, diversity and inclusion

The NHS England report 'Action Plan on Hearing Loss' (2015) states that there are over 45,000 children with long term hearing loss and over 10 million adults who are either deaf or have some degree of hearing impairment in the United Kingdom. The Trust serves a population of approx. 530,000. The figures from the report suggest that up to one in seven people are affected with some kind of hearing impairment. For the Trust, that equates to 75,714 people or 14.2% of its population. As a result the Trust has carried out a number of actions to address this issue. The Hearing Services Centre has distributed Ward Hearing Aid Care

Kits which contain information about caring for patients with a hearing aid. Going forward, we are considering the use of "Facetime" for non-medical discussions. Work has started to try and redress this inequality. Working with an external provider our Interpreting Service is about to launch a text relay service. This will enable deaf patients to send a text message when they need to book a GP appointment, make, change or cancel a hospital appointment or call for an ambulance. This service will be provided 24/7 and will go some way to ensuring that deaf patients have a better experience.

Equality and Diversity remains one of our key priorities and whilst we are compliant with the Care Quality Commission, the Equality, Diversity and Human Rights (EDHR) Public Sector Duties and with current legislation, we are committed to doing more. Over the last year we have made significant progress in ensuring the wellbeing of our patients, visitors and staff, particularly in creating an environment which ensures equal access regardless of age, disability, gender, religion or belief, ethnic background, sexual orientation, gender reassignment or socio-economic status.

We have introduced a number of initiatives to improve experience and outcome for both staff and patients, which includes the introduction of gender neutral toilets across our sites last winter, the establishment of our staff networks for BME, LGBT and disabled colleagues, and meeting our nine diversity pledges:

1. For our Clinical Leadership Executive (CLE) education committee to oversee analysis of training requests and funds versus protected characteristics data. This has been met and continues to be regularly reviewed.

2. For our CLE equality committee and whole board to undertake training in the duties of the Equality Act 2010. This has been met as the board have undertaken two development sessions on inclusion and diversity, and have made connections between the Trust and Birmingham LGBT.

3. For every directorate in the Trust to undertake an EDS2 (A refreshed Equality Delivery System for the NHS) self assessment to generate detailed feedback on the actions needed in their area. This has been met and the recommendations contributed to our Public Health Plan for 2017-20.

4. To collect and examine protected characteristics data on our workforce. This was met in October 2016.

5. To undertake monthly awareness campaigns around protected characteristics. This has been met with awareness raised around deafness (disability), gender equality, celebration of Eid and launch of Ramadan, LGBT Pride celebrations, eye health campaign (disability), Live and Work Homeless Project and marking National Apprenticeship Week (age).

6. To add a series of structured programmes for people with protected characteristics to our leadership development portfolio. This has been met with different initiatives including the launch of Birmingham LGBT Leadership Development Programme which started with three staff members in September 2016, and the introduction of opportunities for staff from Black and Ethnic Minority groups to be trained recruitment panellists qualified to sit on interviews across the Trust.

7. To facilitate an independent review to ensure our workforce policies and procedures match our ambitions and commitments. This has been met in full with policies on Dignity at Work, Grievance and Disputes at Work and Recruitment and Selection Procedure being reviewed.

8. To set up staff networks focussed on groups with protected characteristics. This has been met with staff networks on LGBT, BME and Disability launched in November 2016. Each network has a Chair and Vice Chair who are engaged staff members voted into their positions by colleagues. The Chairs are working with their executive sponsors to shape the activities of their network over the next year. They have a small operational budget to host events and interventions and are supported by the Equality and Inclusion Officer and a HR Business partner.

9. To work with senior leaders with protected characteristics for them to provide visible support within the organisation to others. This work is ongoing.

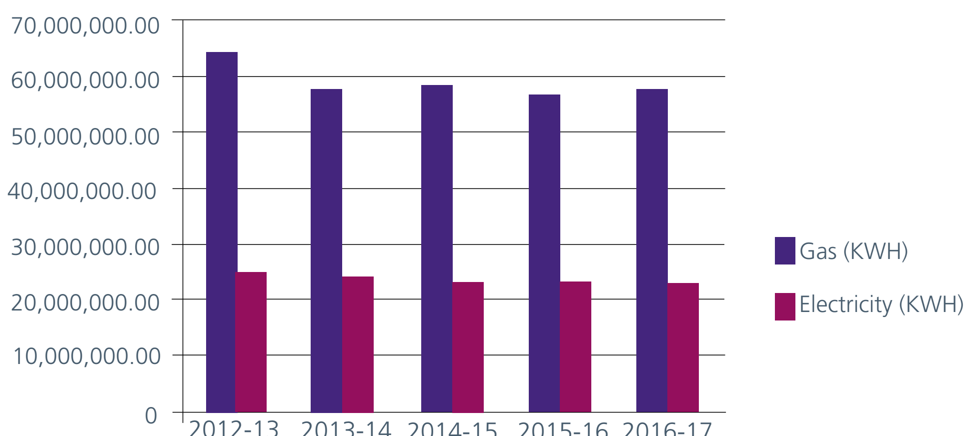
The Board and Clinical Leadership Executive have reviewed new diversity pledges for the coming year.

Sustainability Report

The Trust continues to carry out work to reduce our impact on the environment and use resources more efficiently. Since 2011, we have been working to reduce our environmental impact by using energy and water wisely, managing waste disposal to reduce adverse environmental impacts, engaging our staff and other sustainable initiatives. We are working to deliver our Sustainability Action Plan and embed Sustainability into the core of our organisation. Our overarching aim is to deliver high quality care without exhausting resources or causing excessive environmental damage. We also have a growing number of Sustainability Champions who help increase the awareness of Sustainability throughout the Trust.

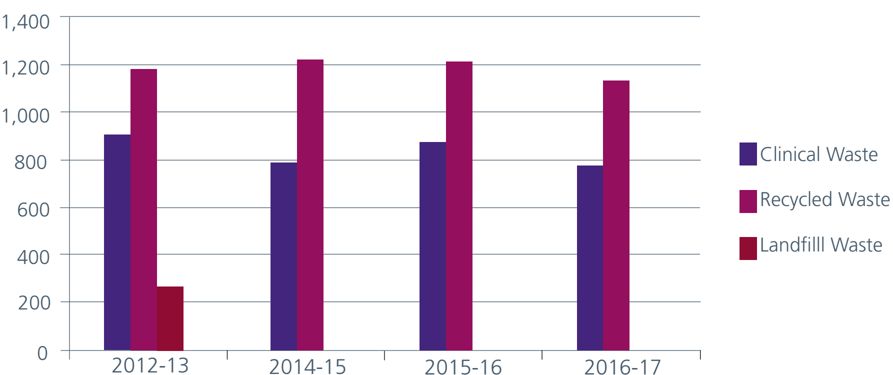
Energy and water use in our building

Each year we spend around £4 million heating and lighting our estate. We remain committed to stabilising and then reducing our energy consumption. Overall energy usage has remained similar to the previous year, although we have seen the addition of new equipment and facilities. We have delivered a number of energy efficiency schemes, including boiler replacements, upgrade of lighting to LED, solar PV at City Hospital and Rowley Regis Hospital, chiller replacements, optimisation of heating controls, and staff engagement. Our carbon emissions generated from energy consumption for 2016/17 totalled 24,324* tCO_2e. Our water consumption has increased around 7% based on the previous year. In 2016/17, the Trust used 248,511.70* m^3 of water – in carbon emissions that equates to 226 tCO_2e. Water is essential in maintaining high levels of hygiene but through on-going improvements it is hoped that water consumption will stabilise.



Waste

The Trust has been working to reduce unnecessary wastage of resources. Through engaging with staff, moving to paperless/paper light working, and liaising with our waste contractor, we have significantly reduced the amount of clinical and general waste generated. Since 2013/14, the total combined volume of general and clinical waste generated by the Trust has reduced by 20%. Alongside this, since 2014, the Trust has been diverting general (domestic) waste from landfill. Clinical waste is sent for incineration with energy recovery and 100% of our general waste is recycled or reprocessed at a local facility.



Transport and Travel

The Trust is gathering data on the impact of our transport services. We are also supporting staff in moving towards more sustainable and active modes of travel with new cycle storage facilities, dedicated cycle lanes, pool bikes for staff, travel information kiosks, free bike checks for staff, and many more. Our work has been recognised with the following awards:

- Birmingham Connected Sustainable Travel Award (2015)
- Winner of the Centro 'Most Proactive Organisation, Cycling' Award (2015)
- Gold Standard Top Cycling Location (2015)
- Top Walking Location (2016)
- Platinum Top Active Travel Location (2016)

We will soon be installing electric vehicle charge points across the Trust for staff, patients and visitors to access.

Wider 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 now been achieved. We will continue to improve on this year-on-year. The Trust is also working to ensure that our new Midland Metropolitan Hospital is energy efficient and easily accessible by sustainable modes of travel.

A bike specialist from Bike Right at our Sustainability Garden Party carrying out free bike checks for staff.

Solar PV panels on BMEC at City Hospital

(Left to right) Shabanah Mohammed, financial accountant, Jennie Appleyard, group finance manager, and Tim Reardon, associate director of finance.

Our finances and investments

Directors' Report
Although a surplus was reported for 2015/16 the Trust exited the 2015/16 finance year with an underlying deficit in excess of £16m. Throughout 2016/17 operational teams have been challenged to identify and deliver internal efficiencies that would address both this deficit and the efficiency saving required as part of the 2016/17 tariff. The environmental factors that contributed to the underlying deficit brought forward have continued to impact the Trust in 2016/17. Manifestations of these include greater acuity in attendances at A&E, high levels of beds occupied by people medically fit for discharge as well as difficulties in the recruitment of certain staff groups.

As a consequence of these factors elective income is below the level planned and agency spend has continued at high levels. These have contributed to the deficit reported for the 2016/17 financial year. While reporting a deficit is disappointing that the level of reported deficit has been maintained at nearly £5m below the underlying brought forward position is encouraging. This is particularly so given the progress made in respect of CQC actions, the MMH project and the EPR implementation.

However, the long-term target for the Trust is to generate underlying, cash backed surpluses in order to support the necessary investment programme. Consequently from a financial perspective the 2017/18 financial year will be dominated by a focus on addressing the underlying deficit while securing performance levels required for MMH. The Trust exits the 2016/17 financial year with an underlying deficit in excess of £25m. The business planning process indicates that this can be addressed within the coming financial year but that there are some key external dependencies to this and so a high degree of risk is attached to this outcome. It is expected that the original financial performance trajectory that was envisaged as part of the Midland Met investment plan will not be recovered until after 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 2016/17 the Trust agreed an income and expenditure target surplus of £6.6m. Due to the factors outlined above this was reset during the year to a deficit of £6.84m. Achievement of this revised target was subject to delivery of an in year recovery programme. This programme depended on a combination of additional income and pay bill reduction. Material components of both income and pay bill improvement depended on resolution of issues in the wider health economy and consequently not directly controllable by the Trust executive. That these were not resolved within the financial year impacted on the recovery programme and so the Trust deviated further from plan and delivered a deficit of £11.933m. On the basis of this performance the Trust has failed to meet its main budgetary objective of break even.

For the purpose of measuring statutory accounts performance, the Trust generated a deficit in year of £6.996m.

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 2016/17 Statutory Accounts (separate document).

Figure 6.1 shows how the Trust's reported performance is calculated. The deficit in the published Statutory Accounts is subject to 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	2016/17	2015/16
	£000s	£000s
Income for Patient Activities	416,916	405,531
Income for Education, Training, Research & Other Income	43,281	38,167
Total Income	460,197	443,698
Pay Expenditure	(311,043)	(295,516)
Non Pay Expenditure including Interest Payable and Receivable	(151,033)	(147,586)
Public Dividend Capital (PDC) - Payment	(5,117)	(4,850)
Total Expenditure (Including Impairments and Reversals)	(467,193)	(447,952)
Surplus/(Deficit) per Statutory Accounts	(6,996)	(4,254)
Exclude Impairments and Reversals	(5,161)	8,390
Adjustment for elimination of Donated and Government Grant Reserves	224	(279)
Surplus/(Deficit) per DH Target	(11,933)	3,857

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 reported performance of the Trust's I&E was below plan, local positions within Clinical Groups and directorates, indicate further divergence from this plan. The scale of the divergence is such that the operational performance would have resulted in a deficit position in excess of £25m rather than the reported £11.9m deficit. Challenges to achieving the required level of operational performance throughout the year have been consistent and include elective capacity and interim staffing levels. As a consequence of these factors capacity management and patient flow initiatives have been a focus of executive led projects throughout the year and will remain central to the business planning undertaken in readiness for the 2017/18 financial year. It is intended that this 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 throughout the current two year planning period.

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 £18.968m for 2016/17, the Trust's relevant expenditure was £18.967m, thereby undershooting by £0.001m 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 £56.399m, the Trust's cash flow financing requirement was £46.962m, thereby undershooting by £9.437m 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 of £460.197m in 2016/17 are shown in the following in Figure 6.2 which shows an overall increase of £16.499m, 3.72%.

The largest items driving this increase are £5.3m sustainability and transformation fund money (STF), £3m taper relief and £3m in relation to the end of life care contract which the Trust won. These represent new income streams for 2016/17. STF is central funding made available to Trust's to support performance of emergency services and is allocated on the basis of 2014/15 costing information. Taper relief relates to funding for elements of the MMH project while end of life funding is money due to the Trust

for services provided under that contract.

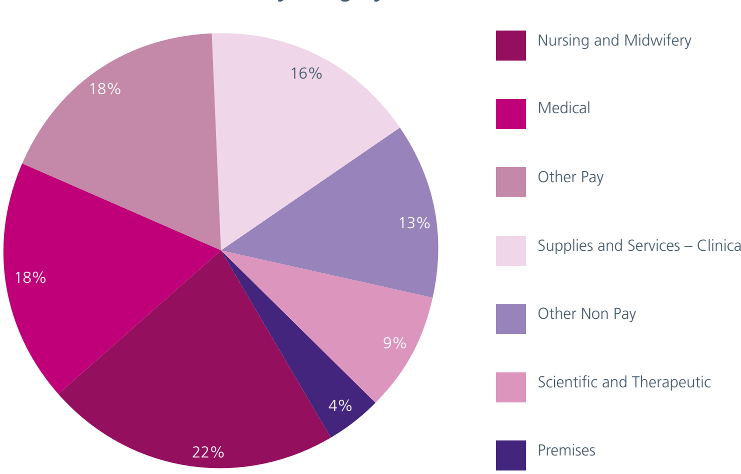
While there have been some reclassifications of income, including a grossing up of charges relating to staff recharges to other organisations which has the impact of appearing to increase income and expenditure between years while in fact the overall net impact of this is nil, income growth was planned as part of the MMH initiative. Repatriation of certain activity was a key part of this and so some level of income growth was expected.

Figure 6.2

Sources of Income	2016/17	2015/16
	£000s	£000s
NHS England and Department of Health	56,536	53,895
NHS Trusts and Foundation Trusts	3,560	4,078
Clinical Commissioning Groups	343,930	338,649
NHS Other (including Public Health England and Prop Co)	1,070	1,605
Non NHS Patient Income including Local Authorities	11,820	7,304
Education & Research	20,351	20,028
Other Non-Patient Related Services	5,387	7,288
Other Income	17,543	10,851
Total Income	460,197	443,698
Adjustment for elimination of Donated and Government Grant Reserves	224	(279)
Surplus/(Deficit) per DH Target	(11,933)	3,857

Within Figure 6.3, the pie chart below, the largest element, 76%, of the Trust's resources flowed directly from CCGs and 12% from NHSE with the next significant element, 5%, being education, training and research funds. The Trust is an accredited body for the purposes of training undergraduate medical students, postgraduate doctors and other clinical trainees. It also has an active and successful research community.

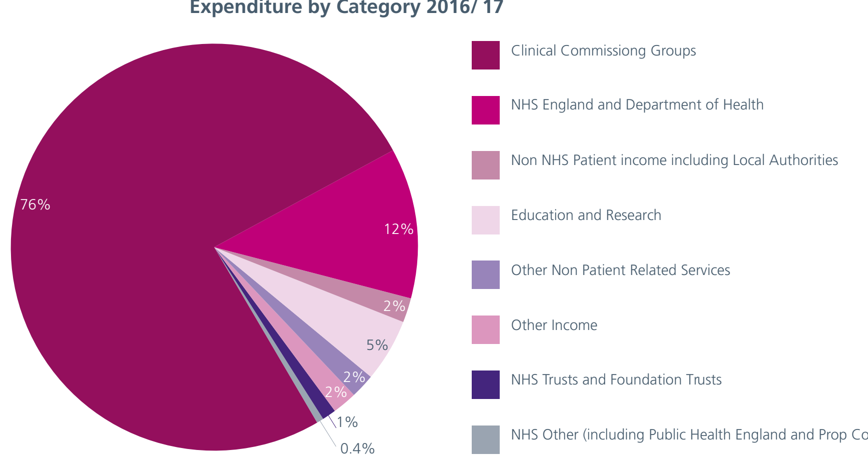
Figure 6.3



Expenditure

In figure 6.4, the pie chart below shows that 67% of the Trust's cost was pay and, within this, the three largest groups were nursing and midwifery (22%), medical staff (18%) and scientific and therapeutic (9%). The remaining 33% of operational expenditure was non pay, the largest element of which was clinical supplies and services which included drug costs at 16%.

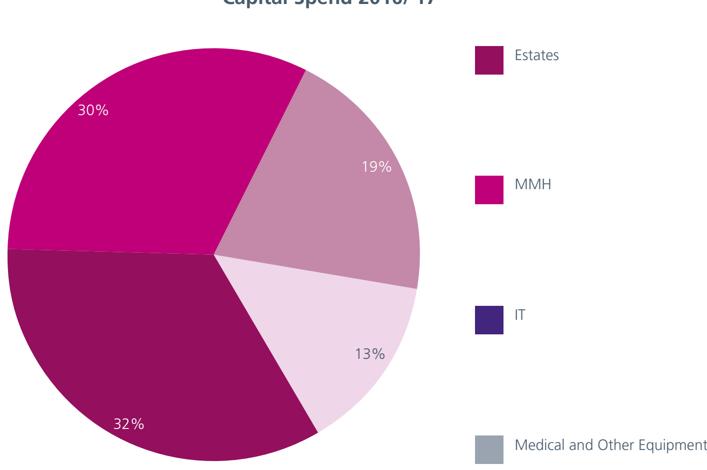
Figure 6.4



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's gross spend during 2016/17 on capital items was £19.029m. This is adjusted by any donated items when measured against the CRL (see earlier). A breakdown of this gross expenditure is shown in the pie chart below.

Figure 6.5



The Trust spent a significant proportion – 62% - of its capital budget on the Midland Metropolitan Hospital (MMH) and Estates. Specifically, £8.596m was spent on MMH and upgrading the Trust's Estate, including ensuring compliance with statutory standards. Medical and Other Equipment accounted for £4.195m while £0.049m was spent on equipment identified for clinical quality improvement. IT spend totalled £4.332m of which £1.861m was for the Electronic Patient Record system.

Staff sickness data will be provided on a national basis by DH for 2016/17 and covers the calendar year ended 31 December.

Audit

The Trust's External Auditors are KPMG LLP. They were appointed for 2015/16 and 2016/17 by Public Sector Audit Appointments Ltd following the demise of the Audit Commission. Further to the demise of the Audit Commission, the Trust itself is now required to take responsibility for the appointment of its auditors. Accordingly a competitive tendering process was undertaken during 2016 for when the current contract expired. Following this process, which included the existing auditors, Grant Thornton were appointed. 2017/18 will be the first year's accounts affected by this change.

The cost of the work undertaken by the Auditor in 2016/17 was £91k including VAT. The fee in respect of auditing charitable fund accounts at £10.4k including VAT is excluded from this sum.

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.

2016-17 Annual Accounts of Sandwell & West Birmingham Hospitals NHS Trust

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

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

- make judgements and estimates which are reasonable and prudent;

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

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

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

1/6/17 ....Date.............................Chief Executive

1/6/17 ....Date.............................Finance Director

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	**2016-17 £000s**	2015-16 £000s
Gross employee benefits	8.1	**(311,043)**	(295,516)
Other operating costs	6	**(148,908)**	(145,715)
Revenue from patient care activities	3	**411,619**	405,531
Other operating revenue	4	**48,578**	38,167
Operating surplus/(deficit)		**246**	2,467
Investment revenue	10	**66**	136
Other gains and (losses)	11	**0**	50
Finance costs	12	**(2,191)**	(2,057)
Surplus/(deficit) for the financial year		**(1,879)**	596
Public dividend capital dividends payable		**(5,117)**	(4,850)
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		**(6,996)**	(4,254)

Other Comprehensive Income

	2016-17 £000s	2015-16 £000s
Impairments and reversals taken to the revaluation reserve	**654**	(36,230)
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 comprehensive income for the year	**(6,342)**	(40,484)

Financial performance for the year

	2016-17 £000s	2015-16 £000s
Retained surplus/(deficit) for the year	**(6,996)**	(4,254)
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**0**	1,368
Impairments (excluding IFRIC 12 impairments)	**(5,161)**	7,022
Adjustments in respect of donated gov't grant asset reserve elimination	**224**	(279)
Adjustment re absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**(11,933)**	3,857

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 in 2016-17 this has resulted in an increase to Asset Values. The increase is represented in the accounts as a reversal of previous impairments of Buildings of £5.9m, £0.6m of which was carried through the Revaluation Reserve which reverses impairments charged from prior years. The remaining reversal of impairment of £5.2m has been recognised as a credit to the SOCI. In addition the Trust impaired intangible assets of £0.05m. Impairments and Reversals 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 £0.62m. 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, £0.286m, 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 (£0.224m)

The notes on pages 93 to 128 form part of this account.

Statement of Financial Position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets:			
Property, plant and equipment	14	**207,430**	196,381
Intangible assets	15	**166**	386
Investment property		**0**	0
Other financial assets		**0**	0
Trade and other receivables	19.1	**43,017**	846
Total non-current assets		**250,613**	197,613
Current assets:			
Inventories	18	**5,268**	4,096
Trade and other receivables	19.1	**17,100**	16,308
Other financial assets		**0**	0
Other current assets		**8,043**	0
Cash and cash equivalents	20	**23,902**	27,296
Sub-total current assets		**54,313**	47,700
Non-current assets held for sale		**0**	0
Total current assets		**54,313**	47,700
Total assets		**304,926**	245,313
Current liabilities			
Trade and other payables	21	**(68,512)**	(54,144)
Other liabilities		**0**	0
Provisions	24	**(1,147)**	(1,472)
Borrowings	22	**(903)**	(1,306)
Other financial liabilities		**0**	0
DH revenue support loan	22	**0**	0
DH capital loan	22	**0**	0
Total current liabilities		**(70,562)**	(56,922)
Net current assets/(liabilities)		**(16,249)**	(9,222)
Total assets less current liabilities		**234,364**	188,391
Non-current liabilities			
Trade and other payables	21	**0**	0
Other liabilities		**0**	0
Provisions	24	**(3,396)**	(3,095)
Borrowings	22	**(33,953)**	(25,591)
Other financial liabilities		**0**	0
DH revenue support loan	22	**0**	0
DH capital loan	22	**0**	0
Total non-current liabilities		**(37,349)**	(28,686)
Total assets employed:		**197,015**	159,705
FINANCED BY:			
Public Dividend Capital		**205,362**	161,710
Retained earnings		**(24,979)**	(17,993)
Revaluation reserve		**7,574**	6,930
Other reserves		**9,058**	9,058
Total Taxpayers' Equity:		**197,015**	159,705

The notes on pages 93 to 128 form part of this account.
The financial statements on pages 88 to 92 were approved by the Board on 1st June 2017 and signed on its behalf by

Toby Lewis
(Chief Executive)
Date 01/06/2017

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**161,710**	**(17,993)**	**6,930**	**9,058**	**159,705**
Changes in taxpayers' equity for 2016-17					
Retained surplus/(deficit) for the year		(6,996)			**(6,996)**
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			0		**0**
Impairments and reversals			654		**654**
Other gains/(loss) (provide details below)				0	**0**
Transfers between reserves		10	(10)	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**
Temporary and permanent PDC received - cash	43,652				**43,652**
Temporary and permanent PDC repaid in year	0				**0**
PDC written off	0	0			**0**
Transfer due to change of status from Trust to Foundation	0	0	0	0	**0**
Other movements	0	0	0	0	**0**
Net actuarial gain/(loss) on pension		0		0	**0**
Other pensions remeasurement		0		0	**0**
Net recognised revenue/(expense) for the year	**43,652**	**(6,986)**	**644**	**0**	**37,310**
Balance at 31 March 2017	**205,362**	**(24,979)**	**7,574**	**9,058**	**197,015**

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
Balance at 1 April 2015	**162,210**	**(13,758)**	**43,179**	**9,058**	**200,689**
Changes in taxpayers' equity for the year ended 31 March 2016					
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 assets held for sale			0		0
Impairments and reversals			(36,230)		(36,230)
Other gains / (loss)				0	0
Transfers between reserves		19	(19)	0	0
Reclassification Adjustments					
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under		0	0		0
On disposal of available for sale financial assets			0		0
Originating capital for Trust established in year	0				0
New PDC received - cash	0				0
PDC repaid in year	(500)				(500)
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	**(500)**	**(4,235)**	**(36,249)**	**0**	**(40,984)**
Balance at 31 March 2016	**161,710**	**(17,993)**	**6,930**	**9,058**	**159,705**

Information on reserves

1 **Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additiona PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NH foundation trust, is payable to the Department of Health as the public dividend capital dividend.

2 **Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the NHS trust.

3 **Revaluation Reserve**
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

4 **Other reserves**
The Other Reserve reflects the differences between the value of the fixed assets taken over by the Trust at inception and the corresponding figure in its originating debt

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	**2016-17 £000s**	2015-16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**246**	2,467
Depreciation and amortisation	6	**14,015**	12,946
Impairments and reversals	16	**(5,161)**	8,390
Other gains/(losses) on foreign exchange	11	**0**	0
Donated Assets received credited to revenue but non-cash	4	**(62)**	(527)
Government Granted Assets received credited to revenue but non-cash		**0**	0
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**(1,172)**	(629)
(Increase)/Decrease in Trade and Other Receivables		**(42,773)**	864
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**12,463**	10,270
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions utilised		**(910)**	(3,139)
Increase/(Decrease) in movement in non cash provisions		**844**	199
Net Cash Inflow/(Outflow) from Operating Activities		**(22,510)**	30,841
Cash Flows from Investing Activities			
Interest Received		**66**	136
(Payments) for Property, Plant and Equipment		**(16,718)**	(22,925)
(Payments) for Intangible Assets		**0**	(53)
(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)		**0**	50
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		**(16,652)**	(22,792)
Net Cash Inform / (outflow) before Financing		**(39,162)**	8,049
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**43,652**	0
Gross Temporary and Permanent PDC Repaid		**0**	(500)
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		**0**	(1,000)
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		**(84)**	(1,017)
Interest paid		**(2,145)**	(2,011)
PDC Dividend (paid)/refunded		**(5,655)**	(4,607)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**35,768**	(9,135)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(3,394)**	(1,086)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**27,296**	28,382
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	**20**	**23,902**	27,296

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 2016-17 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.

Going Concern

These accounts have been prepared on a going concern basis

NHS organisations are required to produce financial statements in line with International Accounting & Financial Reporting Standards. The NHS also has the benefit of additional guidance in the group accounting manual (GAM). The impact of this is that Trusts should prepare financial statements on a going concern basis unless management concludes that the entity is not a going concern. IAS 1 requires this conclusion to be based on a management assessment of an entity's ability to continue as a going concern.

Management Assessment of Going Concern

In line with financial forecasts SWBH Trust has reported a deficit position for 2016/17 which, following the underlying deficit generated in 2015/16, is expected to result in a shortage of internally generated cash in 2017/18. The underlying deficit for 2016/17 is £25.8m which is carried forward into 2017/18

SWBH Trust has developed two year financial plans that address the current underlying deficit and secure underlying break even over that period. These recognise a delay in recovery and consequent short-term cash requirements and, through DH loan, secure liquidity in the short and medium term. This financing facility also implicitly recognises and addresses the risk of further delay to financial recovery and the sensitivity of the liquidity position to the assumptions about financial recovery.

The Black Country Sustainability and Transformation Plan involves SWBH Trust as a partner. The Trust's existing contribution to the health economy is recognised and appears to remain an integral component over the course of the planning cycle.

The Trust's Commissioners' intentions indicate that SWBH Trust services are required to deliver the CCG's plans for serving the needs of the local population.

Based on this evidence it is clear that SWBH Trust has financial plans which address the liquidity risks and secure the Trust's ability to make good liabilities as they fall due. In addition published documents indicate a requirement for the services currently provided by the Trust. SWBH Trust meets the criteria to be considered a going concern and the financial statements for the period 2016/17 have been prepared on that basis.

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.

NOTES TO THE ACCOUNTS

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

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.

Charitable Funds

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 2016 / 2017 were £1.2m and total resources expended were £2.1m which represent 0.27% 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 Department of Health Group Accounting Manual for 2016-17.

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.

Managed Equipment Scheme
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. The accounting treatment for the scheme was determined to be considered as an IFRIC12 Service concession and included within 'on SOFP' PFI schemes included in Note 27.

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 annual valuation is performed at 31st March to ensure a true and fair view was reflected.

NOTES TO THE ACCOUNTS

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

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 Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a 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 NHS 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.

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 NHS trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- Collectively, a number of items have a total 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.

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.

NOTES TO THE ACCOUNTS

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

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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment 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. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

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 and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

Subsequent expenditure

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

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

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

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

Measurement

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

NOTES TO THE ACCOUNTS

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

1.11 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

At each financial year-end, the NHS trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

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 are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

NOTES TO THE ACCOUNTS

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

The NHS trust as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.16 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 NHS 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 or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

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 initial 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 NHS 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 accrual 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 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.

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.

NOTES TO THE ACCOUNTS

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

1.17 Inventories

Inventories are valued at the lower of cost and net realisable value using the *[first-in first-out/weighted average]* 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 rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
• A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
• A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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 NHS trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.20 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 24.

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 trust 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.

NOTES TO THE ACCOUNTS

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

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 where there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Financial assets are initially recognised at fair value. 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 that occurred after the initial recognition of the asset and that have 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 historic 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.

NOTES TO THE ACCOUNTS

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

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 NHS trust's functional 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 34 to the accounts.

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 NHS trust not been bearing its 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 trust 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.

NOTES TO THE ACCOUNTS

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

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 2016-17. 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 from Contracts with Customers - 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 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.

1.36 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

2. Operating segments

The Board, as 'Chief Operating Decision Maker', has determined that the Trust operates in one material segment which is the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure.

The provision of healthcare (including medical treatment, research and education) is within one main geographical segment, the United Kingdom, and materially from Departments of HM Government in England.

The Trust has only one business segment which is provision of healthcare. A segmental analysis is therefore not applicable.

3. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS Trusts	**284**	629
NHS England	**51,239**	53,199
Clinical Commissioning Groups	**343,930**	338,649
Foundation Trusts	**3,276**	3,449
Department of Health	**0**	196
NHS Other (including Public Health England and Prop Co)	**1,070**	1,303
Additional income for delivery of healthcare services	**0**	500
Non-NHS:		
Local Authorities	**9,008**	5,640
Private patients	**172**	159
Overseas patients (non-reciprocal)	**1,100**	192
Injury costs recovery	**1,283**	1,283
Other Non-NHS patient care income	**257**	332
Total Revenue from patient care activities	**411,619**	405,531

4. Other operating revenue

	2016-17 £000s	2015-16 £000s
Recoveries in respect of employee benefits	**0**	0
Patient transport services	**135**	166
Education, training and research	**20,351**	20,028
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure -non- NHS	**0**	0
Receipt of charitable donations for capital acquisitions	**62**	527
Support from DH for mergers	**0**	**0**
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**5,190**	6,595
Sustainability & Transformation Fund Income	**5,297**	0
Income generation (Other fees and charges)	**9,893**	6,544
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**0**	0
Other revenue *	**7,650**	4,307
Total Other Operating Revenue	**48,578**	38,167
Total operating revenue	**460,197**	443,698

* Other Revenue includes £3m that the Trust received for non recurrent funding in support of the development and transition to the Midland Metropolitan Hospital (MMH). That funding is part of a total of £22.3m which the trust expects to receive over the period 2016-2020. Such funding is in line with national arrangements for supporting large scale infrastructure projects such as MMH

5. Overseas Visitors Disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**1,100**	**192**
Cash payments received in-year (re receivables at 31 March 2016)	**143**	**98**
Cash payments received in-year (iro invoices issued 2016-17)	**166**	**33**
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**0**	**0**
Amounts added to provision for impairment of receivables (iro invoices issued 2016-17)	**735**	**162**
Amounts written off in-year (irrespective of year of recognition)	**123**	**86**

6. Operating expenses

	2016-17	2015-16
	£000s	£000s
Services from other NHS Trusts	**1,782**	1,020
Services from CCGs/NHS England	**0**	0
Services from other NHS bodies	**507**	2,146
Services from NHS Foundation Trusts	**6,947**	7,434
Total Services from NHS bodies*	**9,236**	10,600
Purchase of healthcare from non-NHS bodies	**3,397**	1,596
Purchase of Social Care	**0**	**0**
Trust Chair and Non-executive Directors	**64**	66
Supplies and services - clinical	**79,133**	71,033
Supplies and services - general	**6,950**	6,485
Consultancy services	**930**	852
Establishment	**4,518**	3,884
Transport	**1,839**	1,527
Service charges - ON-SOFP PFIs and other service concession arrangements	**2,166**	863
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	**1,597**	1,299
Premises	**17,429**	16,207
Hospitality	**0**	0
Insurance	**90**	110
Legal Fees	**97**	49
Impairments and Reversals of Receivables	**1,382**	515
Inventories write down	**8**	57
Depreciation	**13,853**	12,714
Amortisation	**162**	232
Impairments and reversals of property, plant and equipment	**(5,219)**	8,278
Impairments and reversals of intangible assets	**58**	112
Impairments and reversals of financial assets [by class]	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Internal Audit Fees	**220**	197
Audit fees **	**91**	91
Other auditor's remuneration	**14**	27
Clinical negligence	**7,577**	6,476
Research and development (excluding staff costs)	**242**	242
Education and Training	**1,111**	1,206
Change in Discount Rate	**388**	(23)
Capital Grants in Kind	**0**	0
Other	**1,575**	1,020
Total Operating expenses (excluding employee benefits)	**148,908**	145,715
Employee Benefits		
Employee benefits excluding Board members	**309,639**	294,183
Board members	**1,404**	1,333
Total Employee Benefits	**311,043**	295,516
Total Operating Expenses	**459,951**	441,231

* Services from NHS bodies does not include expenditure which falls into a category below
** Audit Fees - External Audit fees are disclosed inclusive of VAT. (The contract for 2016/17 was £75,380 plus VAT)

7. Operating Leases

7.1. Sandwell and West Birmingham Hospitals NHS Trust as lessee

	Land	Buildings	Other	2016-17 Total	2015-16
	£000s	£000s	£000s	£000s	£000s
Payments recognised as an expense					
Minimum lease payments				**44**	138
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**44**	138
Payable:					
No later than one year	18	0	25	**43**	131
Between one and five years	73	0	47	**120**	216
After five years	127	0	24	**151**	146
Total	**218**	**0**	**96**	**314**	493
Total future sublease payments expected to be received:				0	0

8. Employee benefits

8.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**262,812**	253,134
Social security costs	**23,743**	18,800
Employer Contributions to NHS BSA - Pensions Division	**27,185**	26,766
Other pension costs	**0**	0
Termination benefits	**0**	0
Total employee benefits	**313,740**	298,700
Employee costs capitalised	**2,697**	3,184
Gross Employee Benefits excluding capitalised costs	**311,043**	295,516

8.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**9**	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	**323**	201

8.3. 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 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this ‘employer cost cap’ assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

9. Better Payment Practice Code

9.1. Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	107,147	255,483	112,909	157,420
Total Non-NHS Trade Invoices Paid Within Target	56,239	204,246	99,996	138,820
Percentage of NHS Trade Invoices Paid Within Target	52.49%	79.95%	88.56%	88.18%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,141	31,490	2,022	28,228
Total NHS Trade Invoices Paid Within Target	1,011	16,038	1,449	18,762
Percentage of NHS Trade Invoices Paid Within Target	47.22%	50.93%	71.66%	66.47%

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.

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

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	1	2
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	1	2

10. Investment Revenue

	2016-17 £000s	2015-16 £000s
Interest revenue		
Bank interest	66	136
Total investment revenue	66	136

11. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	0	50
Gain/(Loss) on disposal of assets other than by sale (intangibles)	0	0
Total	0	50

12. Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	0	4
Interest on obligations under finance leases	0	0
Interest on obligations under PFI contracts:		
- main finance cost	1,332	1,391
- contingent finance cost	813	618
Interest on late payment of commercial debt	1	2
Total interest expense	2,146	2,015
Other finance costs	0	0
Provisions - unwinding of discount	45	42
Total	2,191	2,057

13. Auditor Remuneration

13.1. Other auditor remuneration

	2016-17 £000s	2015-16 £000s
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	0	0
2. Audit-related assurance services	10	19
3. Taxation compliance services	0	0
4. All taxation advisory services not falling within item 3 above	4	8
5. Internal audit services	0	0
6. All assurance services not falling within items 1 to 5	0	0
7. Corporate finance transaction services not falling within items 1 to 6 above	0	0
8. Other non-audit services not falling within items 2 to 7 above	0	0
Total	14	27

14.1. Property, plant and equipment

2016-17	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 2016	16,640	140,725	0	10,283	101,531	3,833	31,689	1,997	**306,698**
Additions of Assets Under Construction				3,540					**3,540**
Additions Purchased	0	4,732	0		1,805	0	6,193	0	**12,730**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	49	0	13	0	**62**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	0	**0**
Additions Leased (including PFI/LIFT)	0	105	0		2,592	0	0	0	**2,697**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(694)	0	(35)	0	**(729)**
Revaluation	0	(1,149)	0	0	0	0	0	0	**(1,149)**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Impairments/reversals charged to reserves	0	654	0	0	0	0	0	0	**654**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2017	**16,640**	**145,067**	**0**	**13,823**	**105,283**	**3,833**	**37,860**	**1,997**	**324,503**
Depreciation									
At 1 April 2016	0	0	0		82,000	3,295	23,461	1,561	**110,317**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		(694)	0	(35)	0	**(729)**
Revaluation	0	(1,149)	0		0	0	0	0	**(1,149)**
Impairment/reversals charged to reserves	0	0	0		0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	(5,219)	0		0	0	0	0	**(5,219)**
Charged During the Year	0	6,369	0		4,533	170	2,710	71	**13,853**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0		0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0		0	0	0	0	**0**
At 31 March 2017	**0**	**1**	**0**	**0**	**85,839**	**3,465**	**26,136**	**1,632**	**117,073**
Net Book Value at 31 March 2017	**16,640**	**145,066**	**0**	**13,823**	**19,444**	**368**	**11,724**	**365**	**207,430**
Asset financing:									
Owned - Purchased	16,640	124,681	0	13,823	10,826	368	11,712	364	**178,414**
Owned - Donated	0	329	0	0	769	0	12	0	**1,110**
Owned - Government Granted	0	861	0	0	0	0	0	0	**861**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	19,195	0	0	7,849	0	0	1	**27,045**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2017	**16,640**	**145,066**	**0**	**13,823**	**19,444**	**368**	**11,724**	**365**	**207,430**

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 2016	4,684	2,239	0	0	7	0	0	0	**6,930**
Movements (specify)	0	644	0	0	0	0	0	0	**644**
At 31 March 2017	**4,684**	**2,883**	**0**	**0**	**7**	**0**	**0**	**0**	**7,574**

Additions to Assets Under Construction in 2016-17

Land	0
Buildings excl Dwellings	3,540
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**3,540**

14.2. Property, plant and equipment prior-year

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**
Reclassifications as Held for Sale and Reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(3,572)	0	0	0	**(3,572)**
Revaluation	(7,446)	(6,580)	0	0	0	0	0	0	**(14,026)**
Impairment/reversals charged to reserves	0	0	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	(13,654)	(22,576)	0	0	0	0	0	0	**(36,230)**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
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**
Reclassifications as Held for Sale and Reversals	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		(3,572)	0	0	0	**(3,572)**
Revaluation	(7,446)	(6,580)	0		0	0	0	0	**(14,026)**
Impairment/reversals charged to reserves	0	0	0		0	0	0	0	**0**
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**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0		0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0		0	0	0	0	**0**
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**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	18,618	0	0	0	0	0	0	**18,618**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2016	**16,640**	**140,725**	**0**	**10,283**	**19,531**	**538**	**8,228**	**436**	**196,381**

14.3. (cont). Property, plant and equipment

The Trust's property assets (land and buildings) were revalued during the year by the District Valuation Service and using Modern Equivalent Asset valuation techniques with a valuation date of 31st March 2016. 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 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 excl Dwellings	12 to 50
Plant & Machinery	1 to 10
Transport Equipment	1 to 5
Information Technology	1 to 10
Furniture and Fittings	1 to 10
Software Licences	1 to 4
Licences and Trademarks	1 to 1

15. Intangible non-current assets

15.1. Intangible non-current assets

2016-17	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 2016 (As Restated) *	**0**	**2,954**	**101**	**0**	**0**	**3,055**
Additions of Assets Under Construction						**0**
Additions Purchased	0	0	0	0	0	**0**
Additions Internally Generated	0	0	0	0	0	**0**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations and Government Grants	0	0	0	0	0	**0**
Additions Leased (including PFI/LIFT)	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	(58)	0	0	**(58)**
Impairments/reversals charged to reserves	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption	0	0	0	0	0	**0**
At 31 March 2017	**0**	**2,954**	**43**	**0**	**0**	**2,997**
Amortisation						
At 1 April 2016 (As Restated) *	**0**	**2,669**	**0**	**0**	**0**	**2,669**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as Held for Sale and Reversals	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**	**0**
Upward revaluation/positive indexation	**0**	**0**	**0**	**0**	**0**	**0**
Impairment/reversals charged to reserves	**0**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**
Charged During the Year	**0**	**162**	**0**	**0**	**0**	**162**
Transfers to NHS Foundation Trust on authorisation as FT	**0**	**0**	**0**	**0**	**0**	**0**
Transfer (to)/from Other Public Sector bodies under Absorption	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2017	**0**	**2,831**	**0**	**0**	**0**	**2,831**
Net Book Value at 31 March 2017	**0**	**123**	**43**	**0**	**0**	**166**
Asset Financing: Net book value at 31 March 2017 comprises:						
Purchased	0	123	43	0	0	**166**
Total at 31 March 2017	**0**	**123**	**43**	**0**	**0**	**166**

* The values at 1 April 2016 for Licences and Trademarks have been restated from those presented in the 2015/16 Accounts, to remove the accumulated amortisation and present the correct Net Book Value in the Cost/Valuation section.

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**

15.2. Intangible non-current assets prior year

2015-16	IT - in-house & 3rd party software £000's	Computer Licenses £000's	Licenses and Trademarks £000's	Patents £000's	Development Expenditure - Internally Generated £000's	Total £000's
Cost or valuation:						
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**
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**
Impairments/reversals charged to reserves	0	0	0	0	0	**0**
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**
Net book value at 31 March 2016 comprises:						
Purchased		285	101			**386**
Total at 31 March 2016	0	0	0	0	0	0

15.3. Intangible non-current assets

Asset lives for intangible assets (purchased computer software) range from 0 to 5 years. Assets are initially recognised at cost and amortised over the expected life of the asset. They have not been revalued.

An intangible asset in respect of Carbon Emission Credits is included in the Trust's accounts to reflect the receipt and consumption of these credits. They are valued at market price at 31st March 2017.

16. Analysis of impairments and reversals recognised in 2016-17

	2016-17 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	0
Changes in market price	(5,219)
Total charged to Annually Managed Expenditure	**(5,219)**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(5,219)**
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	58
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**58**
Total Impairments of Intangibles charged to SoCI	**58**
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	**(5,161)**
Overall Total Impairments	**(5,161)**
Donated and Government 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

16. Analysis of impairments and reversals recognised in 2016-17

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total
					£000s
Impairments and reversals taken to SoCI					
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**
Unforeseen obsolescence	0	58	0	0	**58**
Loss as a result of catastrophe	0	0	0	0	**0**
Other	0	0	0	0	**0**
Changes in market price	(5,219)	0	0	0	**(5,219)**
Total charged to Annually Managed Expenditure	**(5,219)**	**58**	**0**	**0**	**(5,161)**
Total Impairments of Property, Plant and Equipment changed	**(5,219)**	**58**	**0**	**0**	**(5,161)**

Donated and Government 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**

17. Commitments

17.1. Capital commitments

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

	31 March 2017	31 March 2016
	£000s	£000s
Property, plant and equipment	**2,659**	2,177
Intangible assets	**0**	0
Total	**2,659**	2,177

18. 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 2016	**1,761**	**2,217**	**0**	**118**	**0**	**0**	**4,096**	0
Additions	37,831	1,336	0	74	0	0	**39,241**	0
Inventories recognised as an expense in the period	(38,061)	0	0	0	0	0	**(38,061)**	0
Write-down of inventories (including losses)	(8)	0	0	0	0	0	**(8)**	0
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	**0**	0
Balance at 31 March 2017	**1,523**	**3,553**	**0**	**192**	**0**	**0**	**5,268**	**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 6 of these Accounts

19.1. Trade and other receivables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**9,462**	10,372	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**5,415**	3,665	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,090**	1,310	**0**	0
PDC Dividend prepaid to DH	**190**	0	0	0
Provision for the impairment of receivables	**(3,134)**	(1,819)	**(156)**	(238)
VAT	**2,003**	1,115	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income excluding PFI lifecycle	**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	**2,074**	1,665	**43,173**	1,084
Total	**17,100**	16,308	**43,017**	846
Total current and non current	**60,117**	17,154		
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.

19.2. Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000s	£000s
By up to three months	**860**	1,038
By three to six months	**1,454**	1,323
By more than six months	**2,708**	2,013
Total	**5,022**	4,374

19.3. Provision for impairment of receivables

	2016-17	2015-16
	£000s	£000s
Balance at 1 April 2016	**(2,057)**	(1,644)
Amount written off during the year	**149**	102
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(1,382)**	(515)
Transfers to NHS Foundation Trust on authorisation as FT	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2017	**(3,290)**	(2,057)

Impairment of receivables is based on an assessment of individual amounts receivable taking into account the age of the debt and other known

20. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	**27,296**	28,382
Net change in year	**(3,394)**	(1,086)
Closing balance	**23,902**	27,296
Made up of		
Cash with Government Banking Service	**23,873**	27,272
Commercial banks	**0**	0
Cash in hand	**29**	24
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**23,902**	27,296
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**23,902**	27,296
Third Party Assets - Bank balance (not included above) See Note 34	**1**	2
Third Party Assets - Monies on deposit	**0**	0

21. Trade and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS payables - revenue	**13,774**	10,203	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**2,652**	2,406	**0**	0
Non-NHS payables - revenue	**12,896**	3,841	**0**	0
Non-NHS payables - capital	**7,218**	4,965	**0**	0
Non-NHS accruals and deferred income	**25,836**	26,966	**0**	0
Social security costs	**3,408**	2,746		
PDC Dividend payable to DH	**0**	347		
Accrued Interest on DH Loans	**0**	0		
VAT	**0**	0	**0**	0
Tax	**2,728**	2,670		
Payments received on account	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**68,512**	54,144	**0**	0
Total payables (current and non-current)	**68,512**	**54,144**		
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	**3,762**	1,158		

22. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
Loans from Department of Health	**0**	0	**0**	0
Loans from other entities	**0**	0	**0**	0
PFI liabilities - main liability	**903**	1,306	**33,953**	25,591
LIFT liabilities - main liability	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**903**	**1,306**	**33,953**	**25,591**
Total other liabilities (current and non-current)	**34,856**	**26,897**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	0	903	**903**
1 - 2 Years	0	2,188	**2,188**
2 - 5 Years	0	5,791	**5,791**
Over 5 Years	0	25,974	**25,974**
TOTAL	**0**	**34,856**	**34,856**

23. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Opening balance at 1 April 2016	**4,707**	4,858	**0**	0
Deferred revenue addition	**5,040**	4,707	**0**	0
Transfer of deferred revenue	**(4,707)**	(4,858)	**0**	0
Current deferred Income at 31 March 2017	**5,040**	4,707	**0**	0
Total deferred income (current and non-current)	**5,040**	4,707		

24. Provisions

	Total	Comprising: Early Departure Costs	Legal Claims	Restructuring	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**4,567**	963	373	70	2,850	311
Arising during the year	**500**	72	181	0	110	137
Utilised during the year	**(910)**	(96)	(215)	(61)	(227)	(311)
Reversed unused	**(47)**	(3)	(37)	0	(7)	0
Unwinding of discount	**45**	13	0	0	32	0
Change in discount rate	**388**	68	0	0	320	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 2017	**4,543**	**1,017**	**302**	**9**	**3,078**	**137**
Expected Timing of Cash Flows:						
No Later than One Year	**1,147**	92	302	9	607	137
Later than One Year and not later than Five Years	**907**	368	0	0	539	0
Later than Five Years	**2,489**	557	0	0	1,932	0

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

	£000s
As at 31 March 2017	154,786
As at 31 March 2016	130,664

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 £2,614,000, HMRC Off Payroll Engagement £325,000 and National Poisons potential expenditure of £74,653

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.

25. Contingencies

	31 March 2017 £000s	31 March 2016 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(188)**	(202)
Employment Tribunal and other employee related litigation	**0**	0
Redundancy	**0**	0
Other - Pension and Injury Benefits	**(92)**	(507)
Net value of contingent liabilities	**(280)**	(709)
Contingent assets		
Contingent assets	**0**	0
Net value of contingent assets	**0**	0

26. Analysis of charitable fund reserves

The Trust has not consolidated charitable funds within this set of accounts

27. 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 Spring 2019. 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 £13,107,786 (2015/16 £10,283,792) 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 and accounts for a Managed Equipment Service (MES) as a PFI scheme. The values below represent the financial obligations relating to the BTC and MES Scheme only

Birmingham Treatment Centre (BTC)

Length of Contract is 30 Years

The purpose of the scheme was to provide a modern, acute facility on the City Hospital site which has now been fully operational since June 2005.The Trust is committed to the full unitary payment until 30th June 2035 at which point the building will revert to the ownership of the Trust

Managed Equipment Scheme (MES)

Length of Contract is 10 Years

The Scheme provides for the maintenance and replacement of the Trust's Imaging Equipment. This contract was assessed against the scope of IFRC12 to establish the appropriate accounting treatment and it was determined that the criteria to account for the scheme as an on SOFP service concession arrangement had been met. The contract, with Siemens Healthcare Limited, commenced on 1st May 2016 and the Trust is committed to the full unitary payment until May 2026 at which point the ownership of the equipment will revert to the Trust

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

	2016-17	2015-16
	£000s	£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	**2,166**	863
Total	**2,166**	863
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**2,570**	929
Later than One Year, No Later than Five Years	**10,286**	3,955
Later than Five Years	**23,242**	17,741
Total	**36,098**	22,625

The estimated annual payments in future years are not expected to be materially different from those which the Trust is committed to make during the next year.

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

	2016-17	2015-16
	£000s	£000s
No Later than One Year	**(5,868)**	2,638
Later than One Year, No Later than Five Years	**12,546**	8,760
Later than Five Years	**34,439**	31,134
Subtotal	**41,117**	42,532
Less: Interest Element	**(14,304)**	(15,635)
Total	**26,813**	26,897

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due	**2016-17**	2015-16
Analysed by when PFI payments are due	**£000s**	£000s
No Later than One Year	**(7,140)**	1,306
Later than One Year, No Later than Five Years	**7,979**	3,990
Later than Five Years	**25,974**	21,601
Total	**26,813**	26,897

Number of on SOFP PFI Contracts

Total Number of on PFI contracts	**2**
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**

28. Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes	2016-17 Income £000s	2016-17 Expenditure £000s	2015-16 Income £000s	2015-16 Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)				
Depreciation charges		**1,723**		450
Interest Expense		**2,145**		2,005
Impairment charge - AME		**0**		1,368
Impairment charge - DEL		**0**		0
Other Expenditure		**2,167**		863
Revenue Receivable from subleasing	**0**		0	
Impact on PDC dividend payable		**(140)**		(284)
Total IFRS Expenditure (IFRIC12)	**0**	**5,895**	**0**	**4,402**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		**6,404**		3,643
Net IFRS change (IFRIC12)		**(509)**		**759**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		2,697		414
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		756		656

	2016-17 Income/ Expenditure IFRIC 12 YTD £000s	2016-17 Income/ Expenditure ESA 10 YTD £000s	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	**1,723**		450	
Interest Expense	**2,145**		2,005	
Impairment charge - AME	**0**		1,368	
Impairment charge - DEL	**0**		0	
Other Expenditure				
Service Charge	**2,167**	**6,404**	863	3,643
Contingent Rent	**0**		0	
Lifecycle	**0**		0	
Impact on PDC Dividend Payable	**(140)**		(284)	
Total Revenue Cost under IFRIC12 vs ESA10	**5,895**	**6,404**	**4,402**	**3,643**
Revenue Receivable from subleasing	**0**	**0**	**0**	**0**
Net Revenue Cost/(income) under IFRIC12 vs ESA10	**5,895**	**6,404**	**4,402**	**3,643**

29. Financial Instruments

29.1. 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 CCG's and the way those CCG's 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 the Trust’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 NHS Improvement. 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.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

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 2017 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 CCG's, 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.

29.2. 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		9,462		**9,462**
Receivables - non-NHS		5,415		**5,415**
Cash at bank and in hand		23,902		**23,902**
Other financial assets	0	0	0	**0**
Total at 31 March 2017	**0**	**38,779**	**0**	**38,779**
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

29.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	0		**0**
NHS payables		13,774	**13,774**
Non-NHS payables		12,896	**12,896**
Other borrowings		0	**0**
PFI & finance lease obligations		34,856	**34,856**
Other financial liabilities	0	0	**0**
Total at 31 March 2017	**0**	**61,526**	**61,526**
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

30. Events after the end of the reporting period

There are no events to report that occurred after the reporting period

31. 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 2016/17 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
NHS Birmingham Cross City CCG
Health Education England
NHS Birmingham South & Central CCG
NHS Walsall CCG
NHS Litigation Authority
NHS Business Services Authority
The Dudley Group NHS Foundation Trust
Walsall Healthcare NHS Trust

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 including Sandwell & West Birmingham Hospitals NHS Trust Charity, certain of the trustees for which are also members of the Trust board. The summary financial statements of the Funds Held on Trust are included in this annual report and accounts.

32. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	196,248	53
Special payments	144,805	76
Gifts	0	0
Total losses and special payments and gifts	341,053	129

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

33. 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.

33.1. 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	2016-17 £000s
Turnover	327,536	348,475	359,161	384,774	387,870	424,144	433,007	439,022	446,590	443,698	460,197
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)	(6,996)
Adjustment for:											
Timing/non-cash impacting distortions:											
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	0	0
Prior Period Adjustments	0	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	0	36,463	9,533	(2,395)	8,872	8,922	(263)	8,390	(5,161)
Adjustments for impact of policy change re donated/government grants assets						358	1,092	334	331	(279)	224
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				(557)	(455)	(640)	0	0	0	0	0
Absorption accounting adjustment							0	0	0	0	0
Other agreed adjustments	5,726	0	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**	**(11,933)**
Break-even cumulative position	**(4,402)**	**2,122**	**4,669**	**11,929**	**14,122**	**15,985**	**22,508**	**29,259**	**33,912**	**37,769**	**25,836**

* 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 %	2016-17 %
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	-2.59
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	5.61

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.

33.2. 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%.

33.3. External financing

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

	2016-17	2015-16
	£000s	£000s
External financing limit (EFL)	56,399	(1,217)
Cash flow financing	46,962	(1,431)
Finance leases taken out in the year	0	0
Other capital receipts	0	0
External financing requirement	**46,962**	(1,431)
Under/(over) spend against EFL	**9,437**	214

33.4. Capital resource limit

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

	2016-17	2015-16
	£000s	£000s
Gross capital expenditure	19,029	20,347
Less: book value of assets disposed of	0	0
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	(62)	(527)
Charge against the capital resource limit	**18,967**	19,820
Capital resource limit	18,968	19,860
(Over)/underspend against the capital resource limit	**1**	40

34. 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 2017	31 March 2016
	£000s	£000s
Third party assets held by the Trust - Patients' Monies	**1**	2

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 2017 on pages 88 to 128 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 set out on page 87, 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 2016, 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 2017.

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 2017 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 Department of Health Group Accounting Manual 2016/17; 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.

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

Other matters on which we report by exception – adequacy of arrangements to secure value for money

We are required to report by exception if we conclude that we are not satisfied that the Trust has made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2017.

In considering the Trust's arrangements for securing sustainable resource deployment, we identified the following matters:

- The Trust incurred a deficit of £11.9 million in 2016/17 against a planned surplus of £6.6 million. This resulted in an underlying deficit of £25.8 million as at 31 March 2017.

- The deterioration in the Trust's financial outturn was due to the Trust not meeting its elective income targets; incurring agency expenditure of £23.2 million against a planned expenditure of £14.9 million and NHSI ceiling of £11.7 million; and only achieving £5.3 million of its £11.3 million allocation of Sustainability and Transformation Funding Income.
- The Trust's two year plan includes a challenging efficiency programme of £49 million and a potential cash flow requirement of £24.5 million which may require an interim revenue support loan during 2017/18 and 2018/19.

On the basis of our work, with the exception of the matters reported above, we are satisfied that, in all material respects, Sandwell and West Birmingham Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2017.

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

1 June 2017

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.

City Hospital patient Norma Davies (right) with her friend Mary Davies (no relation).

April - The cardiology department at Sandwell and West Birmingham Hospitals NHS Trust has been accredited by the British Society of Echocardiology.

May - Kelly Stackhouse won the prestigious Patient's Choice Award at the Royal College of Nursing (RCNi) Awards.

August - Sandwell and West Birmingham Hospitals NHS Trust signs up to RCM Health and Wellbeing Charter.

September - Trust signs contract with Cerner to provide major Electronic Patient Record programme.

December - Work with our Comunity groups to introduce people to the services we offer to HIV and AIDS patients.

January - Robotic X-ray scanner arrives at Sandwell Hospital delivering a much higher quality image and generates a lower dosage of radiation.

June - The Sustainability Garden Party at City Hospital.

July - Dr Parijat De, Consultant in Diabetes & Endocrinology has been appointed as a Clinical Champion for Diabetes UK.

October - Launch of new End of Life care Co-ordination Hub.

November - Zog flies in to help launch Your Trust Charity.

February - Consultant Midwife Kathryn Gutteridge was named Midwife of the Year by the British Journal of Midwifery.

March - Launch of new regional specilist centre for haemoglobinopathy.

Notes

Notes

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