Appendix 1

ANNUAL GOVERNANCE STATEMENT 2011/12

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

1. SCOPE OF RESPONSIBILITY

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

1.2 In my role as Chief Executive of the Trust I fulfil my own responsibilities as its Accountable Officer in close association with the Chief Executive and senior officers of the Strategic Health Authority, the Chief Executives of the local Primary Care Trusts and the Council Leaders of the local authorities. Governance and risk issues are regularly discussed at a variety of Health Economy wide fora, including formal review meetings with the Strategic Health Authority, monthly meetings of Chief Executives and via the Partnership Board for the Health Economy-wide development plan, known as 'Right Care, Right Here'.

2. THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

2.1 The organisation is led by the Trust Board, which in turn is supported in its duties by five committees, as follows:

Audit Committee

Chair: Non –Executive Director

- Considers the annual plans and reports of both the External and Internal Auditors
- Provides an overview and advises the Board of Directors on the internal control arrangements put in place by the Trust Board
- Acts as the co-ordinator of all support documentation in relation to assurance to the Chief Executive for the sign off of the Annual Governance Statement
- Reviews all matters of internal control
- Reviews the annual work plan and monitors progress with the work of the Local Counter Fraud Specialist function
- Liaises with the Quality and Safety Committee as appropriate
- After due process of review recommends the adoption of the Annual Accounts to the Trust Board

Frequency: Five times a year, including a specific meeting to review and approve the annual accounts

Membership: all Non Executive directors (excluding the Chair). The CEO and Director of Finance attend as required.

Quality and Safety Committee

Chair: Non –Executive Director

- Monitors and provides assurance to the Board that clinical services are appropriately delivered in terms of quality, effectiveness and safety
- Ensures that the Trust has effective and efficient arrangements in place for quality assessment, quality improvement and quality assurance
- Where quality and performance falls below acceptable standards, ensures that action is taken to bring it back in line with expectations, and to promote improvement and excellence
- Ensures that service user and carer perspectives on quality are at the heart of the Trust's quality assurance framework

Frequency: Six times per year

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

Finance and Performance Management Committee

Chair: Non –Executive Director

- Considers regular financial reports and forecasts, including prime statement of accounts and supporting analyses and forecasts
- Reviews the performance of the Trust's major clinical and corporate divisions and considers remedial action plans in the case of significant variances/deviations
- Reviews the annual financial plan and budget, prior to submission to the Trust Board for approval
- Monitors performance against external targets set by the Department of Health, Strategic Health Authority, commissioners and Monitor
- Monitors performance against a range of internally developed clinical, financial and operational indicators
- Considers plans and business cases in support of significant investment, prior to presentation to the Trust Board for approval

Frequency: Monthly

Membership: Four Non Executive directors, CEO, Director of Finance and Chief Operating Officer

Remuneration and Terms of Service Committee

Chair: Trust Chair

- Sets the pay and conditions of senior managers
- Recommends the remuneration and terms and conditions of employment for any employees who are not subject to national terms and conditions of service
- Scrutinises and agree any termination payments made to the Chief Executive and Executive Directors
- Ensures the consistent application of the Trust policy on remuneration and terms and conditions of employment for the Chief Executive and the Executive Directors

Frequency: The committee meets as required

Membership: All Non Executive Directors.

Charitable Funds Committee

Chair: Non Executive Director

- Monitors the safeguarding of those assets donated or bequeathed in cash or other forms to the Trust's charitable funds
- Ensures as far as is practical that the expressed wishes of donors or benefactors are met in the deployment of funds.
- Monitors and reviews banking and audit arrangements
- Monitors the performance of the Trust's Charitable Funds portfolio
- Advises on the appointment of investment brokers

Frequency: Four times per year

Membership: All voting Directors

2.2 The Trust Board and its committees are administered by a Trust Secretary who maintains the Directors' Register of Interests and a register of attendance at meetings.

2.3 On an annual basis, the Trust Board is asked to consider and approve a proposed cycle of business for the forthcoming year, which is largely based on the best practice guidelines suggested in the Dr Foster publication, 'The Intelligent Board' and the National Leadership Council's report, 'The Healthy Board'. The reporting cycle is customised with items of local interest and significance to the Board, with matters being categorised into Quality, Safety and Governance; Strategy & Development; Performance Management; and Operational Management sections.

2.4 Integral to the preparation for the Trust's application for Foundation Trust status, is a number of Board development activities and opportunities. An independent facilitation of this work involved a comprehensive assessment of the skills and capabilities of Board members and the associated output has informed a development plan. Given the thoroughness of the external scrutiny and the Board's close engagement with the work, a formal internal self-assessment has not been necessary this year. The Board development work also included observations and feedback sessions on a series of Board and Committee meetings, a review of the Trust's Integrated Business Plan and a preparatory mock Board to Board meeting in advance of formal assessments. Again, the outcome from these processes has been carefully considered by the Board and informed the action plan to address areas in need of development. Finally, the development plan is monitored by the Board on a routine basis.

2.5 The Board considers that the Trust has, throughout the 2011/12 reporting year, applied the principles and met the requirements of the Code of Governance. In summary, the Trust has been headed throughout the by an effective board of directors, which has taken collective responsibility for leading the organisation, exercising its statutory powers and setting the strategic direction of the Trust.

2.6 A particular area of development within the last year has been a revised approach for reporting to the Trust Board on the activities of and matters considered by the Trust's committees. In addition to the minutes of the Committee meetings being presented to the Trust Board as a matter of course, a comprehensive verbal update is provided by the relevant sub-committee Chair following the most recent Committee meeting. Annual reports on the work of each of the Committees are also presented as part of the annual reporting cycle of the Trust Board.

2.7 The publicly held Trust Board meetings cover the full gamut of clinical, corporate and business risk and discuss and monitor the delivery of corporate objectives and the detail of the Assurance Framework. Members of the Trust Board are encouraged to make as wide a range of public contributions in such discussions as possible and a representative from the Local Involvement Networks (LINks) regularly sits with the Trust Board during its monthly public meeting. For major service changes, more targeted work is undertaken to include the patient and public perspective within the decision-making process and associated risk assessments.

2.8 The Board's routine reporting includes a review of performance against the priorities of the Operating Framework, principally through the consideration of an assessment against the NHS Performance Framework. The assessment reported the Trust to be classified as a 'Performing' organisation throughout the year. As part of the work to meet the priorities, good progress has been made in a number of key areas, including the Trust's application for Foundation Trust status. The Trust was also successful in meeting its recruitment and expansion target for Health Visitors and as a result, has been identified as a national pilot site for Health Visitor improvement. In conjunction with this, the Trust is regarded as one of the regional leaders in respect of Family Nurse Partnerships, having delivered a number of measurable improvements for families as a consequence. In terms of Dementia care, a Rapid Assessment Interface and Discharge (RAID) service is fully embedded at the City Hospital site, which has proved highly successful in establishing a good practice model of care for patients with Mental Health difficulties within the Trust.

2.9 In support of the 'Right Care, Right Here' Programme and service reconfiguration proposals, the Trust has met frequently with the Joint Local Authority Overview and Scrutiny Committees in Birmingham and Sandwell. The risk associated with this project and wider Trust objectives is assessed in the context of external influences from patients, public, ministers and the DH and wider societal interests.

2.10 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust's compliance with equality and diversity issues is also monitored through the Equality and Diversity Steering Group, which reports quarterly to the Trust Board. During 2011/12, new Trust services, policies and functions have been subjected to an equality impact assessment, the details of which are publicly available on the Trust's internet site.

2.11 As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and

that member pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

2.12 The Trust has undertaken risk assessments and Carbon Reduction Delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

2.13 The Trust is fully compliant with the CQC essential standards of quality and safety. However within the year, the Trust has been subject to a responsive review of compliance by the CQC in connection with Outcome 17, Complaints. An action plan developed to address the shortfalls identified against the requirements was implemented and has been provided to the CQC for its consideration which recently confirmed its satisfaction with the measures taken. Additionally, within the year, the Trust's position was assessed for compliance against Outcomes 1 and 5, covering the Trust's responsibilities for privacy, dignity and nutrition. Following an initial inspection which reported major concerns at Sandwell Hospital in respect of compliance with Outcome 1, and later moderate concerns, a robust action plan was developed to address the issues raised, which received close Trust Board and Executive oversight. Compliance with the outcomes was confirmed following a third visit by the Care Quality Commission in December 2011.

3. RISK ASSESSMENT AND THE RISK & CONTROL FRAMEWORK

Management of risk and leadership

3.1 Sandwell and West Birmingham Hospitals NHS Trust has a comprehensive, trustwide system for managing risk, based on approved policies and strategies available on the Trust intranet.

3.2 The Trust has a Board approved Risk Management Strategy which identifies that the Chief Executive has overall responsibility for risk management within the Trust. The Chief Executive is supported with his responsibilities by the Director of Governance. All managers and clinicians accept the management of risks as one of their fundamental duties. Additionally the Strategy recognises that every member of staff must be committed to identifying and reducing risks. In order to achieve this the Trust promotes an environment of accountability to encourage staff at all levels to report when things go wrong, allowing open discussion to prevent their re-occurrence.

3.3 In Clinical Directorates, Clinical Directors, supported by Divisional Directors, General Managers and Heads of Nursing are responsible for managing risk. In all non-clinical directorates and departments, the appropriate Executive Director is responsible for managing risk through the chain of reporting.

3.4 The Trust has a designated Head of Risk Management within the Governance Directorate.

Risk management process

3.5 The risk management process is an integral part of the Trust's business planning process and budget setting and performance review frameworks.

3.6 At a strategic level, risks are identified by the nominated directors against the Trust's strategic objectives and Annual Priorities. These identified risks provide information to support the Board Assurance Framework and where risks are identified as being 'serious', these are escalated to the Corporate (Trust) Risk Register and are monitored by the Trust Board and its delegated committees.

3.7 At an operational level, risks are maintained in appropriate local risk registers. Where a risk cannot be managed locally (requiring a supporting business case), has a major impact on service capability or Trust reputation or may result in major litigation, this will be presented for inclusion on the Corporate Risk Register.

3.8 Actions identified from risk assessments are mitigated at the appropriate level, and where actions require escalation, the risk will be escalated to the next tier of risk management.

3.9 The process is to be strengthened within the next year to ensure that those risks that are presented for addition to the corporate risk register will be presented monthly to the Trust Board. The Trust Board will be asked to decide whether a risk should be tolerated or treated. This information will be communicated to the 'owner' of the risk who will provide quarterly updates for the Trust risk register. An overview of the current status of risks on the Corporate Risk Register will be made available to the Trust Board on a quarterly basis.

3.10 The decision to treat a risk will be based on the actions required to mitigate that risk, its resource implications balanced against the possible financial penalty if the risk is realised. Every risk identified is backed up by a full risk assessment which covers the points above and an action plan to enable risk reduction, avoidance, transfer or elimination. The action plan defines the time for completion and who is responsible for carrying out the action. The status of the action plan will be monitored at intervals determined by the risk rating and be presented to the Board in a quarterly report. Any difficulties in meeting the deadlines of the actions or in securing resources to enable mitigation will be reported on the monthly risk register update that the Board receives.

Quality and Risk Profile (QRP)

3.11 The Trust routinely receives its Quality and Risk Profile (QRP), which is used by the Care Quality Commission to assist with identifying areas of potential non-compliance by producing a set of 'risk estimates' of non- compliance, one for each of the 16 essential standards. The QRP is presented to the Trust's Quality and Safety Committee at the soonest opportunity following publication. To date, there have been no matters of significance or concern to draw to the Committee's or Trust Board's attention.

Quality Account

3.12 The Trust has in place robust processes to develop its annual Quality Account. Following the preparation of the Quality Account for 2010 and 2011, a comprehensive action plan was developed to address recommendations raised within the External Auditor's review of Quality Account and to pick up local matters of improvement identified. The progress with the action plan has received significant oversight and scrutiny, both at an Executive level and by the Trust Board via a report to the Audit Committee which is communicated upwards as part of the routine Committee updates.

Transformation Plan Quality Impact Assessment

3.13 A major piece of work undertaken within 2011/12 has been the development of the Transformation Plan, a five year view of how the Trust means to achieve the required cost savings within the period 2012/13 – 2016/17 in line with national efficiency requirements and local strategy. Although acknowledging that efficiency savings within the NHS are an integral part of the yearly cycle of business and financial recovery planning, over the past few years it has become more important than ever to ensure that plans, whilst having the desired efficiency saving element, do not pose a risk to the quality of patient care that the Trust wishes to and does provide. As such, Quality Impact Assessment of plans put forward as part of the 2012/13 element of the Transformation Plan was undertaken, which highlighted some schemes where quality of care may be impacted and in these cases mitigation plans were produced, to minimise the effects of any risk realised. Responsibility for monitoring the actions has been devolved to divisions and where a risk is no longer controlled by those mitigating actions, the matter will be escalated.

NHSLA accreditation

3.14 Building on the successful accreditation against the NHSLA Risk Management general standards at Level 2 in February 2011, work continues to prepare for the reassessment against general standards in February 2013 and the assessment against CNST maternity standards at Level 2 also planned for February 2013.

Corporate risks

3.15 The Trust Board operates a comprehensive risk management system, one of the outputs of which is the corporate risk register. During the financial year risks have been identified which include, but are not limited to, a delay in the approval of the new hospital outline business case, adherence to the essential standards for quality and safety, financial risks associated with any shortfalls in savings plans, new GP led commissioning processes, service line economics, and general staff engagement issues during a period of change. Of these, the most significant new risks concern savings plans as related to the five year Transformation Plan as well as preparing for the introduction of new GP led commissioning arrangements. In each case, detailed consideration of the risk has been undertaken by the Board including approval of the Risk treatment plan, accountabilities, severity (pre and post mitigation) and expected date of completion. The overall risk management processes are designed to capture new risks alongside the monitoring and management of existing risks ensuring that these are mitigated in accordance with the treatment plan.

Board Assurance Framework

3.16 The Trust has a Board Assurance Framework which includes all key components required, including objectives, risks, controls, positive assurance, gaps in control and/or assurance and remedial action. In a recent review by Internal Audit, it was determined that **Significant Assurance** was provided by the Board Assurance Framework, with further areas for development identified to assist the Trust with continued improvement to the effectiveness of the processes in 2012/13.

The Board Assurance Framework is considered on a quarterly basis by the Trust's Governance Board, Quality and Safety Committee and Trust Board.

The Board Assurance Framework informs the declarations made in this Governance Statement.

Gaps in controls and assurance of the management of the risks associated with the delivery of a number of the Trust's objectives were identified, however the Trust has taken remedial action to address them which is reported in the quarterly update of the Board Assurance Framework.

Information security

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

Regular reports are produced to identify information security incidents and the appropriate action planned to reduce the risk impact or likelihood of reoccurrence. These incidents are reviewed by the Information Governance Steering Committee to ensure appropriate action is taken and are also reported on a quarterly basis to the Governance Board through the IM & T governance update.

3.18 Within the year, two serious data security breaches were reported.

In October 2011 a clinical operating diary was found to be missing from a consultant's office but was recovered in February 2012 when it was found inside a set of healthcare records. The Information Commissioner's Office was informed that the diary had been recovered.

In February 2012 a community midwife's car was stolen whilst undertaking a community clinic. The car contained a number of maternity records. The police were informed at the time of the incident and there is an ongoing police investigation. The Trust has controls in place, which have been reinforced to ensure all mobile staff groups are aware of their responsibilities. In parallel, the Trust, as part of the development of an agile working solution, is exploring the use of mobile devices to support this staff group with patient management in the community.

Both incidents were promptly reported to the Information Commissioners Office and Strategic Health Authority.

Counterfraud and Whistleblowing

3.19 The Trust is supported through its Internal Audit function by a Counter Fraud service, that reports routinely to the Audit Committee. The service, whose annual workplan is approved by the Audit Committee, is proactive in its role deterring fraudulent activity within the Trust. A whistleblowing policy also exists and may be accessed by staff via the Trust's intranet, which provides the basis by which legitimate concerns can be fairly, effectively and speedily aired and responded to by the use of internal mechanisms. The policy sets out that concerns should initially be raised at a local level with the facility for employees to register concerns directly with a designated Non Executive Director if necessary. This provides the Trust with the opportunity to address concerns and for remedial action to be taken where appropriate.

Alignment with the local context

3.20 The Trust is working closely with emerging Clinical Commissioning Groups to ensure alignment with their strategies and objectives these bodies have for improving the health, intervention, experience and outcomes for their patients within the overall context of the 'Right Care, Right Here' programme.

Internal Audit opinion

3.21 The **Internal Auditor's Year End Report** and opinion on the effectiveness of the system of internal control is commented on below. The internal auditor's overall opinion is that **Significant Assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The weighted opinion considers specific audit reviews and the level of assurance assigned to each. In addition to this, the overall arrangements put in place by the Board for conducting its own assessment of the system of internal control is reviewed. The principal tool for such an assessment is the Board Assurance Framework (BAF) and the internal auditor concluded that the BAF has been designed and is operating to meet the requirements of the 2011/12 Governance Statement and provides reasonable assurance that there is an effective system of internal control to manage the principal risks to the organisation.

The internal auditor concluded that in his view, taking account of the respective levels of assurance provided for each audit review, an assessment of the relevant weighting of each individual assignment and the extent to which agreed actions have been implemented, that the Trust has a generally sound system of internal control.

5. REVIEW OF EFFECTIVENESS

5.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the

Board Assurance Framework and on the controls reviewed as part of the internal audit work. The overall level of assurance provided by the Head of Internal Audit Opinion for 2011/12 is **Significant**. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by reports and comments made by the external auditor, the Care Quality Commission and the NHS Litigation Authority, clinical auditors, accreditation bodies and peer reviews.

5.2 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Finance and Performance Management Committee, Quality & Safety Committee, Clinical Quality Review Group, Governance Board, Health and Safety Committee and the Adverse Events Committee**.** A plan to address weaknesses and ensure continuous improvement of the system is in place.

5.3 The Trust Board is responsible for reviewing the effectiveness of internal control and the Board is supported in this by its corporate committees.

5.4 The Trust Board has received a quarterly update from the Director of Infection Prevention and Control (a role currently within the remit of the Chief Nurse) on performance against national infection rate targets, together with effectiveness of structures in place to support infection control and measures to ensure continuous improvement in this area

5.5 Individual Executive Directors and managers are responsible for ensuring the adequacy and effectiveness of internal control within their sphere of responsibility.

5.6 Internal Audit carries out a continuous review of the internal control system and report the result of their reviews and recommendations for improvements in control to management and the Trust's Audit Committee.

5.7 Specific reviews have been undertaken by Internal Audit, External Audit, NHS Litigation Authority as well as various external bodies.

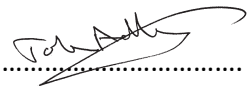
6 Significant control issues

6.1 Within the year, two serious data security breaches were reported, the detail of which is included in section 3.18. In both instances, the incidents were promptly reported to the Information Commissioners Office and Strategic Health Authority.

6.2 Two inspections by the Care Quality Commission which occurred within the year reported that there were concerns over compliance with Outcomes 1 and 5 at Sandwell Hospital, prompting the development of robust action plans to address the issues raised, progress with the delivery of which was given close Trust Board and Executive management and oversight. Compliance with the outcomes was confirmed following the Care Quality Commission's visit in December 2011.

7 Concluding remarks

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

Signed  Chief Executive (On behalf of the Board)

Date 28/06/2012

APPENDIX 2

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

We are required by the Audit Commission 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 2012 ("the Quality Account") as part of our work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). 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 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). We are required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

Respective responsibilities of Directors and auditors

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 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

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

- the Quality Accounts 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 consistent with the requirements set out in the Regulations. We read the Quality Account and conclude whether it is consistent with the requirements of the Regulation and to consider the implications for our report if we become aware of any inconsistencies.

Audit Commission External assurance on NHS Trust Quality Accounts

This report is made solely to the Board of Directors of Sandwell and West Birmingham Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Assurance work performed
We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. Our limited assurance procedures included:

− making enquiries of management;
− comparing the content of the Quality Account to the requirements of the Regulations.

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
The scope of our assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived. 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. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.

KPMG LLP

Chartered Accountants
One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

27 June 2012